WELCOME

Coordination of Care
After Hospital Discharge
Symposium

For wireless access:

Select: **ETF-BOARD** (online access portal)

Pass code: **3TFBoard!**

AGENDA

1:00 pm to 1:15 pm	Welcome and Introductions – Lisa Ellinger and Dr. Tom Hirsch
1:15 pm to 2:15 pm	Keynote Speaker – Dr. Amy Kind, MD, PhD, William S. Middleton VA Hospital *"Transitional Care; Improving Quality, Empowering Patients, Cutting Costs"*
2:15 pm to 2:30 pm	Break
2:30 pm to 3:00 pm	Dr. Hilary Bingol, MD, Gundersen Health System *"Integration of Palliative Medicine into a Lung Cancer Clinic"*
3:00 pm to 3:30 pm	Dr. Patrick Pederson, MD, HealthPartners and Rory Malloy, Senior Performance Improvement Manager, Regions Hospital *"The Journey of Medication Reconciliation: An Important Part of Safe Transition"*
3:30 pm to 3:45 pm	ETF COC Requirements – Dr. Tom Hirsch "*Collaborating to Improve Wisconsin Health Care* "
3:45 pm to 4:15 pm	Q & A – Speaker Panel
4:15 pm to 4:30 pm	Summation and Closing - Lisa Ellinger and Dr. Tom Hirsch

Welcome and Introductions

Lisa Ellinger
Administrator
Department of Employee Trust Funds
and
Thomas Hirsch, MD, MS

KEYNOTE SPEAKER

Amy Kind, MD, PhD
William S. Middleton VA Hospital

Transitional Care:

Improving Quality, Empowering Patients, Cutting Costs

Amy JH Kind, MD, PhD
Assistant Professor, Division of Geriatrics
University of Wisconsin School of Medicine and Public Health
Madison VA GRECC

Health Innovation Program
Integrating healthcare research and practice

Financial Disclosures

- Funding:
  - ✓ NIH/National Institutes on Aging
  - ✓ John A Hartford Foundation
  - ✓ US Department of Veterans Affairs
  - ✓ Wisconsin Partnership Program

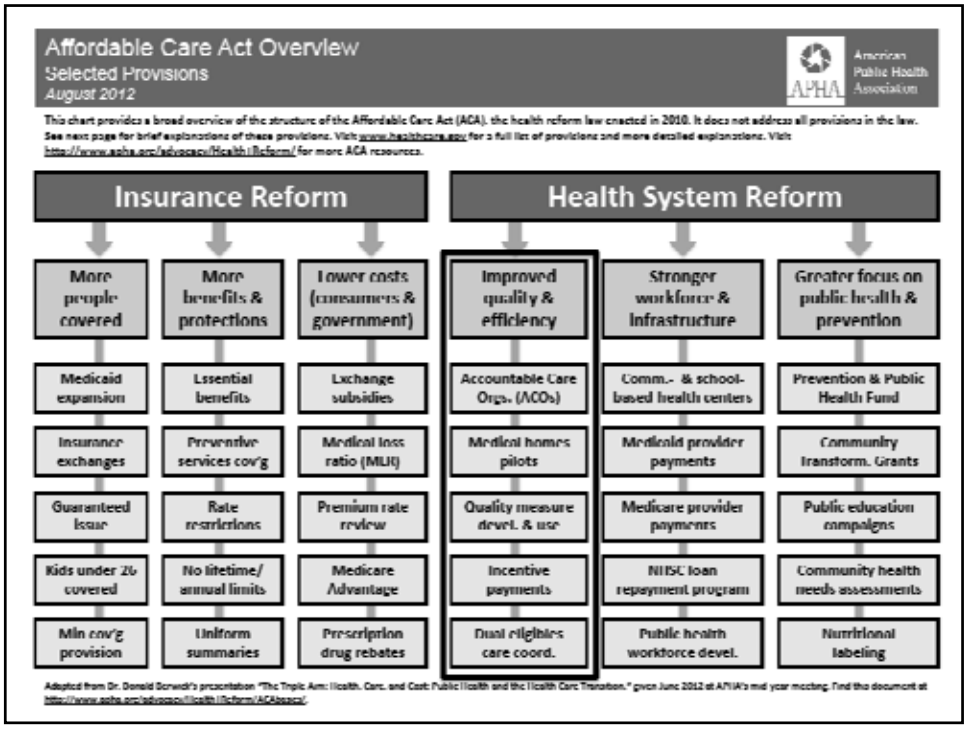
Mr. A's Story

- 65yo hospitalized with allergic reaction to an antibiotic
- Original antibiotic stopped and discharged home on different antibiotic
- Rehospitalized after allergic reaction recurred
- Mr. A reported taking both antibiotics after discharge because staff told him to "be sure to finish your antibiotics"

30 Day Rehospitalizations: A Major Health System Problem

- Affect 1 in 5 hospitalized patients over 65y
- Account for over $30 billion annually
- Major target in health reform

* Jencks et al, *NEJM*, 2009. 360: 1418-28.



Medicare Rehospitalization Reduction Program

- Public reporting of rehospitalization rates
- Medicare payment penalties for 30 day rehospitalizations
  - ✓ Total payments
  - ✓ 2012: CHF, MI, Pneumonia
  - ✓ 2015: COPD, Elective total hip arthroplasty, Elective total knee arthroplasty
  - ✓ Hospital-wide

* Patient Protection and Affordable Care Act, H.R. 3590, Sec. 3025 (2010)

Outline

- Health system fragmentation contributes to rehospitalizations
- Education-based transitional care services decrease rehospitalizations in those going home
- Overview of the Coordinated-Transitional Care (C-TraC) Program

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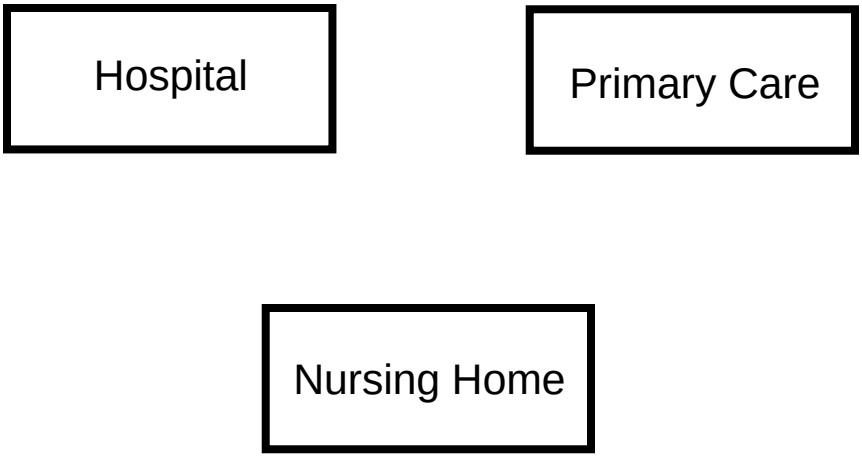
The Problem: Health System Fragmentation



Contributors to Health System Fragmentation

- Organization of the health system into distinct, independent institutions (”silos”)
- Lack of formal relationships/information systems between care settings
- Communication between settings is often poor
- Patients move frequently between care settings
- Transitional care given little emphasis in traditional clinical training programs

* Coleman. JAGS. 2003;51: 549-555; Ma et. Al. J Am Geriatr Soc 2002; 49(4):S35.

Care Transitions Can Be Dangerous

- 41% of patients have laboratory tests pending at time hospital discharge; primary care providers are unaware of 61% of these
- Poor communication of care plans to primary care provider can lead to inappropriate, delayed care
- Over half of rehospitalized patients do not see their outpatient provider between the time of discharge and rehospitalization

*Roy et.al, Ann Int Med, 2005; Moore et al, Arch Int Med, 2007.; Jencks, NEJM, 2009.

Difficult for Patients to Overcome Health System Fragmentation

- Patients are often not prepared for next setting
- Little patient empowerment in hospital
- Lack of patient education

* Coleman. JAGS. 2003;51: 549-555.

Outline

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Definition

- *Transitional Care:* A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location

* Coleman. JAGS. 2003

Transitional Care Services Combat System Fragmentation

- Health care staff bridge the hospital and home
- Post-hospital home visits to teach patients about their care and conditions
- Not designed for dementia patients
- Usually exclude nursing home patients

* Naylor, JAMA, 1999; Coleman, Archives, 2006.

