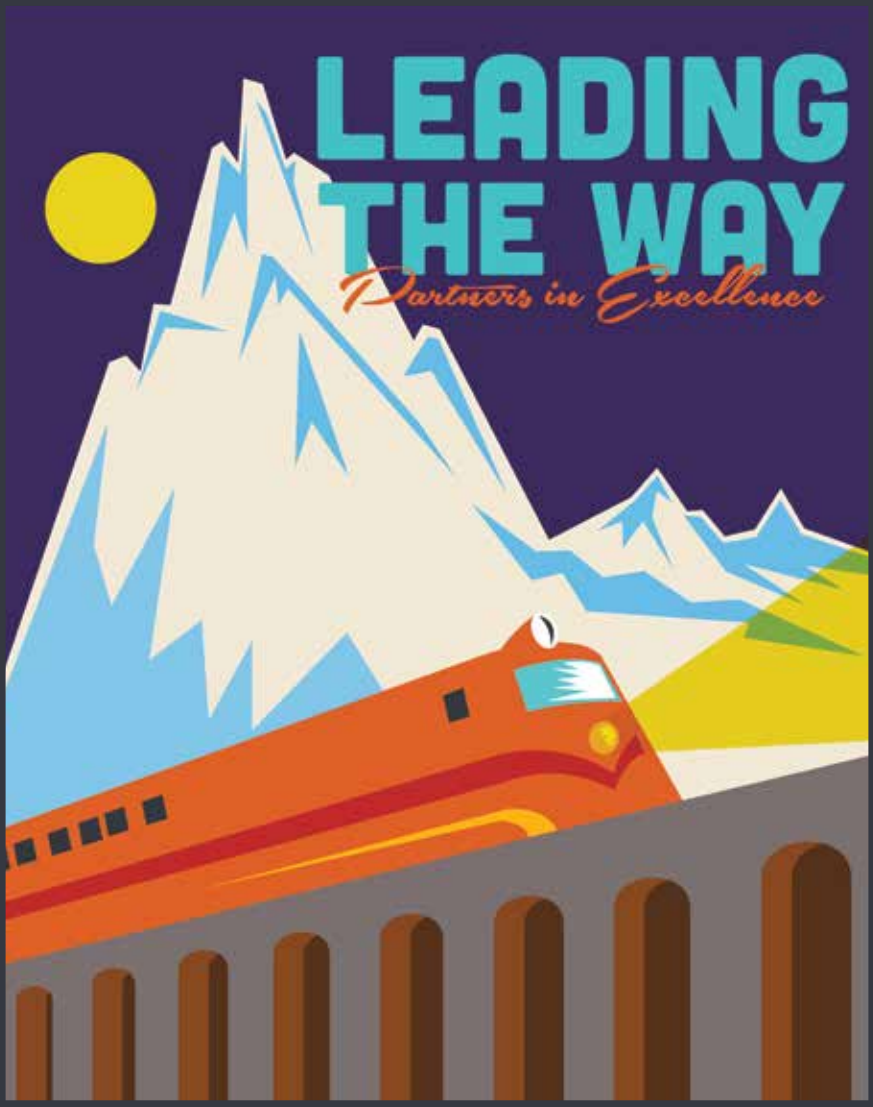

INNOVATIONS IN HEALTH CARE RECOGNITION

HealthPartners®

Celebrating peers who are leading the way to improved health, experience and affordability.

2015 Innovations in Health Care Awards

Six cutting-edge approaches, aimed at improving health, patient experience, and controlling the total cost of care, received HealthPartners' eighth annual Innovations in Health Care Award.

The Innovation awards, presented at HealthPartners annual Partners in Excellence dinner, recognized 34 diverse applicants overall, representing all levels of the health delivery system that made transformational changes. They demonstrated how the response to delivering care in our community has been and are -- innovative, continuous in rapid improvement, and deeply committed to the Triple Aim of quality outcomes, excellent patient experience and affordability.

We recognize and appreciate all the efforts each of you are making in achieving the Triple Aim on behalf of our members, your patients. Full details on the Innovation winners and all applications are available under Partners in Quality on our provider website.

Early Stage Breast Cancer Project: Actions for Continuous Learning, Best Care and Lower Cost

Allina Health
Contact: Angie Meillier angie.meillier@allina.com

Challenge

A significant, quantifiable need for quality and performance improvement exists within oncology care. Both financial outlay for cancer care and national transparency efforts are likely to continue to drive this agenda. In addition, evidence has shown significant delays when incorporating research into clinical practice. This phenomenon impedes integration of evidence-based practices into the clinical setting and augments missed opportunities, waste and harm.

Innovation

Structured and implemented a high-value early stage breast cancer project, with strategies focused on all dimensions of the IHI triple aim framework to achieve care maximization from diagnosis through survivorship via integration of the evidence-based, continuous learning.

Improving Health

- Transitioned to a learning model, based on Institute of Medicine, to decrease time from publication to clinical integration
- Used near point-of-care data to better identify opportunities and monitor improvement progress
- Launched multiple evidence-based improvement strategies across the spectrum of care
    - Implemented referral of patients to cancer rehabilitation after initiation of chemotherapy to evaluate and improve cognitive and physical functioning

Enhancing Patient Experience

- Focused on aligning patient-clinician partnerships and enhancing experience through expansion of Shared Decision Making for lumpectomy vs. mastectomy, with direct patient and provider feedback citing the associated value
- Integrated tactics to reduce patient travel and time spent within the health care setting, based on best evidence
    - Decreased average number of onsite radiation therapy sessions from 33 to 16 days for 55% of eligible patients

Taking Aim at Affordability

- Considered total cost of care and selected improvement initiatives that not only improved quality and experience, but also decreased cost
    - Increased and sustained use of intraoperative pathologist evaluation of lumpectomy margins to 98% to reduce re-excision of margins, which requires an additional surgical event
    - Decreased total cost of radiation therapy and associated expenses for patients undergoing short course radiation therapy

Medical and Surgical Weight Management in a Multidisciplinary Setting

CentraCare Health Bariatric Center
Contact: Kristin Ewing ewingkri@centracare.com

Challenge

Weight management requires a multidisciplinary approach to address the complexity of obesity as a chronic condition along the spectrum of associated comorbidities. Providing exercise, nutrition, medical, behavioral, and surgical options to patients in an efficient, comprehensive, and cost-effective manner is the purpose of the CentraCare Bariatric Center.

Innovation

The CentraCare Bariatric Center was created to offer a multidisciplinary approach to weight management at one site. Exercise and behavioral health coaches trained in motivational interviewing were integrated with a team of providers, surgeons, and registered dietitians to offer care to surgical and medical weight loss patients. Our mission is to address obesity management, population health and wellness initiatives, and life-long care for bariatric surgery patients.