Transitional Care Model

- Nurse practitioners
  - ✓ Visit patient in hospital
  - ✓ Discharge planning
  - ✓ Series of post-hospital in-home visits
  - ✓ Available to patient 7 days/week for 3 months
- RCT:
  - ✓ 45% fewer rehospitalizations at 24 weeks
  - ✓ $3031/patient savings at 24 weeks– unclear if this includes costs of intervention

* Naylor, JAMA, 1999

Care Transitions Intervention

- Nurse practitioner
  - ✓ Visits patient in hospital
  - ✓ Coaching of patient
  - ✓ Series of in-home visits post-hospital x 4 wks
- Four Pillars of Transitional Care ™
  - ✓ Medication self management
  - ✓ Patient centered record
  - ✓ Follow-up
  - ✓ Red flags
- RCT: 34% lower 90 day rehospitalizations, $488/patient saved in hospital costs not including cost of intervention

* Coleman. Archives. 2006

Others

- Project RED
  - ✓ Re-engineering of the discharge process
  - ✓ Discharge advocate, specialized discharge packet, post-hospital call by pharmacist
  - ✓ RCT: 25% fewer 30-day ER visits; lowered rate of hospital use; cost?
- Project BOOST
  - ✓ Sponsored by society of hospitalist medicine
  - ✓ Mentored intervention tailored to each hospital
  - ✓ Outcomes: mixed; cost?

* Jack, Annals of Internal Med, 2009; www.hospitalmedicine.org

Limited Cost-Effectiveness Data

- Little information on per patient costs of real-world implementation
- Enrollment/efficiency appears to be key
- Patient refusals appear to be a major issue in implementations of home-visit based transitional care programs
  - ✓ >50% refusal rates in 2 studies*

* Stauffer et al, Archives, 2011; Voss et al, Archives, 2011

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Available Transitional Care Models: Not Appropriate for Madison VA Hospital

- Home visits impractical given patient dispersion
  - ✓ Veterans travel up to 4.5 hours
  - ✓ 75% reside beyond the reach of a home visit
- No randomized controlled trials of telehealth interventions to support transitional care
- Currently available models exclude dementia
- None tested within a VA setting

* Kind, *Health Affairs*, 2012.

VA Coordinated-Transitional Care Program (C-TraC)

- Phone-based program
- Specially-trained RN nurse case manager
- Protocolized encounters
- Teachings based on theory of Spaced Retrieval*
  - ✓ Method of learning information by practicing recalling that information over increasingly longer periods of time
  - ✓ Applicable in early stages of dementia
- Caregivers involved, activated at each step

* Bourgeois, et al, J Comm Disord, 2003; Camp et al, Appl Cog Psych, 1996.

C-TraC Goals

1. Educate and empower the veteran/caregiver in **medication management**
2. Ensure the veteran/caregiver has **medical follow-up**
3. Educate the veteran/caregiver regarding **red flags**
4. Ensure the veteran/caregiver knows **whom to contact** if questions arise

* Kind, *Health Affairs*, 2012.

Veteran Eligibility

- Hospitalized on non-psychiatric acute-care ward
- Discharged to community

AND one or more of the following:

1. Have documentation of dementia, delirium or cognitive impairment
2. 65 years or older AND
   - lives alone OR
   - had a previous hospitalization in past 12 months

* Kind, *Health Affairs*, 2012.

Protocol: Identification

NCM = 'Transitional Nurse-Case Manager'

- Veteran identification
  - ✓ NCM reviews daily electronic list of all hospitalized veterans
  - ✓ NCM participates in daily multi-disciplinary discharge round on each targeted inpatient ward to offer transitional care and outpatient viewpoint to inpatient care team

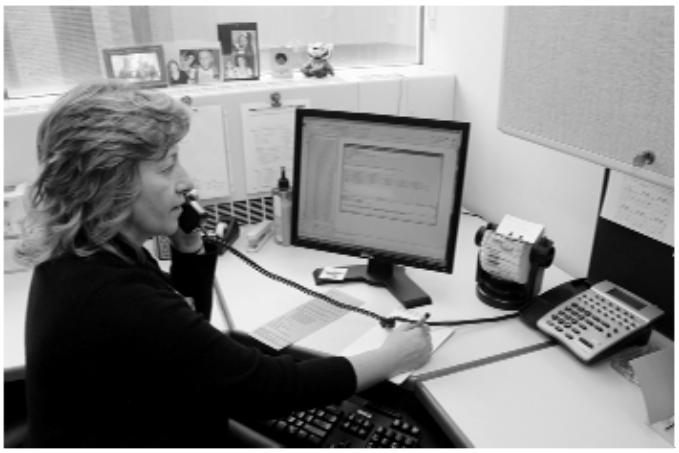
* Kind, *Health Affairs*, 2012.

Protocol: In-Hospital Visit

- NCM meets with eligible veteran during their hospital stay for a brief educational intervention
  - Introduction
  - Medical follow-up
  - Red Flags
  - Contact information
- Contact reinforced by a brightly colored ½ page handout documenting 3 red flags, date/time of next NCM call, date of next f/u appointment and contact information for NCM and triage nurse

Protocol: In-Hospital Visit

Protocol: Telephone Follow-up



Protocol: Telephone Follow-up

- Initial call is 48-72 hours after discharge with caregiver/veteran to reinforce
  - ✓ Medication management
  - ✓ Medical follow-up
  - ✓ 3 Red flags
  - ✓ NCM contact information
- Medication discrepancies or red flags prompt additional action
- Coordination with PCP

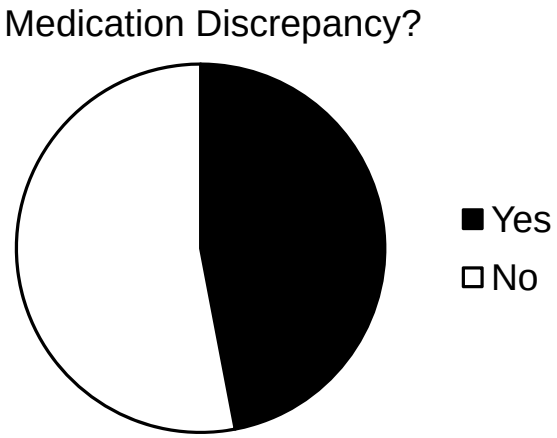
A Note on Medication Counseling

- Veteran is asked to have all pill bottles in front of them during initial call
- Veteran is asked: "Tell me how you take your medications." NOT "Do you take drug X?"
- Good medication reconciliation and counseling takes the bulk of the phone time during the follow-up calls
  - ✓ Average 36 min/call

Veterans Served

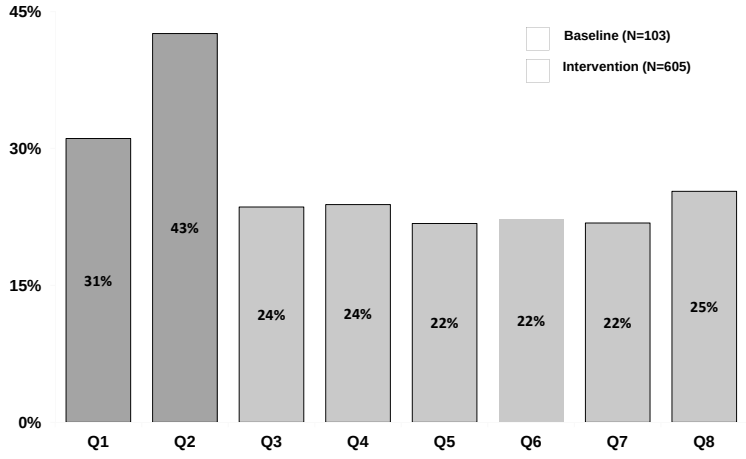
- 605 Veterans approached, enrolled over first 18 months
- 5 approached and refused (<1%)
- ~1/3 of veterans had caregivers
- 22% had dementia/cognitive impairment

Percent of Veterans with Medication Discrepancy Detected at 48-72h by C-TraC



* Kind, *Health Affairs*, 2012.

30-Day Rehospitalization Rates for Veterans in VA C-TraC Program During Baseline and Intervention Periods, Overall



Q = 3-month period (ie. quartile)
Average rehospitalization rates for baseline (34%) and intervention (23%), P-value = 0.013

Multivariate Analysis

C-TraC Group (N = 500)	30 Day Rehospitalization		
	Adjusted** Odds Ratio	95% CI	P-Value
Establishment period (Months 1-6), n = 103	1.00		Ref
Intervention period (Months 7-18), n= 397	0.56	(0.33, 0.94)	0.029

**Multivariate logistic regression model adjusted for veteran age, gender, race, Medicaid status, education level, VA service connected status; whether veteran lives alone; presence of dementia/other cognitive impairment/delirium; charlson comorbidity score; needing more help with bathing, dressing, transferring and toileting in 2 weeks prior to hospitalization; decline in ability to stand or walk in 2 weeks prior to hospitalization; and whether veteran manages own medications

* Kind, *Health Affairs*, 2012.

Estimated Cost Avoidance

- Total up-front program cost = $250/veteran enrolled
- Gross direct cost avoidance of $966,167 over 18 months
- After accounting for all programmatic costs, net cost avoidance of $1,225/veteran enrolled

* Kind, *Health Affairs*, 2012.

Limitations

- Single site
- Current data relies on pre-post design
  - ✓ Adjusted analyses, prolonged assessment to maximize rigor
  - ✓ Multi-site RCT would offer stronger data

* Kind, *Health Affairs*, 2012.

Next Steps for C-TraC

- UW launched July, 2013
- Expansion to Tomah and Iron Mountain VAs
  - ✓ ORH funding successfully obtained ($1.5m over 3y)
  - ✓ Spring 2014 for launch
- Free on-line toolkit (www.hipxchange.org)
  - ✓ >145 downloads since December 2012
- RCT funding in review

Next Steps for C-TraC

- Expansion to other populations
  - ✓ Nursing home and rehabilitation patients
    - Pilot launched April 2013

What Can You Do?

- Consider incentivizing transitional care quality
  - ✓ Monitor rehospitalizations
  - ✓ Payments for transitional care programs
  - ✓ Encourage adoption of transitional care programs
  - ✓ Support platforms, like conferences or web portals, for program dissemination
  - ✓ Educate members about the importance of transitional care

Acknowledgements

Collaborators/Mentors

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•Madison VA GRECC
•UW Hartford Center of Excellence in Geriatrics Medicine and Education
•UWHC Quality Through Safety Grant
•VA T-21 Funding: Innovative Patient Centered Alternatives to Institutional Care
•VA Office of Rural Health Funding
•Wisconsin Partnership Program New Investigator Award

Health Innovation Program
Integrating healthcare research and practice

BREAK

"Integration of Palliative Medicine into a Lung Cancer Clinic"

Hilary Bingol, MD
Gundersen Health System

Introduction to Palliative Medicine Out-Patient Clinic

Hilary Bingol, MD
Palliative Medicine
Gundersen Lutheran Health System

GUNDERSEN HEALTH SYSTEM.

Palliative, Palliate

- 1. to make seem less serious
- 2. to make less severe or intense
- 3. to relieve the symptoms of a disease or disorder.

Historically- the Palliative Approach

- Original medical approach was focused on helping the patient to not suffer as there were not a lot of options for treatment.
- When things started to become more complex, this is when medicine changed it's focus.

Definition of Palliative Care

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

73FR 32204, June 5, 2008
Medicare Hospice Conditions of Participation Final Rule

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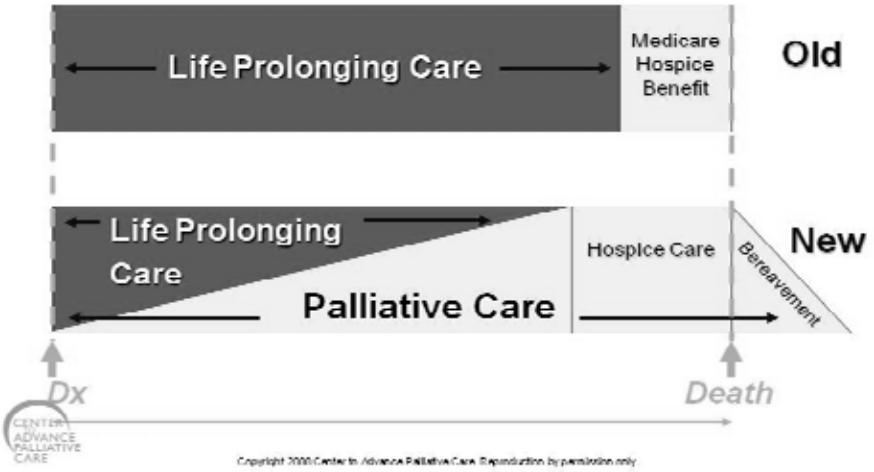
Conceptual Shift for Palliative Care



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How Does Palliative Care Differ From Hospice?

- Non hospice palliative care is appropriate at any point in a serious illness. It is provided at the same time as life-prolonging treatment. No prognostic requirement, no need to choose between treatment approaches.
- Hospice is a form of palliative care that provides care for those in the last weeks/few months of life. Patients must have a 2 MD-certified prognosis of <6 months + give up insurance coverage for curative/life prolonging treatment in order to be eligible.

(Medicare Hospice Benefit: 84% Medicare, 5% Medicaid, 3% uninsured)

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Why Palliative Care? Quality.

Defined as care that is:

1. Beneficial
2. Patient centered
3. Efficient
4. Timely
5. Safe
6. Equitable

National Quality Forum (www.qualityforum.org)

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Palliative Medicine Consults At Gundersen Lutheran Health System

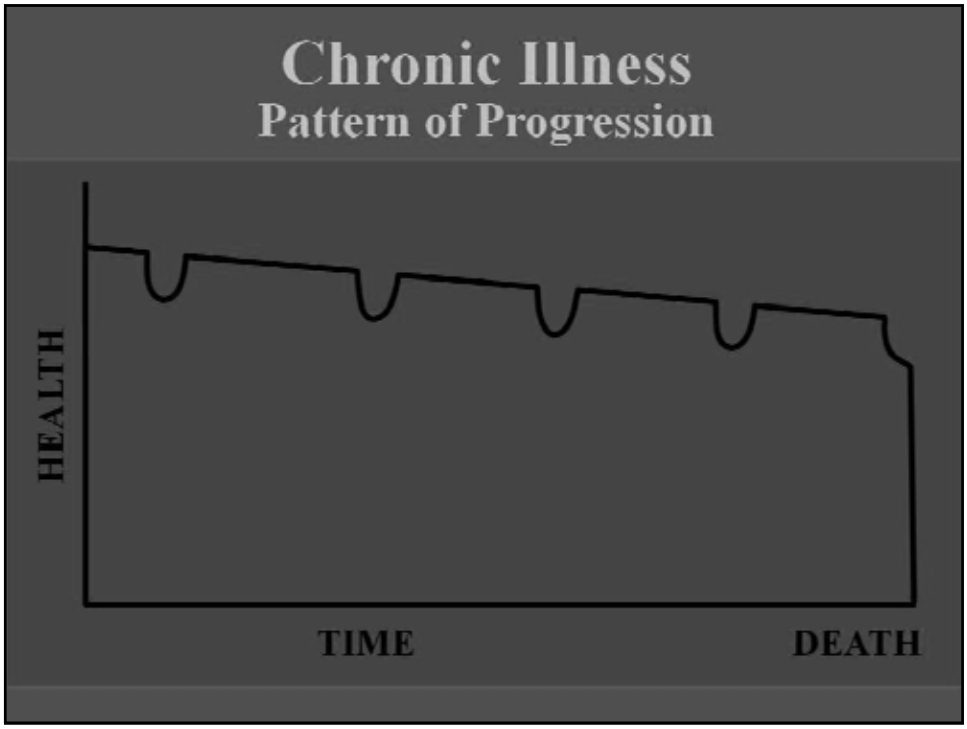
- Three Pronged approach
  - Aggressive and complex Symptom management
  - Establishment of Goals of Care through:
    - Advanced Directives
    - POLST
    - Next Steps
  - Close Follow up and Readdress goals of care throughout treatment with transition to hospice if and when appropriate.

CMS Demonstration Project 646

- The 646 Demo project was opened in early 2006, seeking collaboration with **integrated health systems**
- 646 aimed at testing new **comprehensive approaches to care** that would improve quality and reduce cost

Target Population: Patients with Chronic Illness

- 75% of all US health care expenditures are associated with diagnosis and treatment of chronic diseases (CHF, CAD, COPD, DM, Cancer), which increase in frequency and impact as we age.
- Providing responsible, sustainable care for this population is perhaps THE medical challenge of your and my careers.



Why Gundersen Lutheran?