Improving Health

- Utilize surgical and medical weight loss strategies to achieve significant weight loss
- Track and manage obesity related comorbidities
- Collaborate with other specialists
- Focus on weight maintenance strategies to promote long-term outcomes

Enhancing Patient Experience

- Offer early morning and evening appointment options
- Provide telephonic and electronic appointment options
- Utilize motivational interviewing techniques to meet patients where they’re at
- Offer all visits at one site and with one contact point

Affordability

- Reduction in weight results in decreased costs related to diabetes and overall health care
- Weight maintenance services are provided long-term at no extra cost to patients to enhance long-term outcomes

Heart Failure Patient Activation to Improve Outcomes and Lower Costs

CentraCare Health System, Heart and Vascular Center
Contact: Kathy Parsons Parsons@centracare.com

Challenge

Heart failure costs the nation an estimated $32 billion annually; and beyond the financial burden, each hospital admission significantly diminishes a patient's quality of life. Given the fact that successful health outcomes depend heavily on a patient's ability to understand and follow their medical regimen, it is critical that a greater responsibility for managing congestive heart failure shifts from the clinician to the patient. This would require a shift in mindset; the belief when a patient is "connected" or "plugged in" to their chart that they are engaged.

Innovation

Leveraging mobile and cloud technologies, we activated heart failure patients to take ownership of their health. Patients interact with an iPad that prompts them to take their medications and perform self-care activities based on their personal lifestyle schedule, receive patient education specific to their current situation, and ask questions and communicate relevant health events with clinicians. All patient interaction synchronizes *in real time* to a portal dashboard which provides the ability for clinicians to focus their energy on patients who are deviating from their regimen, have questions, or are not adhering to their regimen. The new paradigm is the patient, as the primary driver, takes a more active role in self-management rather than the clinician.

Improving Health

- Increased patient activation
- Closed the feedback loop: created the ability to make data actionable by the right person at the right time
- Increased overall adherence to medical regimen
- Maintained reconciled medication list at all times in an outpatient setting

Enhancing Patient Experience

- Patients feel in control
- Improved real-time patient/provider communication
- Patients have peace of mind and feel safe knowing that someone will reach out and contact them if needed

Taking Aim at Affordability

- 47% reduction in all cause admissions
- 33% reduction in 30 day readmissions for heart failure

Wide Awake Carpal Tunnel Release Surgery in the Clinic

HealthPartners Hand Surgery
Contact: Christina Ward christina.m.ward@healthpartners.com

Challenge

Carpal tunnel syndrome is a common problem, and we sought to provide the most affordable and efficient care. Previously, hand surgeons at our institution performed most carpal tunnel release (CTR) procedures in the operating room with sedation. We created a program to transition CTR procedures into the clinic under local anesthetic only.

Innovation

We provided education to surgeons regarding in clinic CTR, increased supplies and staffing in clinic procedure rooms to accommodate additional CTR procedures. We performed a patient satisfaction survey after all CTR to ensure patients remained comfortable during and after the procedure whether done in the OR or in the clinic. From May 2014 to May 2015, we increased the percentage of procedures done in clinic from 26% to 67%

Improving Health

- Provides safe and effecive CTR surgery without the use of sedation

Enhancing Patient Experience

- Decreases time spent in the clinic/OR from an average of 239 minutes to 79 minutes
- Patients are able to eat and drink up to the time of their procedure, and avoid the side effects of sedation

Taking Aim at Affordability

- Decreased CTR cost for patients and insurance program by approximately 50% for participating patients. For the 192 patients treated from May 2014 to May 2015, that represents a cost savings of approximately $288,000.
- Decreased weight of waste created during the procedure by 88%.

Choose Health

Lakewood Health System 

Contact: Rachel Delaney racheldelaney@lakewoodhealthsystem.com

Challenge

Childhood and adult obesity were two of the key focus areas that were identified from our Community Health Needs Assessment. This program takes action on improving obesity rates in our region.

Innovation

Developed a program that provides free health foods, recipes, food demonstrations and education to local families who meet criteria (low income, food insecure) as indicated by our medical providers

Improving Health

- Provides locally-grown, healthy food to families and health assessments/tracking measure results
- Improves access to programs such as SNAP and WIC through our work with Hunger Solutions – MN Food HelpLine.

Enhancing Patient Experience

- Free health food which will lead to better health outcomes including lower obesity rates.
- Engaging the patient as an active partner in their health and positive choices

Taking Aim at Affordability

- Provides FREE CSA baskets ($250 value) every other week to low income families in our communities.
- Provides FREE cooking demonstrations and education so families know how to use the foods
- Provides FREE support such as monthly check-in calls.

Psychiatric Assistance Line

PrairieCare Medical Group 

Contact: Todd Archbold tarchbold@prairie-care.com

Challenge

The nationwide shortage of child and adolescent psychiatrists has shifted the burden of providing treatment to the primary care settings and emergency rooms.

Innovation

PrairieCare Medical Group has developed the Psychiatric Assistance Line (PAL) which creates free on-demand statewide access to mental health triage and child psychiatry to the primary care setting.

Improving Health

- Provides immediate access to evidence-based mental health triage and referrals.
- Allows for convenient and on-demand consultation with child psychiatry from primary care setting, thus avoiding long wait lists, costly referrals to a sub-specialists, and risk of mismanagement of their disorder in the meantime.

Enhancing Patient Experience

- Children and adolescents are able to receive psychiatric care in a timely manner
- Care is provided in a familiar and friendly environment by their primary care provider.
- Patients are assured that recommendations for assessment and treatment have been made through consultation of a board certified child and adolescent psychiatrist.

Taking Aim at Affordability

- This service is free to all primary care providers and healthcare professionals.
- Referrals and treatment recommendations are evidence-base and proven effective
- Each successful consultation is estimated to save approximately $3,500 in costs that could otherwise be incurred in referrals to a subspecialist and risk of decomposition while waiting for further treatment

Medical Weight Loss – A Truly Integrated Approach

Allina Health
Contact: Deborah Vanderhall deborah.vanderhall@allina.com

Challenge
Primary care providers caring for patients with a diagnosis of overweight or obesity did not have an evidence-based quality program to refer patients to.

Innovation
Created a comprehensive, integrated, multi-disciplinary medical weight loss program for patients with a BMI > or = to 30. This is the only truly physician-led, comprehensive adult medical weight loss program in the area.

Improving Health
- Provides an alternative to community- based retail weight loss programs.
- Physican supervised program
- Created team approach to weight loss; medical, nutrition, lifestyle and wellness components.
- Patients see a physician, dietitian, exercise staff, and health coaches

Enhancing Patient Experience
- All services are provided in one clinic setting and are coordinated.
- Personalized treatment plans; no one-size-fits-all approach
- Flexible scheduling
- Flexibility to enhance program through additional physician and dietitian visits
- Additional fee-for-service exercise and wellness components available.

Taking Aim at Affordability
- Enrollment fee is significantly lower than community based programs.
- Measuring metrics for reduction of medications for hypertension, dyslipidemia, diabetes and need for CPAP use for patients with obstructive sleep apnea.
- Weight loss contributes to significant decreases in total cost of medical care.
- We were successful in getting our program covered as a "Be Fit" benefit for employees, which means they will be able to get the majority of their retail fee portion of program refunded to them upon completion of the program.

Intensive Outpatient Program- School Readiness Focus

Aris Clinic
Contact: Molly Wilson mwilson@aris-clinic.com

Challenge
Patients chronically struggling with behavioral health issues at the start of the school year leading to mental health services needed at IOP, PHP, and sometimes inpatient levels of care.