- Institutional priority of national leadership and key positive attributes
  - International leader in advance care planning
  - Identified nationally as a high quality, economically sustainable health care system
  - Successful care coordination and palliative care programs
  - Integrated health care system in mid-sized community

Brief early history

- Dr. Hammes and palliative team asked in Jan 2006 by administration to develop an approach to care utilizing GL system to demonstrate quality care
- Proposal developed and sent in September of 2006
- GL and two other applicants nationally were chosen from hundreds of interested health care systems
  - Final approval: Spring 2009
  - Project commenced: Feb 2010

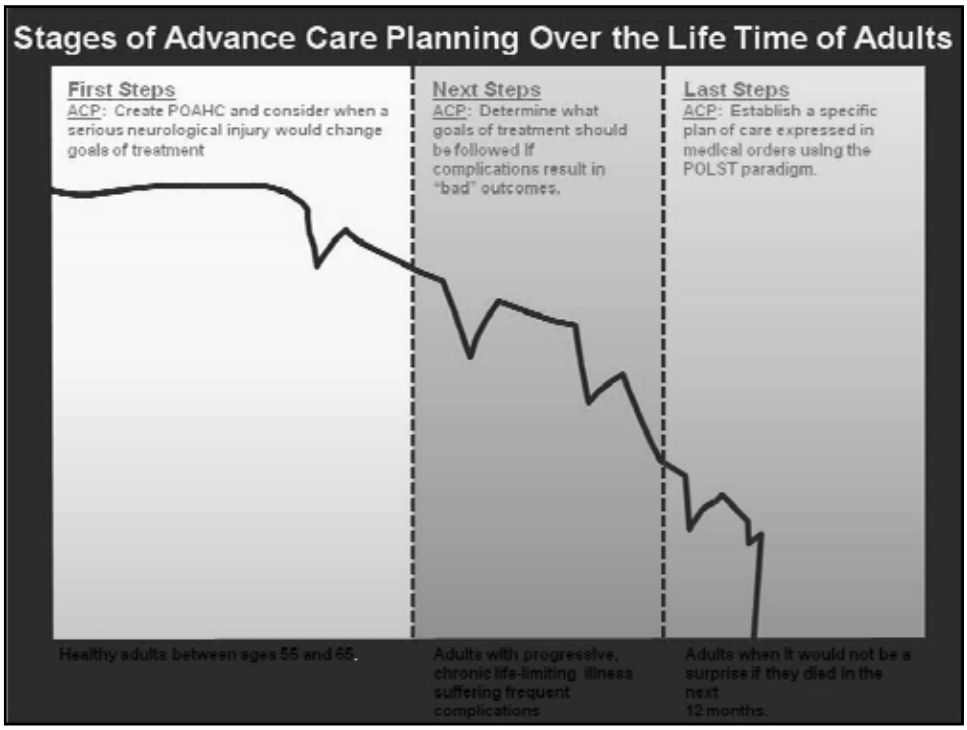
Elements of Care Model

- Care model is a linked service model focused on utilizing GL health system to effectively address challenges of advanced chronic illness.
- Key elements are:
  - advance care **planning**
  - Skilled **coordination** of subsequent care
  - **Acute care support** tailored to patient circumstance and goals

Element 1: advance care planning

New Advance Care Planning tool, called "Disease Specific Patient Centered Advance Care Planning", (DS-PCACP) developed at GL over past decade

- 60-90 minute structured conversation with patient **and surrogate**
- Specific to chronic illness (e.g., CHF) with deeper, richer narrative gathering and documentation
- Similar to palliative bedside conversations, but replicable and directly researched
- Named "**Next Steps Conversation**" for marketing/demo project



Element 2: care coordination

- Developed at GL in 2001-4 in conjunction with health plan
  - Utilizes experienced RN/SW team (avg RN work exp. 27+ years!)
  - Focused on providing quality nursing and managing resources to high resource utilizing patients
- Many positive outcomes…
  - Improved patient satisfaction and quality of life
  - Reduced resource utilization

Care Coordination outcomes

- For patients enrolled and alive for 2 years after activation
  - **32.5**% decrease in hospitalizations
  - **29.5**% decrease in inpatient days
  - **49**% decrease in ED visits
  - Total cost savings per patient greater than $**15,000** per patient per year
- Substantial positive impact on quality of life as well

Element 3: Palliative Care

- Consultative service created in 1997, expanded in 2005 to current model
  - Inpatient consulting/admitting 7 day/wk,
  - Outpatient consultative service with primary follow up when needed.
  - Many positive outcomes identified
    - Improved family satisfaction with care
    - Reduced resource use/cost

More Medical Care Leads to *Lower* Satisfaction with Care

Family members of decedents in high-intensity hospital service areas report lower quality of:

- Emotional support
- Shared decision-making
- Information about what to expect
- Respectful treatment

Teno et al. JAGS 2005,53:1905-11

Physicians practicing in high health care-intensity regions report more difficulty:

- Arranging elective admissions
- Obtaining specialty referrals
- Maintaining good doctor-patient relations
- Delivering high quality care

Sirovich et al. Annals Intern Med 2006, 144:641-649

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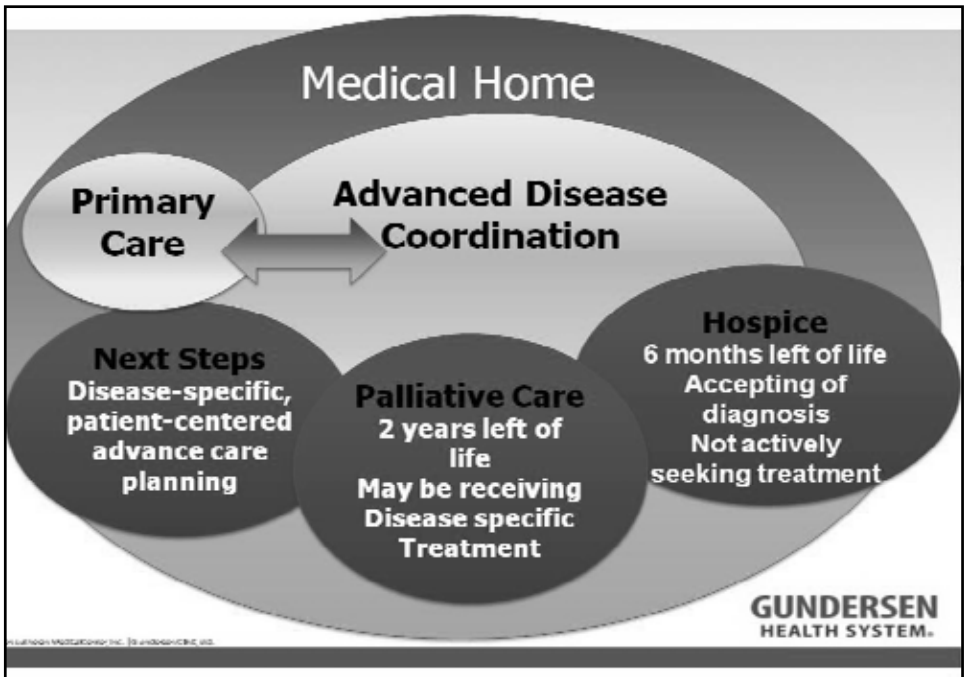
GL Post death family satisfaction data

- In 2006, families of patients who died at GL were surveyed for satisfaction with care received
- There were 131 respondents
  - 75 palliative
  - 56 control
- Families of patients seen by palliative care had equal or higher satisfaction scores than controls in nearly all categories



When to consult Palliative Medicine

Criteria for a Palliative Care Assessment

A potentially life-limiting or life-threatening condition and . . .

Primary Criteria

- The "surprise question": You would not be surprised if the patient died within 24 months or before adulthood 23–25
- Frequent admissions (e.g., more than one admission for same condition within several months)26–30
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)6, 31
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)6
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)6, 31

Secondary Criteria

- Admission from long-term care facility or medical foster home
- Elderly patient, cognitively impaired, with acute hip fracture
  Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Current or past hospice program enrollee
- Limited social support (e.g., family stress, chronic mental illness
- No history of completing an advance care planning discussion/document

JOURNAL OF PALLIATIVE MEDICINE
Volume 14, Number 1, 2011
*Mary Ann Liebert, Inc.
DOI: 10:1089/jpm.2010.0347

How We are Integrating Palliative Care into Oncology

An Integrated Lung Clinic with Palliative Medicine

Our first step

How does this look?

- We have a multispecialty clinic with
  - The patient and their family
  - Radiation Oncology
  - Medical Oncology
    - Possibly a Fellow or resident
  - Palliative Medicine
    - Sometimes a Care Coordinator
    - Occasionally a Chaplain
    - Social Worker usually meets prior
  - Occasionally a Cardiothoracic surgeon

What does the patient think?

- The feedback we get is:
  - They appreciate the team work that goes on before their eyes.
  - They like only having to tell their story once.
  - They are able to get their family together for 1 big appointment rather than 3 separate ones.
  - They can feel overwhelmed by us all.

Are there downsides?

- Initially, the oncologists struggled with how to introduce me.
- The patients and family often heard my specialty and immediately assumed they were dead.
- It is hard to fit my conversation into this hour long apt.

The Flipside?

- Now the oncologists are more comfortable introducing me to any of their patients.
- More people are learning about us and expect us there, it is becoming expected.
- We have developed a rhythm. They start the conversation and I wrap up unless the Social Worker informs us the patient and family are not interested in treatment, then I might start.

How has this changed our involvement in lung cancer patient care?

- Patients are more apt to see us in follow up than if they meet us after they meet the other specialists.
- Patients have their advanced care planning conversation earlier and can help to come up with THEIR goals of care.
- The unexpected benefit: The providers seem less worried about patients choosing no treatment or limited treatment.