Innovation
Designed and implemented a school readiness curriculum delivered throughout Intensive Outpatient Program

Improving Health
- Proactively prepares patients to cope with behavioral health challenges when returning to school
- Increased self image and confidence having succeeded returning to school

Enhancing Patient Experience
- Supports patients though transition to school and addresses acute issues as they arise
- Tailored approach to meet the needs of the patients participating in the program

Taking Aim at Affordability
- Shorter length of stay for school readiness vs. traditional IOP duration
- Avoidance of more costly higher level of care by proactively treating behavioral health issues

Project BrainSafe

Project BrainSafe [Funded by CentraCare Health Foundation.] *Partner organizations included:* CentraCare Health, Health Partners, St. Cloud Medical Group, Williams Integracare, Veterans Administration, Sartell Pediatrics, St. Cloud Orthopedics. *Other active participants include:* St. Cloud State University, St John's University, College of St. Benedict's, Central MN area school districts, Minnesota Brain Injury Alliance.
Contact: Tracy Arduser ardusert@centracare.com

Challenge

Community-wide, there is limited awareness regarding concussions, their symptoms and the possible long term consequences. In addition, as a medical community, we lack consistent standards for evaluating, diagnosing and managing this population. As a result, many patients struggle for months before receiving the proper diagnosis and treatment to help them successfully resume their prior roles at school/work /community.

Innovation

Implemented a community-wide collaborative to improve the recognition, diagnosis and management of concussions/mild traumatic brain injuries for people of all ages living in central Minnesota with an initial focus on the schools in the St. Cloud region. This network includes medical providers, educational facilities, athletics, community partners and patient advocates.

Improving Health

- Standard screening for concussions in sports, trauma cases as and those with increased risk - whiplash, falls, head laceration, etc.
- Consistent standards of care for evaluation and management across all phases of care
- Prevention of repeat concussions and/or prolonged recovery secondary to under or mismanagement
- Increased community and provider education to minimize the number of missed/delayed diagnoses and adverse patient consequences

Enhancing Patient Experience

- Consistent care management approach across all medical and non-medical entities
- Standardized educational materials so patients receive a consistent message throughout the course of care
- Clear guidelines for Return to Learn/Return to Play/Return to Work

Taking Aim at Affordability

- Free baseline ImPACT testing for high school athletes to allow improved clinical decision making following concussion
- A community ImPACT account to improve accesibility of test scores, improving efficiency as patients transition between care entities
- Best practice guidelines to improve efficiency - number of visits, tests, types of services provided, referrals
- Early and accurate diagnosis as well as proper identification of clinical trajectory leads to more efficient and effective treatment, decreased recovery time, as well as reduced secondary sequelae requiring additional testing and treatment

BLEND, Better Living: Exercise and Nutrition Daily

CentraCare Health Foundation
Contact: Jodi Gertken gertkenj@centracare.com

Challenge

BLEND (Better Living: Exercise and Nutrition Daily) was created to accomplish an ambitious goal of reducing childhood obesity by 10% in Central Minnesota by 2016.

Innovation

BLEND is a community collaborative leading community-wide efforts to increase physical activity and promote healthy eating through transformations in policies, systems and our environment. BLEND is governed by synergistic and passionate people representing health care, business, community policy makers, schools and parents.

BLEND's initiatives include 5-2-1-0 (a prescription for healthy living), healthy fundraisers, safe routes to school (SRTS), family fitness events, and NuVal (an easy food scoring system). School fundraising with Walk-A-Thons has replaced selling candy and unhealthy foods with a day of school spirit and physical activity. Since 2008, more than 12,000 students at 22 area schools have walked over 63,000 miles! More than $600,000 in funds has been raised with area schools retaining 100 percent of the proceeds.

Improving Health

- Rates of overweight and obesity among 12 year olds have dropped by 14% in the St. Cloud area since BLEND began its work in 2008, including a 28% drop among boys.
- More children are now walking or biking to school – 23-40% more in participating SRTS schools.
- Over 8,550 kids participate in the Fit Kids Club events, many of which are available for free or reduced prices for families.

Enhancing Patient Experience

- BLEND's focus on childhood health allows CentraCare Health to focus on families and health, rather than on sick care.
- CentraCare's providers can approach their patients with a positive health-building discussion with BLEND as that conversation catalyst.

Taking Aim at Affordability

- BLEND is the first coalition in the country to demonstrate a significant and sustained drop in obesity rates highly attributable to policy and environmental changes at schools and in the community.

Centralized Registry

CentraCare Health System
Contact: Lisa Porter portere@centracare.com

Challenge

In order to meet quality measures and pay for performance goals, there was the need to work on chronic diseases and preventative services registries. This was done by nurses in each, individual clinic. However, with the busy schedules of nurses, working of the registries received less priority and was normally taken care of when staff members had time. Due to this, patients were often overdue on their office visits and lab management, thus affecting quality measures.

Innovation

Trained centralized registry staff and developed workflows to allow them to reach out to all of our patients listed on the Asthma and Depression registries in a standardized manner that meets guideline recommended care.

Improving Health

- Improvement in optimal chronic disease outcomes
- Improvement in standardized use of guideline care
- Ensure systematic follow-up visits when appropriate

Enhancing Patient Experience

- Increased patient satisfaction knowing that the clinic is proactively reaching out to determine if treatment is effective
- Immediate follow-up appointment is scheduled based on guidelines established
- Timely between visit care

Taking Aim at Affordability

- Increased LPN availability on the floor
- Decreased variability between clinics
- Better outcomes resulting in potential savings of healthcare dollars due to uncontrolled disease
- Centralizing resources vs. each site having their own registry staff

Screening Brief Intervention and Referral to Treatment

CentraCare Health System

Contact: Daniel Backes Daniel.backes@centracare.com

Challenge

It was identified that substance use in the primary clinic setting could be addressed more efficiently and effectively through the use of evidence based tools in a structured model. Referrals to chemical dependency programs do not always result in actual visits when patient no-show appointments or fail to schedule.

Innovation

The Screening, Brief Intervention, Referral to Treatment (SBIRT) model was used in conjunction with the Alcohol Use Disorder Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST) to screen patients for risky substance use. A social worker was also utilized in the clinic to see patients for brief interventions on the day the screening was completed.

Improving Health

- Improvement in goal setting and follow through for reduction in substance use.
- Improved follow-through with chemical dependency visit
- Reduction in risky alcohol and drug use

Enhancing Patient Experience

- Patients are able to speak with someone the same day a substance use issue is raised.
- Patient interactions included elements of motivational interviewing

Taking Aim at Affordability

- Same day handoff between the provider and the social worker are more efficient than rescheduling a visit.
- Allows provider to continue to see other patients thereby increasing productivity
- Less risky substance use leads to less alcohol and drug related ED visits and costly health complications

Implementing Best Practice: Integrating Active Care and Spinal Manipulation for Adult Low Back Pain

Chiropractic Care of Minnesota, Inc

Contact: Vivi-Ann Fischer, D.C. vfisher@chirocaremn.org

Challenge

Active care remained an underutilized activity across the chiropractic community. With the support of documented clinical benefits and a growing demand by key stakeholders, CCMI sought to develop a program that educates and trains its network providers on the advantages and application of active care.