Where is this leading us?

- We are now working with both Radiation and Medical Oncology to make "mandatory" consults on all patients with Stage IV cancer
- Nursing staff have been empowered to place these consults.
- Exception for now is Head and Neck
  - We are working through this.

Can this be automated.

- We have started a Best Practice Alert on our Electronic Medical Record.
- Right now it is alerting for CKD and Cardiac Disease and COPD
- Our hope is to add Cancers and Neurological disorders such as ALS, Parkinson's, Dementias etc.

Thank you for your time…Questions?

- References: CAPC.org, Journal of Palliative Medicine and Gundersen Health System Respecting Choices®

"The Journey of Medication Reconciliation:
An Important Part of Safe Transition"

Patrick Pederson, MD
HealthPartners
and
Rory Malloy
Senior Performance Improvement Manager
Regions Hospital

Regions Hospital
HealthPartners Family of Care

HealthPartners

Park Nicollet

HealthPartners
Our Current Journey with Medication Reconciliation
November 7, 2013

Discussion Leaders:
Physician Lead: *Patrick Pederson, MD*
Improvement Lead: *Rory P. Malloy, MPH*

Regions Hospital®
HealthPartners Family of Care

HealthPartners®

Park Nicollet®

The Organization

HealthPartners -Mission & Vision

Who we are

Head + Heart, Together

MISSION

why we're here

Improve health and well-being in partnership with our members, patients and community.

VISION

where we're headed

Health as it could be, affordability as it must be, through relationships built on trust.

HealthPartners – Integrated Care

Integrated Care – Health Plan

Health Plan

- 1.4 million health and dental members in Minnesota and surrounding states
- Product Design – tiering and defined contribution plans, based on cost/quality, shared savings/withholds based on triple aim results
- Consumer Cost Sharing – 25% of plan members have coinsurance or high deductible products

Integrated Care – Medical Clinics

Medical Clinics

- One million patients
- 1,700 physicians
- 55 medical & surgical specialties
- 45 primary care clinics
- Multi-payer

Integrated Care – Dental Clinics

Dental Clinics

- 60 dentists
- 21 locations
- Specialties: oral surgery, orthodontics, pediatric dentistry, periodontics, prosthodontics

Integrated Care – Education, Research & Foundations

Education, Research & Foundations

- HP Institute for Education & Research
- International Diabetes Center
- Foundations (Hudson, Lakeview, Park Nicollet, Regions, Westfields)

Integrated Care - Hospitals

Hospitals

- Regions: 454-bed Level One trauma & tertiary care center
- Methodist: 426-bed acute care
- Lakeview: 97-bed acute care
- Hudson: 25-bed critical access
- Westfields: 25-bed critical access

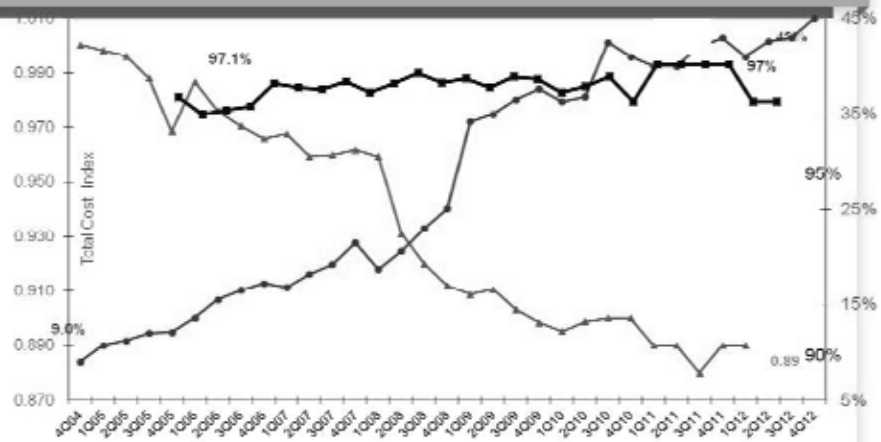
The Triple Aim

Improved
Health of the
population

Exceptional
Experience
for the
individual

Improved
Affordability

TRIPLE AIM: Health-Experience-Affordability
HealthPartners Clinics



Partners for Better Health Goals 2014-Summary

Health Success	Experience Success	Affordability Success
Improved health for our customers and community as measured by: •Better well being, more satisfied and healthy lives. •The best local and national health outcomes and the best performing health care costs in the region.	**Deliver an exceptional experience that customers want and deserve at an affordable cost as measured by:** •The best performance on customer's willingness to recommend our clinics, hospitals and health plan to family and friends. •Feeling well-supported, respected and cared for throughout life.	**Lower health care costs for our customers as measured by:** •Cost trends that are at or below general inflation (Consumer Price Index, a leading economic indicator). •The best performing overall health care costs in the region. •HealthPartners clinics and hospitals will be in the best 10 percent in the region in overall costs of health care.

Results

- Health Plan
  - 94th percentile for NCQA commercial insurance plan rankings
  - 97.5th percentile for Medicare
  - Medicare 5 star rating
- AMGA Acclaim Award Recipients
- The National Committee for Quality Assurance - Accountable Care Organization Accreditation
- State of MN and NCQA Health Care Home and Medical Home designation

Continued Results

Regions Hospital

- Leapfrog Group's Top Hospital designation 2009/10/11/12
- "Distinguished Hospital" by HealthGrades – top 5% in the nation, and "America's 100 Best Hospitals" for Pulmonary Care, Stroke Care and Critical Care.
- Joint Commission Top Hospital 2013
- "Highest Value" hospital by Leapfrog.
- "Most Wired" by Hospitals & Healthcare Networks for use of EMR.

Take me to
Regions Hospital

Continued Results

- Benchmark employee and physician satisfaction
- Growth
  - 20% increase in medical plan membership over three years
  - 15% in dental plan
  - Regions Hospital achieved the Twin Cities top market share position in 2011
  - Clinic active patients increased

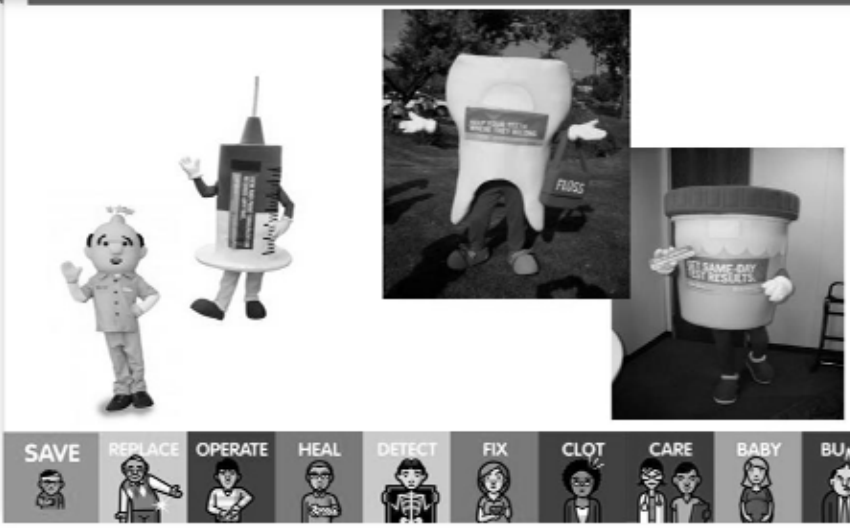
Strategies to Success

- People
  - A highly engaged team delivering on the Triple Aim through Head and Heart together as measured by
    - Organizational results
    - Engagement index
    - A diverse team serving a diverse community
- Health
  - Improved health for our patients, members, and community as measured by:
    - Better well-being, more satisfied and healthy lives
    - The best local and national health outcomes and the best performing health care costs in the region

Strategies to Success

- Experience
  - Interact with those we serve to create exceptional and affordable experiences as measured by:
    - Improved experience
    - Earned the respect and trust for patients, members, and families
    - Recognition of the value of our care and services
    - Engaged and informed patients and members
- Stewardship
  - Deliver greater value, growth, and financial results as measured by
    - Growth in members and patients
    - More affordable care and coverage
    - Financial strength
    - Leadership integrity
    - State and federal reform that furthers our mission

An Organization with Mascots



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Medication Reconciliation

Medication Reconciliation by the Numbers

- Average number of medications per person *(Kaiser Family Foundation, 2011)*
  - Minnesota: 11.8
  - Wisconsin: 12.9
- Average number of clinic visits per person per year *(CDC 2011)*:
  - 300 visits per 100 patients annually
  - That's three opportunities per year for medications to change
- Pharmaceutical Research and Manufacturers of America (PhRMA) estimates 50-75% of all adults do not take their medications properly

Inpatient Med Rec - Background

- 40% of inpatient medication errors due to poor reconciliation on admission (Rozich 2004)
  - 20% of these errors lead to direct patient harm

The Joint Commission

- Joint Commission Patient Safety Goal since 2006
- Society of Hospital Medicine study 2006 showed only 48% of hospitals fully implemented
- CMS EHR meaningful use goal of 50% reconciliation (April 2013)

Current Efforts Nationwide

- Organic development process
  - Medication Reconciliation efforts aimed at transitions of care (TOC) and hand-offs/hand-overs
  - Focus has been on high risk/complex patient groups (the 1%)
  - Estimated that this 1% consumes 21% of healthcare dollars *(Kaiser Health News, 2013)*
- Medication Reconciliation teams are multidisciplinary
  - Need for nurses, pharmacists, physicians, and other healthcare experts to come together

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Medication Reconciliation at Health Partners

HealthPartners Medical Group
Continuous Reinforcement

- Independent nursing visits
  - Review medication bottles
  - set up "pill boxes" for patients
- Post-discharge phone visits
- Focus on Care Transitions
- Online Services
  - 34% of all HP subscribers have accounts
  - Access to their most up to date medication list
- Development of the Medication Transitions Management (MTM) program
  - One-on-one patient counseling with a pharmacist

HealthPartners Medical Group
Care Model Process Regarding Medications

Rooming Staff

- Interview patient & document meds patient taking in electronic record

Provider

- As part of initial assessment, review medication list
- Complete assessment & treatment plan, including instructions regarding medications

Care Team

- Provide plan of care to patient (After Visit Summary)
- AVS includes med list
- Order refills as necessary

HealthPartners MTM Program Pillars

- MTM services leverages pharmacists' unique skill set
- Optimize the medication use experience for patient resulting in:
  - Improved health outcomes
  - Reduced drug related morbidity and mortality
  - Reduced total cost of care
- MTM services are most effective when delivered through existing patient relationships and when they are integrated with primary care
- Drug therapy problems are identified and resolved in the context of the whole patient
- Optimal medication use occurs on a continuum and requires ongoing evaluation and assessment
- MTM services especially helpful for complex and elderly patients

MTM Program Goals

Decrease number of ER visits and hospitalizations

Decrease other health care costs linked to medication-related problems

Increase productivity of other providers

Improve the quality of life for patients

Nursing Home Transitions

- Affects nursing homes within the care network
- Patients at high risk
  - Complex
  - Geriatric
  - Dementia
- Electronic medical record linkages
- Person-to-person sign-outs

Care Plans

- Longitudinal visibility of medications plans for high risk patients
- Multi-disciplinary and multi-department
- Initially developed to stem tide of opiate dependence and/or ER overuse
  - Implementation after 2 months with 27 high risk patients cut ER visits by 65% and yielded $511,000 in savings
- Has led to expansion in other high risk areas (eg CHF, coronary disease)

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Our Challenges and Progress

Obstacles to Implementation

- Patients do not know their medications
  - The more medications, the less accurate the list
- Shared responsibility – no responsibility
  - Pharmacy vs. Physicians vs. Nursing
- Time consuming
- Historically minimal utilization or involvement of pharmacy staff
- Lack of a consistent medical record
- Expensive $$$
- Legal obstacles

Regions Hospital Experience

- Inpatient strategy implementation has been pursued over last 8 to 10 years
- Pilot was implemented in 2011-12, but failed due to legal obstacles
- Financial return on investment was unclear
- Due to obstacles it has not been given the strategic priority

Regions Hospital Moving Forward

- Engagement of the enterprise (HP) as well as the hospital
- Engagement of the hospitalist physician group and pharmacy
- ED and Mental Health Unit pilot
- Implementation of Medication Indication Project
  - At least 50% of hospitalist group participating
  - On over 70% of patient encounters the indications are added
  - Overwhelmingly favored by RNs, PharmDs, and patients (95+%)

Regions Hospital Redefining Process

- Accurate
  - Formulary specific
- Timely
  - Within an hour of admission
  - Med Rec Consult service
- Complete
  - Name – dose – route – frequency
  - New addition: indications

Regions Hospital Moving Forward

- Independent monitoring of patient medication compliance
  - Utilizing outpatient pharmacy claims data
  - Physician alerts
- Utilization of med rec implementation tools
  - SHM Marquis project
  - Structures the intervention
  - Provide estimates of ROI

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Preliminary Results

Patient Experience with MTM

- After first full year of program, participants reported the following:

92%
- Said they 'always' or 'usually' followed recommend-actions

97%
- made one or more lifestyle changes that could reduce their need for medicine

88%
- said they had 100% medication adherence

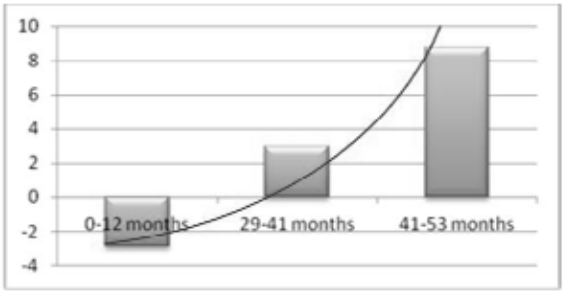
74%
- said they were able to keep glucose at optimal level

85%
- said that the program was completely worth their time

99%
- said that they would recommend HealthPartners MTM to their friends or family

MTM Financial Impact

- Return on Investment (12-month intervals)

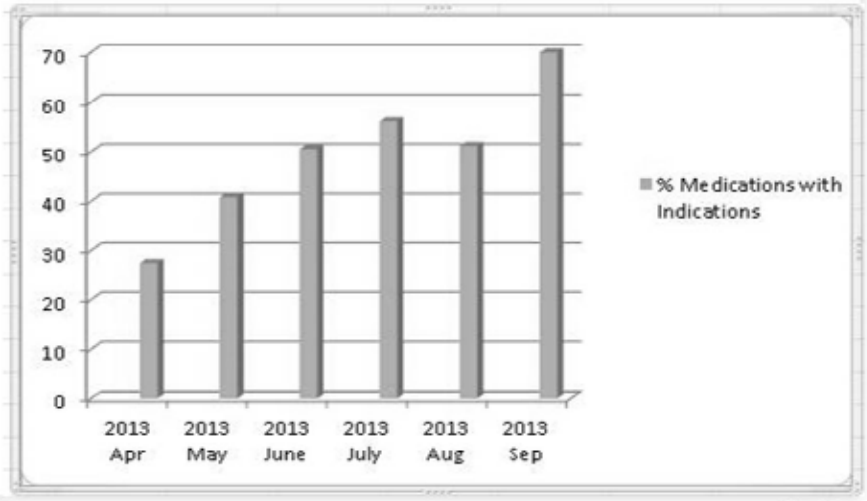


Time Period	ROI
0-12 Months	1:2.9
29-41 Months	3:1
41-53 Months	8.8:1

MTM Return on Investment

- Fully-insured MTM population compared to a matched self-insured population without an MTM benefit
  - ACG score exact match
  - Total claims costs in past year within $1000
  - Gender exact match
  - Age within five years
  - CDC disease grouping within one
- Total Costs compared 1 year pre/post MTM invitation
- 8:1 ROI
  - Reduction in ER visits and inpatient hospitalizations
  - Drug costs did not change
  - ACG-PM probability of high pharmacy cost and ACG-PM probability of high total costs lower in Fully insured MTM population

Regions Medication Indication Project



Summary of Success

- MTM Program
- Medication Indication Project
- Care Transitions
  - Hospital readmission rate at 9.7%
- HP Medical Group Process

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Thank You

Questions?