Innovation

We are committed to preparing our providers for the evolving health environment by providing the tools, information, and education needed to be successful in their business. Our Active Care Certification program is built on a foundation integrating active care and spinal manipulation to improve and advance patient outcomes.

During our four-part program, providers are offered a value-based education, hands-on training, and the take-home tools needed to instruct and inspire their patients to play an active role in their body's recovery. Our Active Care Certification program includes both online and in-person training, is tailored to the specific needs of the chiropractor, and can be completed in 5-6 weeks.

Improving Health

- Current research validates spinal manipulation with active care exercise provides the best long-term patient recovery outcomes.
- Active care activities result in:
  - Faster recovery with increased functional activities
  - Improved muscle strength and joint stability
  - Fewer psychological issues and reduced likelihood of developing chronic pain

Enhancing Patient Experience

- Active care practices are known to decrease the number of episodes of care (chiropractic and otherwise), reduce the amount of care patients require when issues do present themselves, and improve patient satisfaction when care is received
- Patients feel a greater sense of control and empowerment by taking a more active role in their treatment, and experience reduced anxiety and "fear of pain"
- Individualized care plans offer a value-added benefit for patients

Taking Aim at Affordability

- Decrease number of episodes of care (chiropractic and other)
- Fewer recurrences of injury

Primary Care Provider Teams: Developing a Collaborative MD and NP-MA Model

Essentia Health
Contact: Roberta Maughan Roberta.Maughan@essentiahealth.org

Challenge

To achieve the Triple Aim in an ACO environment, the future of healthcare depends on the utilization of team based care and better stewardship of resources. The match of physicians and NPs-PAs in Primary Care was inconsistent and staff was not fully utilized efficiently and at the appropriate skill level within the clinic's panel assignments. High quality, effective care would improve through a consistent care team that has supportive professional role guidelines and shared compensation alignment.

Innovation

- Developed a Physician/NP-PA collaborative model with guidelines for sharing patients and providing care to the appropriate type of patients based on provider type
- Action plans and strategies were developed to close the gap between actual and available capacity
- Designed and utilized a tool to determine ideal staffing ratio for MDs to NPs/PAs to support the team model and ensure the clinic has enough capacity to meet patient demand
- Entered proposed staffing in financial modeling tool to see impact on direct operating margin

Improving Health

- Improved the quality and continuity of care for patients by developing a relationship with their primary care provider team
- Prescriptive guidelines for the collaborative MD/NP-PA team ensured that patients were being seen by the right type of provider

Enhancing Patient Experience

- Increased the ability for patient's to access their primary care team within the clinic
- "Voice of Consumer" surveys found improved satisfaction with the teams providing care.

Taking Aim at Affordability

- MD/NP-PA ratios have improved from 2.69 to 1.83 resulting in savings in Physician/NP-PA salary expenditure of $2.24 million annually
- Action plans improved clinic productivity by closing the gap between actual and available capacity which equaled 26,000 annual encounters.

Designing a Lean Laboratory

Essentia Health – Virginia Clinic & Hospital
Contact: Steve Mattson steven.mattson@essentiahealth.org

Challenge

The previous laboratory at the Virginia hospital was compartmentalized. This contributed to many forms of waste, including the inefficient transport of specimens and movement of staff. The nearby Virginia Clinic laboratory offered redundant services, requiring duplicative laboratory instrumentation and supplies. There was variation in work flows between both labs. In addition, the fractured nature of the hospital laboratory space was prone to safety concerns and provided a less than optimal patient experience.

Innovation

The decision was made to consolidate the hospital and clinic labs into a new hospital space. The innovation involved the design of a new laboratory utilizing Lean principles and involving participants from both labs; maintaining focus on how work flows would serve to decrease the time patients waited for results. Lean design principles, such as waste reduction in motion and transportation, adjacencies and process workflow were employed. Initial lab designs were "mocked-up" using cardboard, 1x2's and other materials in a dimensionally equivalent space to the future-state lab. The team used this "test lab" environment to conduct lab processes. These simulations helped identify additional design changes; supporting patient centricity in the lab's processing of test results. Coupled with testing and workflow efficiencies, a Kanban inventory system was also designed and implemented

Improving Health

- Improved lab result turn-around-time
- State of the art environment provides for optimal laboratory testing and high quality results

Enhancing Patient Experience

- Layout of facility friendlier and aesthetically pleasing for our patients.

Taking Aim at Affordability

- Reduced redundant equipment and reagent costs
- Ability to see efficiency gains in staffing by consolidating laboratory services
- Estimated one time savings of $350,000 with a $375,000 equipment savings over three years

Telehealth Medical Weight Loss Management

Essentia Health
Contact: Nancy Tario nancy.tario@essentiahealth.org

Challenge

More than two-thirds (69%) of adults and one-third (32%) of children are considered to be overweight or obese. As an Accountable Care Organization (ACO), Essentia Health is committed to improving the overall population health. A key component of assisting patients with a weight loss program is to increase the ease and availability of access to their health care teams so that feedback on the patient's efforts can be discussed to ensure healthy habits are reinforced or established. Patients in rural areas would have to spend 3-6 hours driving to and from each appointment in order to receive that care, so they were unlikely to commit to it, especially since winter driving can be treacherous.

Innovation

We provided additional support to primary care practitioners by using telehealth outreach. Services are provided by Dr. Stephen Park, the Bariatrician from our Ely Clinic site.

Improving Health

- With more than 1,400 new encounters, total patient weight loss per year has doubled to over 9,000 lbs.
- Provides a referral source to address obesity, overweight, insulin resistance and metabolic syndrome in both adults and children.
- Improving the general health of the public is to assist them with maintaining a healthy body weight and reduce the probability of some chronic diseases as well as reduce the severity of the effects of those diseases.

Enhancing Patient Experience

- Reduced barriers to patient care by decreasing travel time for the patient.
- Provided a means to improve patient access.

Taking Aim at Affordability

- Reduced physician outreach travel time.
- Provided an alternative to surgical bariatric intervention.
- Reduced cost when compared to traditional visit

Enhancing the Delivery of Transitions Care: Using a Patient Reported Activation Assessment to Guide Discharge Processes

Fairview Health Services
Contact: Carmen Parrotta cparrot1@fairview.org

Challenge

Too often patients with high-risk conditions discharged from an inpatient setting are readmitted within a short period of time either due to the complexity of their condition, inadequate coordination of care and/or low patient compliance with discharge instructions. Addressing the root causes of these readmissions has become a high priority for all health care providers.

Innovation

To improve the rate of post-hospital follow-up visits in a primary care setting our innovation included an initial assessment of a patient's engagement level using the Patient Activation Measure, or PAM), which then determined the version of condition-specific education provided and reviewed by a care transition specialists (CTS) prior to discharge. In addition, streamlined scheduling methods were used to assist in setting a follow-up clinic appointment before patients left the hospital and text (SMS) or email reminders were sent 24 hours prior to the scheduled appointment in the next seven days.

Improving Health

- Enhancements made to post-hospital care coordination efforts lead to:
  - A systematic process for real-time assessment and engagement of patients in their post-hospital care.
  - Higher rates of 7-day follow-up clinic visits in the intervention group when compared to standard of care (47.1% vs. 65%), a 38% improvement.
  - Lower readmission rates in the intervention group when compared to standard of care, 26.5% vs. 10%, about 2.5 times lower.

Enhancing Patient Experience

- Increased opportunity for patient-lead discussion of key barriers to health and short term goals.
- Significant improvement in perception of patients as to "why my follow-up appointment is important to my health".

Taking Aim at Affordability

- During pilot phase (6 months) we estimate 4 readmission were avoided for a group of 22 participants, amounting to more than $160,000 in charges averted.
- Potential cost saving in 30-day readmissions if program was provided to all CMS COPD and pneumonia inpatients is estimated at $3.7 million in a given year.

W.E.L. [Wellness and Exercise for Life]

Fairview Health Services & Fairview Rehabilitation Services

Contact: Aaron Pergolski apergol1@fairview.org

Challenge

Not all patients have a qualifying rehab diagnosis for supervised exercise. (E.g. peripheral artery disease) In addition, cardiac rehab/pulmonary therapy patients often are uncomfortable transitioning to a regular gym without supervision. There was a need to offer a transition environment from outpatient rehab therapy and outpatient therapy to a wellness activity in the community that supports lifestyle changes which optimize health and prevent readmission.

Innovation

Developed an affordable, safe, supervised exercise and education program that enables patients to continue healthy lifestyle changes in order to live longer, healthier lives. Actively seek individual patient feedback through rounding to modify and improve their program to ensure it is consistently meeting their needs.

Improving Health

- Low cost physical activity option where patients can work with a skilled therapist to support health promotion and disease prevention in a safe, monitored setting.
- Increased touch-points between patients and medical professionals to decrease risk of readmissions.
- Encourage participants to join community fitness centers and health clubs in their community when they are ready

Enhancing Patient Experience

- Offers a safe, supportive, comfortable environment to continue with physical activity program.
- Education and expertise in risk reduction for co-morbidities.
- Enhanced relationships and support network through participation
- 84% patients would recommend to others

Taking Aim at Affordability

- Stable affordable pricing and pre-pay discounts comparable to health club and fitness center pricing. ($49/month)
- Over 80 patient scholarship awards through Fairview Foundation to provide financial assistance based on income.
- 263% overall growth since start of program with 16,082 projected patient visits.

Care Model Design to Improve Value of Physical Therapy for Patients at Low Risk of Long Term Disability from Low Back Pain

Fairview Health Services, Orthopedic Service Line & Institute for Athletic Medicine
Contact: Becky McCathie rmccath1@fairview.org

Challenge

Low back pain is costly and ever increasing in incidence. Despite many technological innovations and advances in medical knowledge, the US is not producing better patient-reported outcomes for this large population. Identifying patients at low risk for long term disability based on psychosocial health provides the opportunity for new care models of physical therapy.

Innovation

Piloted a care model design to deliver an intentional, value-driven intervention, focused on education, reassurance and decreased utilization for patients who are at low risk for long term disability due to their back pain

Improving Health

- Demonstrated improvement of their back condition as evidence by the patient-reported global rating of change (4.1/5)
- Reduced low back pain medication use by 77%
- Reported return of usual activities of daily living, zero work days missed, and confidence in their ability to self-manage their current and future episodes of low back pain

Enhancing Patient Experience

- 100% of pilot patients reported the care met their expectations, and they got what they needed from physical therapy
- 94% of pilot patients reported they did not seek additional health care during the six week follow up

Taking Aim at Affordability

- Piloted care demonstrated a 36% reduction in utilization of physical therapy, patient co-pays and indirect costs such as time away from work and family to attend physical therapy visits
- Potential annual savings of physical therapy charges of approximately $1M

Know Thyself: A Diagnostic Tool for Assessing Your Care Team's Health

HealthPartners Orthopedic and Sports Medicine
Contact: Todd Johnson, MD Todd.C.Johnson@HealthPartners.Com

Challenge

Our department functions as a team of teams with each care team consisting of a physician, nurse or medical assistant, athletic trainer and a physician assistant or nurse practitioner/ Our challenge was creating a way to easily visualize how the team felt it was functioning. Specifically, we focused upon how the physician felt he or she was leading the team compared to how the team felt they were being led.

Innovation

We used a modified version of Google's Upward Feedback Survey, a tool that Google uses to allow teams to evaluate their managers. We tailored the survey to better address our healthcare environment and to incorporate the triple aim. Taking Google's evaluation a few steps further, not only would the team members evaluate the physician, we also had the physician evaluate how they felt they were leading the team. Our assessment is bidirectional (veruse Google's unidirectional orientation) and it use radar plots(verses bar graphs) to quickly display areas of disconnection within a dpeartment and individual teams.

Improving Health

- It is easier to prescribe a treatment once the diagnosis is known. Our assessment evaluates the health of a team and quickly identifies areas of disconnection.

Enhancing Patient Experience

- Quite simply, when a team is functioning well, they provide better care and a better patient experience
- Engaged team members take greater ownership in patient care.

Taking Aim at Affordability

- Employee turnover is incredibly costly. Not only does it take time and money to orient a new team member, the departing employee takes with them invaluable institutional memory.
- Better communication leads to a wiser use of resources and healthcare dollars.

A Team Approach to Delivering Efficient, Innovative, and Patient and Family-Centered Care to Orthopedic Surgery Patients

Hudson Hospital & Clinics
Contact: Linda Wlodyga linda.j.wlodyga@hudsonhospital.org

Challenge

Coordinating the needs of orthopedic patients from scheduling to postoperative care is challenging. Inconsistencies and gaps led to fragmented care with multiple disciplines from multiple care organizations performing similar duties without understanding each team members' role in the process. Orthopedic education was not consistently delivered for patients, resulting in less than optimal patient experiences.

Innovation

Developed a total joint orthopedic program that provides patients with 1:1 educational sessions with pharmacy, physical therapy and nursing to enhance the coordination of care prior to surgery and during their hospital stay. This specifically focused on standardizing preoperative education, individualizing medication reconciliation, identifying patients with high risk comorbidities, planning for postoperative anticoagulation, pain management and bowel regimen needs and collaborative rounding during hospitalization.

Improving Health

- Patients home medications reviewed preoperatively for potential drug interactions with postoperative anticoagulant
- Changed anticoagulation plan due to drug interactions and/or incorrect anticoagulant identified
- Preoperative antibiotics adjusted due to allergies
- Tranexamic acid held due to contraindications or increased risks
- Ketorolac doses reduced or held due to impaired renal function

Enhancing Patient Experience

- More actively involved in their care and recovery
- Patients have fewer questions the day of surgery and are more prepared for surgery and recovery
- 100% of scheduled total joint patients had medication reconciliation completed prior to day of surgery (n=121)

Taking Aim at Affordability

- Pre-authorization of anticoagulant medication resulted in four percent of patients changing postoperative anticoagulation plan due to cost
- Start of surgery delays reduced by preparing intraoperative IV medications ahead of time
- On average, a 15 minute time savings was achieved by staff when admitting patient on day of surgery
- Patients informed ahead of time to bring in non-formulary home medications, preventing a non-formulary charge for medications

Integrating Palliative Care into Comprehensive Heart Failure Care

North Memorial Medical Center
Contact: Melissa Klein, NP-C melissa.klein@northmemorial.com