2011 © HealthPartners

Collaborating to Improve Wisconsin Health Care

November 7, 2013

Thomas Hirsch, MD, MS

etf

2008

- ETF began expressing interest in medical management programs to further improve care for its members
- Treatment of LBP was the first intervention
  - With the aid of Dr. John Hansen, ETF convened a committee of Plan/PPO Medical Directors to analyze low back care data and make suggestions regarding improving care

2009 to Present

- ETF began discussing other clinical areas
  - ETF data and/or the literature suggested significant variation in utilization among Plans/PPOs
- Based on peer-reviewed published studies, the interventions of interest had to fulfill all or most of these criteria:
  - Improve patient med/surg outcomes
  - Improve patient safety and/or satisfaction
  - "Right size" utilization based on the literature

Selected Interventions

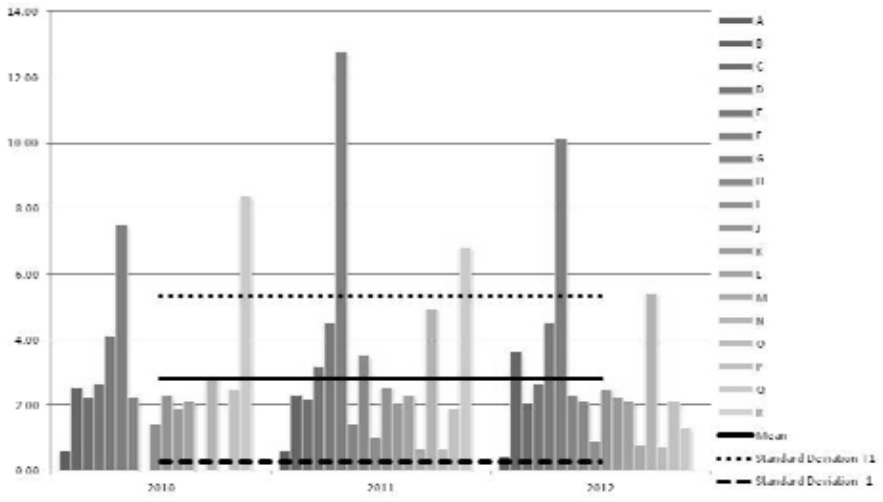
- Management of LBP
- Elective, out-patient high tech radiology
- Coordination of Care around hospital discharge
- Shared decision making
- Improving EOL care

ETF and Plan/PPO Collaboration

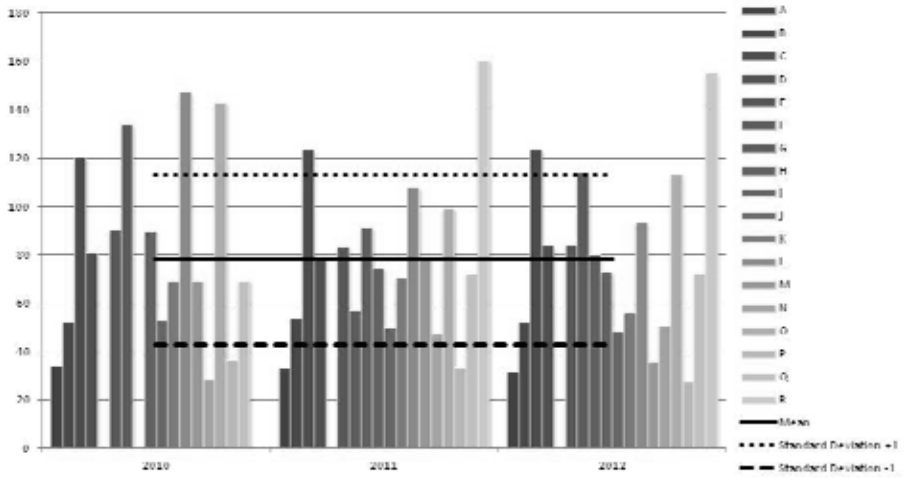
- Annual feedback to Plans/PPOs regarding yearly DMS
- Annual ETF Fall Conference to discuss interventions with Plans/PPOs beginning 11/2010
- Meetings between ETF leadership and Medical Directors requesting feedback re: LBP and SDM
- Pending 11/19/13 and 12/6/13 meetings with Medical Directors requesting feedback re: future of SDM as well as improving EOL care

What Do the Data Show?