Challenge

Despite the many advanced heart failure (HF) therapies available today, individuals still often experience uncontrolled symptoms such as pain, dyspnea, fatigue, and depression. HF carries a high risk of mortality and disability. Many patients do not perceive the life-limiting nature of their illness. Palliative care involvement is a way of helping patients to understand and cope with the chronic and progressive nature of their illness. The literature supports the integration of palliative care as part of the comprehensive care of patients with chronic illnesses such as HF. Standard practice at our organization has not historically involved the support of the palliative care team in routine HF care. A consistent process for palliative care referral for HF patients was needed

Innovation

Implemented a process for palliative care referrals for patients hospitalized with Acute Decompensated Heart Failur (ADHF)

Improving Health

- Improved documentation of patients' care goals
- Better patient/family understanding of the chronic and progressive nature of their illness
- Assistance to patients/families in medical decision-making
- Increased attention to management of distressing symptoms

Enhancing Patient Experience

- Palliative care support promotes patient-centered care
- Extra layer of support to patients/families as they cope with serious illness
- Improved communication of patients' goals of care results in care more in line with patients' wishes

Taking Aim at Affordability

- Reduced re-admission rates
- Reduced incidence of unwanted invasive procedures/testing
- Increased rates of healthcare directive or Provider Orders for Life-Sustaining Treatment (POLST) form completion

Reducing Health Disparities by Increasing Mammography Access: Mammo-a-go-go

Park Nicollet Health Services
Contact: Gladys S.Chuy gladys.chuy@parknicollet.com

Challenge

For women in Minnesota, breast cancer is the most common cancer for every major ethnic group and the second most common cause of cancer death. Mammography screening is a preventative and proactive approach for early detection and reduced mortality. Disparities in breast cancer are attributed to complex and interrelated dynamics specifically, unobtainable and inaccessible screening.

Innovation

A mobile mammography unit was leveraged and utilized to reduce breast cancer disparities. Implemented in 2012, this self-contained truck provides digital mammography within minutes. Leveraging the mobile unit, community outreach focused on medically underserved and disparate populations, with an emphasis on communities of color.

Improving Health

- Early detection decreases mortality rates of breast cancer.
- Equitable care is exemplified by providing screenings to diverse communities, from underserved to corporate settings and community outreach sites to multilingual churches.
- Successfully, 2,880 patients received screens in 2014 spilling into 2015 with 1,796 patients screened as of June 30, 2015. Screens are expected to grow as the mobile unit has sites scheduled for the remainder of 2015.

Enhancing Patient Experience

- The mobile mammography unit demonstrates an alternate means of accommodated patient-centered care that is convenient, efficient, wheelchair accessible whereby eliminating barriers to obtain and access screenings.
- Servicing within the community not only fosters a comfortable and familiar environment but reduces travel and potential clinic wait time.

Taking Aim at Affordability

- Mobile mammography utilizes resources efficiently; rather than investing in a number of fixed units risking underutilization, investment resides in a mobile unit that can be filled to capacity in various physical locations. Affordability is increased to patients in that an established community outreach fund provides service to uninsured or underinsured patients that may be disqualified from other programs that would subsidize their care. Removing the barrier of cost, all patients are treated regardless of ability to pay. Finally, early detection reduces overall total cost of care to the patient.

Shared Care Protocol

Park Nicollet Clinic
Contact: Kari Haeger haegek@parknicollet.com

Challenge
Increase access in Mental Health by improving the process for referral of stable patients with anxiety/depression back to Primary Care.

Innovation
Created a Shared Care protocol to send "stable" patients back to Primary care, opening up access in Psychiatry

Improving Health
- Patients will be able to have more of their needs met by their Primary Care Provider.
- Improved access in Psychiatry for patients with complicated behavioral health conditions requiring specialized behavioral health care.
- The behavioral health plan of care in the problem list improves communication in the referral of patients from behavioral health prescribers back to primary care

Enhancing Patient Experience
- By having stable patients follow-up with Primary Care for their ongoing mental health management, the patients will be able to reduce the number of visits they need to make to address all of their health concerns
- Patients are assured that ongoing mental health medication management recommendations are communicated to the Primary Care Provider by the Behavioral Health Prescriber in the Plan of Care located in the Problem List of the EMR

Taking Aim at Affordability
- Sending stable patients back to Primary Care will enable Psychiatry to see more new patients.
- Primary Care's ability to provide holistic care will be strengthened, leading to an increase health outcomes.
- Mental health maintenance treatment addressed with other health care needs in routine Primary Care visits

Clinical Curriculum Enhances Patient Outcomes & Provider Satisfaction

Physicians' Diagnostics & Rehabilitation Clinics
Contact: Jennifer Missling, MS PT jenniferm@pdrclinics.com

Challenge

Continuing education for physical and occupational therapy providers in the treatment of chronic neck and low back pain is vast as well as expensive. Patient treatment plans oftentimes are dependent upon which provider they are seeing, and what latest and greatest continuing education course the therapist attended. Approaches vary immensely between providers and clinic groups. This makes it difficult to provide measurable outcomes on the care, as the treatment at one clinic may be variable based upon the treating therapist.

Innovation

Our clinic realized an opportunity to provide guidance and standardization of continuing education to ensure that the methods used at our clinic were based upon clinical evidence, and that all providers were trained to a consistent level of skill and expertise. This allows the ability to collect patient outcome data and optimize the care delivery across multiple providers.

Improving Health

- Patient care delivery is optimal, as the treatments are based upon current best evidence and the providers are skills tested and monitored by outcomes.

Enhancing Patient Experience

- Patients receive improved access to appointment times and a flexible schedule because they are free to see any of the providers at the clinic for their care.

Taking Aim at Affordability

- Our data reflects improved health and patient experience. The overall cost of our rehabilitative program is a good value compared to other more invasive procedures. In fact, it is considerably less expensive than an MRI and/or back injection(s).
- Patients that improve their activation level and reduce their emotional barriers to chronicity, as evidenced by our outcomes, stand a greater chance of maintaining self management and decreasing utilization of healthcare longer term. In fact, research on the PAM-13 (patient activation measure) suggests that an improvement in activation score not only reduces health care utilization and cost, it transfers to managing other medical problems and comorbidities.

The Benefits of BLAST: Better Lifestyle, Attitude, and Success Training

Sanford USD Medical Center
Contact: Stephanie Wessels, RN stephanie.wessels@sanfordhealth.org

Challenge

Bariatric surgery is not just a surgical procedure to aid weight loss. It is an attempt to better the patient's quality and length of life in addition to improving or resolving weight related health problems. The goal of Sanford's Metabolic and Bariatric Surgery Program is to provide patients with the necessary tools to help them succeed after surgery. BLAST (Better Lifestyle, Attitude and Success Training) class consists of three one hour classes that occur over a three month time period. Topics covered include mindful eating, menu planning, activity, barriers and feelings. By attending BLAST Class preoperatively, patients are set up for long term success by learning more about the necessary behavior and lifestyle changes that are so important after bariatric surgery.

Innovation

The Sanford Metabolic and Bariatric Surgical Program first started offering BLAST class to Sanford Health Plan patients in 2011. Since inception, we have continuously monitored patient feedback to the program in addition to short and long term outcomes (weight loss). We have also noticed that patients who attend BLAST class are more likely to reach (have) surgery, as they have continuous contact with the bariatric team. The ongoing contact also keeps patients motivated and helps them reach their pre op weight loss goals that are so important from a patient safety perspective. This unexpected outcome has resulted in additional bariatric surgical cases for our program and revenue for Sanford USD Medical Center.

Improving Health

- Offering additional, no charge education prior to bariatric surgery sets our patients up for optimal, long term success after surgery. Patients report that the psychological, emotional and lifestyle changes are the most difficult aspect of surgery. BLAST offers the education and tools to set patients up for long term success; by learning about necessary (post operative) lifestyle changes prior to surgery, patients state it helps them adapt easier afterward.

Enhancing Patient Experience

- Patients who attend monthly classes have more frequent contact with the bariatric team, which may aid the patient in reaching their wellness goals if they feel our team is truly invested in their outcome.
- Patients have ample opportunity to network with others in a similar situation. Some have forged friendships as a result of these classes and are able to support one another throughout their journeys.
- Patients reported feeling better prepared for bariatric surgery and the lifestyle changes that must occur afterward for success.
- Data show that BLAST patients also have better long term weight loss than those who did not attend.

Taking Aim at Affordability

- Patients initially incurred a per class fee of $60, which has since been eliminated (2014) as we feel BLAST should be available to all patients, regardless of ability to pay.
- The classes are also available online in a video format as over 50% of our patients live in outlying/rural areas. This reduces the cost associated with traveling to Sioux Falls for education and allows them to view the videos as often as needed.
- BLAST Class attendees are more likely to reach (have) surgery than those who do not attend; opening the classes up to anyone has proven to have a signficant return on investment.

Physical Activity and Early Stage Breast Cancer

Specialists in General Surgery *[Grant funded by Fairview Physician Associates]*
Contact: Corinne Jordan, MD, FACS cjordan@sgsmn.com

Challenge
Physical inactivity has direct effects on risk of chronic diseases, mental health, quality of life, and early mortality. Women that engage in physical activity after a breast cancer diagnosis may reduce the risk of recurrence and death from this disease.

Innovation
This study examines postmenopausal women with clinical stage I or II breast cancer using the Patient Reported Outcome Measurement Information System (PROMIS) 10 – Global Health Survey, Fitbit Flex, and regular wellness coaching.

Improving Health
- Wellness coaching encourages healthy behaviors - regular physical activity and nutritional eating
- Regular physical activity during treatment and survivorship can improve mental health and physical well-being as well as blood pressure, body mass index, heart rate, and quality of life
- Regular physical activity during treatment and survivorship can reduce the risk of recurrence and death from breast cancer

Enhancing Patient Experience
- Offering access to free weekly wellness coaching to reach health-related goals
- Giving Fitbit Flex as a tracking device to monitor daily steps
- Increasing patient interaction by offering 6 month and 1 year follow-ups to obtain updated vitals and discuss coping strategies for survivorship

Taking Aim at Affordability
- 100% of patients on study had BMI stay the same or decrease from initial consult to postop visit
- 47% of patients met the daily goal of 7,000 steps
- 80% showed significant increases in mental health scores and 60% increased physical health scores

Vadnais Heights Surgery Center (VHSC) Care Suites

Summit Orthopedics
Contact: Jay Scott jscott@summitortho.com

Challenge

Patients having Total Knee or Total Hip Arthroplasty typically spend two or more nights in a hospital, have inconsistent experiences including a lot of pain, varying amounts of rehabilitation, and often are transferred to an extended care facility before going home.

Innovation

A surgery center and home health care program were built under one roof in order for patients meeting specific criteria to have TKA and THA in an outpatient setting, yet allow for Home Health Services as necessary. A detailed clinical pathway was established for these patients in order to improve experience, speed up recovery, and improve outcomes.

Improving Health

- Clinical pathways start at pre-operative visit and continue through post-operative rehabilitation and follow-up
- Clinical pathway (including anesthesia regimen) results in less pain, sooner post-operative ambulation, decreased LOS, and quicker return to work or daily routine
- Lower risk of infection and complications with surgery at VHSC and short stay at Care Suites
- Staff - 100% orthopedic trained

Enhancing Patient Experience

- Experience is seamless – from the time they are a candidate for TKA/THA to 3 months after surgery, patients work with a single organization.
- THA/TKA candidates meet with an Orthopedic CNS who thoroughly educates patient and significant others about what to expect.
- On average, patients walk 3 hours post operatively. After VHSC discharge, rehabilitation continues using Secure Track; only one in Midwest.
- Over 70% of patients rate pain at zero when first asked post-operatively.
- Care team is always present with limited interruptions and quiet environment.
- Care Suites are designed like a luxury hotel with a comfortable place to sleep for companion and catered meals from local restaurants.
- Concierge and valet services for patients/families

Taking Aim at Affordability

- Reduced out-of-pocket cost for patient
- Reduced cost of care to employer/payer for TKA/THA episode
- Reduced time away from work

Point-of-Care Testing for Strep Throat and Influenza in the Community Pharmacy

Target Pharmacy
Contact: Jason Ausili jason.ausili@target.com

Challenge
To improve access to low cost, convenient care for common infections in the community setting

Innovation
In October 2014, we launched Point-of Care Testing (POCT) for Strep throat and Influenza in five Minnesota pharmacies. In this model, the patient presenting wit symptoms is evaluated by a pharmacist for medical stability and administered a rapid diagnostic test (RDT) in a Healthcare Services Room adjacent to the pharmacy. If the RDT is positive, the pharmacist can treat under an evidence-based protocol within a collaborative physician practice agreement

Improving Health
- Provide access to appropriate level of care for patients who don't have a Primary Care Physician (PCP)
- Reduces antibiotic overuse by requiring positive test for antimicrobial treatment
- Supports continuity of care through pharmacist follow-up with documented PCP
- Reduces spread of infectious disease by providing convenient, timely access to care

Enhancing Patient Experience
- Patients receive appropriate level of care at their convenience during the weekday, at night and weekends
- Access to professional care is available in the community without an appointment or prior relationship

Taking Aim at Affordability
- Reduction in cost for treatment of Strep throat or Influenza
- Fewer emergency room and urgent care visits for patients lacking a PCP

Targeted MTM: A Population Health Approach to Improving Medication Use

Target Pharmacy
Contact: Victoria Losinski victoria.losinski@target.com

Challenge

Target is committed to improving the health of our total guest population. In 2014, several Medicare payors had asked Target to perform interventions on individual patients to improve their Star Ratings, but these interventions focused on a small number of Target Medicare guests. A Medication Therapy Management solution that could be applied to the Target total population was needed to improve medication adherence, close gaps in care and provide the most appropriate, effective medications.

Innovation

The TargetedMTM process was innovative because it provided proactive identification and intervention to improve guest care for the total Target Pharmacy population rather than a subset of guests with particular insurance coverage. Target implemented an internal analytic process and service strategy that utilized claims data to identify guests meeting criteria for pharmacist intervention regardless of payor or Medicare status. The pharmacy teams used work queues to reach out to guests to identify, resolve and prevent medication related problems using motivational interviewing techniques. This interaction identified: 1) if there was a clinical issue that needed to be addressed, 2) the health goals of the guest, 3) an appropriate action plan to resolve any issues, and 4) any other barriers that the guest may have in achieving their health goals.