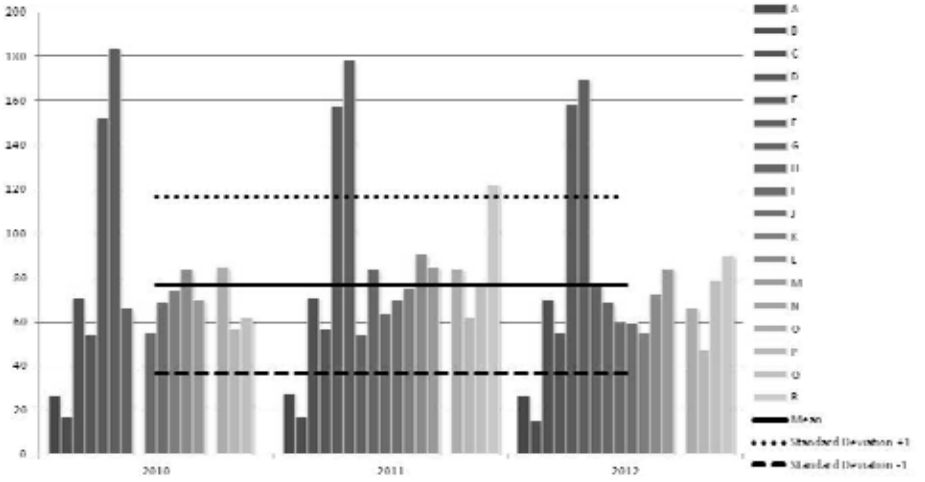
Low Back Surgery/1,000 ETF Members



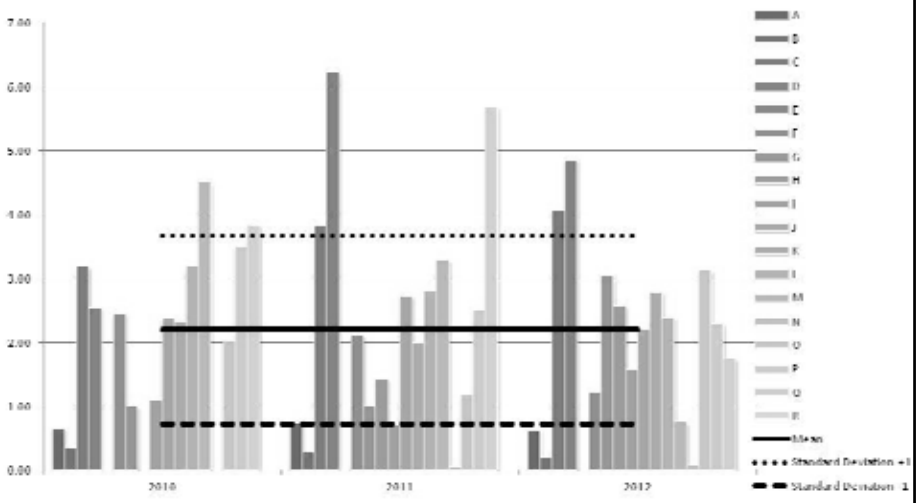
Elective CT/1,000 ETF Members



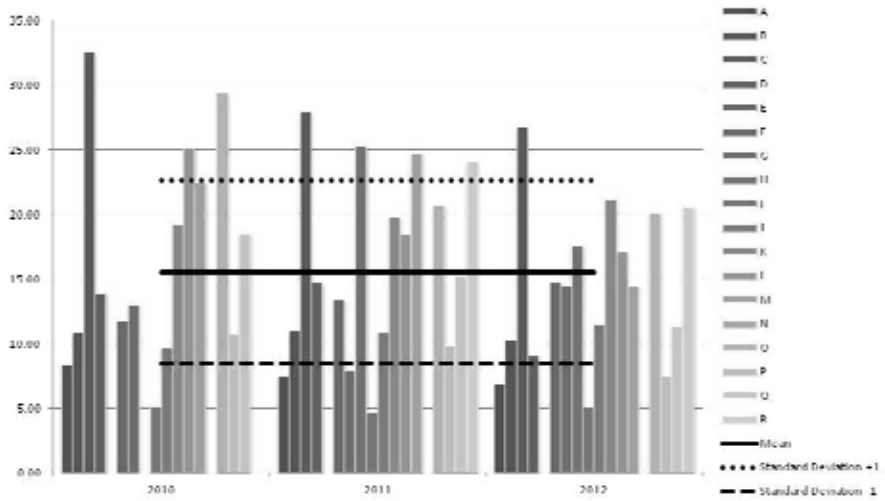
Elective MRI/1,000 ETF Members



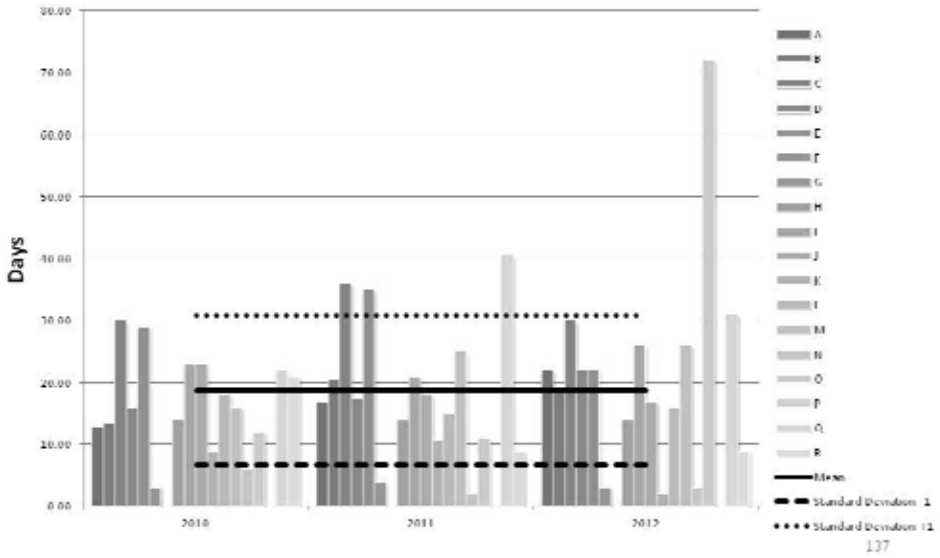
PET Scans/1,000 ETF Members



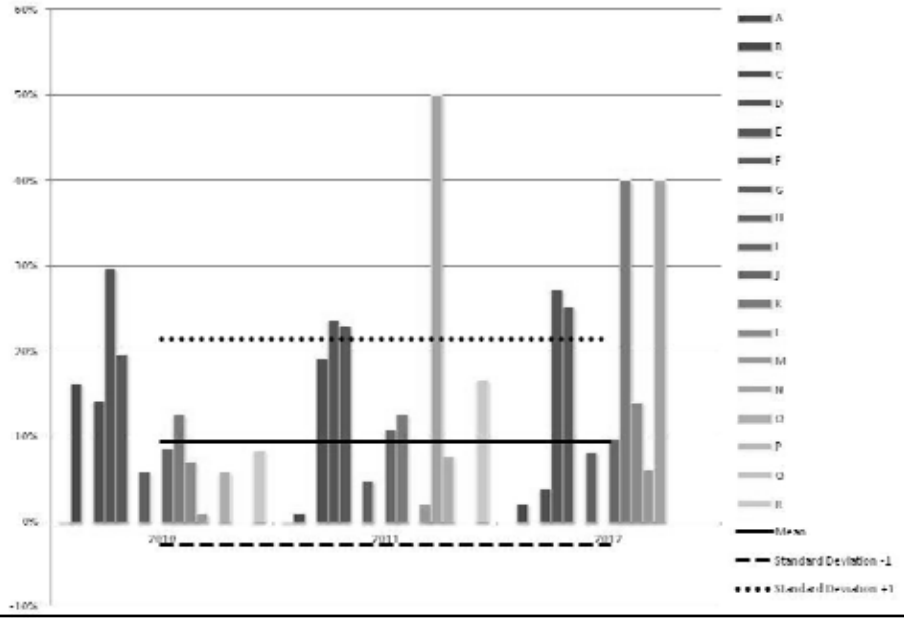
Nuclear ETT/1,000 ETF Members



Median Hospice LOS for Commercial BOB



≤ 1 Day Hospice LOS for Commercial BOB



Preparing for 01/01/13

- ETF created proposals for several prior authorization requirements and requested feedback from all Plans/PPOs
- ETF's governing Board of Directors, The Group Insurance Board, voted to contractually require these prior authorizations starting 01/01/13

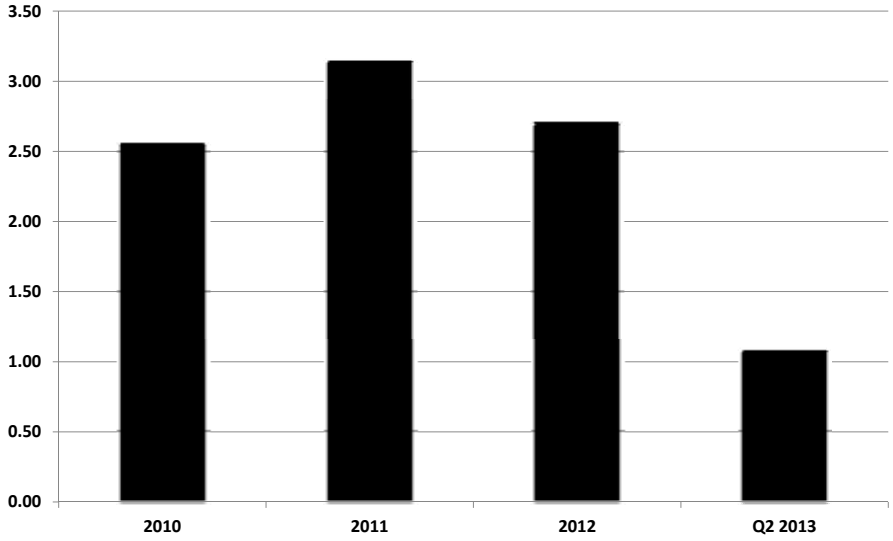
January 1, 2013

- Required interventions:
  - Prior authorization of elective, out-patient CT, MRI, PET and Nuclear ETT
  - Prior authorization for LBP patients before consulting with Orthopedics or Neurosurgery to ensure an adequate course of conservative care
  - Follow-up calls to ETF members discharged with a diagnosis of CHF, AMI or CAP within 2-5 days post-discharge

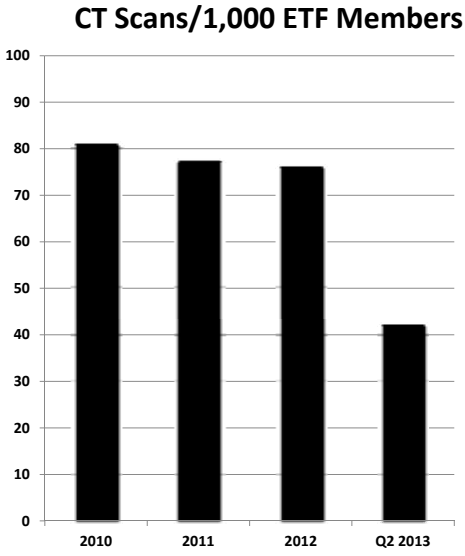
Q2 2013 Data

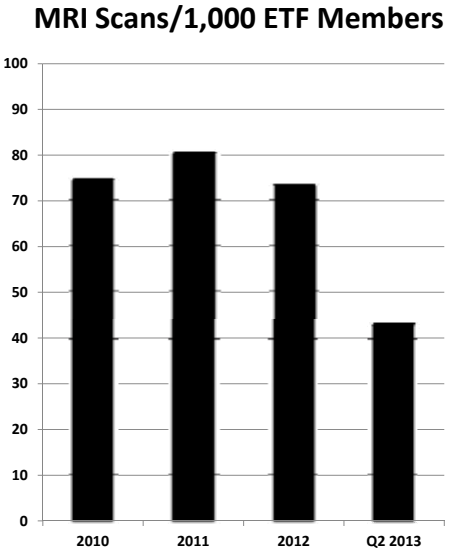
("We're not calling this a trend!")

Low Back Surgeries/1,000 ETF Members

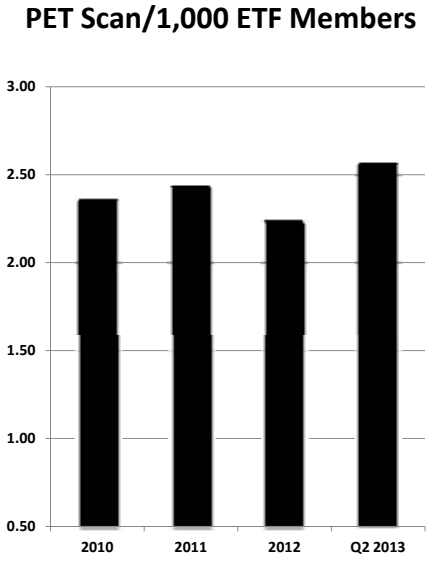


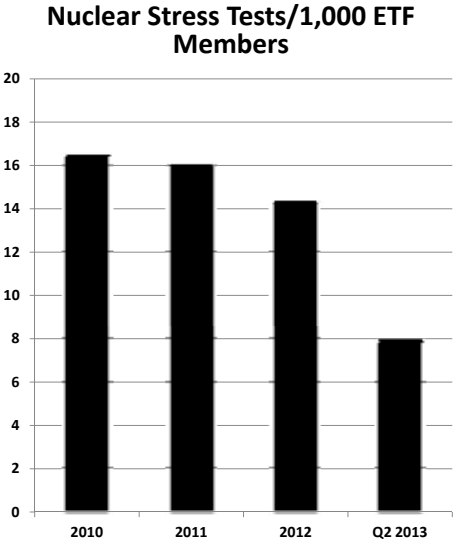
Elective Out-patient Radiology





Elective Out-patient Radiology





Looking Ahead

- Gradual expansion of SDM from 2014-2017
- Advanced Care Planning/ EOL programs possibly for 01/01/15

Please make sure Plan/PPO Medical Directors attend either 11/19 or 12/6 meetings with ETF

Q & A

Speaker Panel

Summation and Closing

Lisa Ellinger

and

Thomas Hirsch, MD, MS