Improving Health

- Improved medication adherence in patient with diabetes, hypertension and high cholesterol
- Reduction in gaps in care for patients with diabetes and hypertension
- Reduction in adverse events for elderly patients on high risk medications
- Systematic tracking of all eligible patients to ensure follow-up
- Communication with prescribing provider to improve care coordination

Enhancing Patient Experience

- Decrease prescription transfers by 65.2%
- On-going access to trusted health care advisor (pharmacist)
- Increased guest loyalty

Taking Aim at Affordability

- 0.6% estimated decrease in total cost of care for guests with diabetes receiving an intervention (Congressional Budget Office, 2012) based up on 3% Proportion of Days Covered improvement

A Pharmacy-based Management Program for Epilepsy

Thrifty White Pharmacy
Contact*:* Flora Harp fharp@thriftywhite.com

Challenge

For patients who have been prescribed medication for epilepsy, it has been found that seizures persist in 20-30% of cases.[1] Thrifty White Pharmacy has partnered with MOBĒ™ to address modifiable factors which could lead to improved seizure control in patients on anti-epileptic drug therapy.

Innovation

Developed a process to ensure patients with epilepsy get a consistent generic product that is the same size, shape, color and ingredients month after month. This was coupled with a care management program developed in partnership with MOBĒ™ and provided by Care Partners and pharmacists located at the Thrifty White Pharmacy Patient Care Center in Fargo, North Dakota. The program included a motion monitor tool which allowed Care Partners to monitor the patients' activity levels. With this information, Care Partners were able to help identify opportunities for monthly coaching around the importance of medication adherence and the importance of meeting physical activity goals.

Improving Health

- The epilepsy care management program has four goals:
    - Improve patient self-management
    - Improve medication management
    - Reduce the cost of care (e.g., reduce hospital admissions and ER visits
    - Improve clinical outcomes

Enhancing Patient Experience

- "At-home" pharmacy experience – no long lines, no waiting and a pharmacy team who has time to provide comprehensive support
- Frequent patient outreach – Care Partners reach out to patients at least 4 times each year (up to monthly if enrolled in Rx MedSync®)
- Enhanced support – Care Partners coach patients or caregivers on the benefits of medication adherence and meeting activity goals
- Accessibility – Dedicated Care Partner who patients can contact Monday-Saturday during extended hours
- Timely Delivery – Next day delivery of all new prescriptions

Taking Aim at Affordability

- By providing patient self-care and medication management support, we were able to keep patients adherent (PDC >80%). Studies have associated medication adherence to a decrease in total cost of care due to a reduction in inpatient and ER utilization.

[1] Devinsky O. Patients with refractory seizures. *N Engl J Med* 1999;340(May (20)):1565—70.

Sports Concussion Program

TRIA Orthopaedic Center
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Challenge

Sport concussion program services can vary widely. There is a distinct difference between simply treating concussion and having a concussion program. In our Market analysis, we found that not all disciplines of medicine that are specifically trained in concussion management were included in existing programs. In addition, other programs may not include athletic trainers, who are the front line providers of concussion care. TRIA's challenge was to develop an evidence based sport concussion care model to meet our community's needs.

Innovation

Same-day access to a multi-disciplinary team that develops a formalized management plan based on an athlete's symptom cluster, evaluates when an athlete is ready to return to full sports and a concussion care coordinator for follow-up care. Our program will include an athlete concussion support group for those struggling to return to their desired activity.

Improving Health

- Guideline and screening standards for concussion injury that include:
  - Sideline concussion evaluations
- Ensure timely but safe return to sport through specialized sport specific return to play protocols and exertion therapy.

Enhancing Patient Experience

- One-location for timely access & resources
- Reassure athletes and parents about recovery through education, objective screening and "return to learn" programs.
- Guided communication between parents, coaches, athletic trainers, primary care physicians, school educators by designated concussion coordinator.

Taking Aim at Affordability

- Reduce cost associated with ED , advanced imaging & multiple provider visits
- Early identification and reduction in duration or burden of symptoms

Reducing Catheter Associated Urinary Tract Infections through Implementation of a Comprehensive Education Bundle

United Hospital
Contact: Jennifer Barry Jennifer.Barry@allina.com

Challenge

Urinary Tract Infections (UTI) are the most common type of hospital acquired infections and most are associated with the placement of a urinary catheter. Catheter associated UTIs (CAUTIs) can lead to prolonged length of stays, increased costs, morbidity, and mortality. CAUTI are also included measures in Federal pay for performance programs and can adversely impact reimbursement. Minnesota hospitals, including United Hospital, had a higher incidence of CAUTI infections than desired. An analysis was conducted to assess insertion and maintenance practices and to identify possible interventions which could be implemented to help reduce the risk of CAUTI.

Innovation

Implemented a comprehensive bundle composed of CAUTI prevention education and urinary catheter insertion competency assessment by trained Super Users for all of our inpatient nurses. Change in practice protocol requires a two person insertion technique designed to ensure asepsis is maintained for every insertion.

Improving Health

- Increased staff awareness of CAUTI prevention recommendations
- Ensured asepsis during urinary catheter insertions
- Decreased risk of CAUTI minimizes a patient's risk of further complications following a hospital associated UTI including: secondary bloodstream infections, Clostridium Difficile, and surgical site infections.

Enhancing Patient Experience

- Infection risk has been greatly reduced, furthering the decreased risk of lengthened hospital stays, morbidity and mortality.

Taking Aim at Affordability

- 95% of inpatient nurses completed the Cutting CAUTI education and competency by December 31st, 2014.
- 100% of new nurses complete the Cutting CAUTI education and competency upon hire.
- CAUTI infections decreased by 77% hospital wide; with only five infections since education launch

Improving Efficiency in Living Organ Donation

University of Minnesota Health, Living Donor Kidney Program
Contact: Rebecca A. Stepan rstepan2@fairview.org

Challenge

The time from inquiry to evaluation for potential kidney donors was too long due to inefficiency in living donor workflow and matching processes. Donors, recipients and physicians had expressed dissatisfaction about the delay and process.

Innovation

Designed and implemented an innovative living organ donation workflow which improved health outcomes, satisfaction, cost and expanded the Paired Exchange Program (PEP!).

Improving Health

- Designed one standard workflow process based on donor intent—an innovation we believe to be the first in the nation—which used value-stream mapping to ensure donation occurs in a timely manner
- Reduces the time recipients receive an organ therefore decreasing adverse outcomes of a recipient continuing to suffer from kidney failure

Enhancing Patient Experience

- Decreased waste time in the evaluation period by 11 business days (nearly 2 weeks of unnecessary waiting)
- 100% of patient care team surveyed say the changes made in this innovation were safe for our patients and resulted in improved patient satisfaction
- 100% of the patient care team would participate in an additional Quality Improvement Innovation project in the future demonstrating the innovation improved likelihood of caregivers to continue improving patient satisfaction by our new design model

Taking Aim at Affordability

- Reduced unnecessary testing for crossmatches by 15%
- Decreased costs by $1,400 for each patient