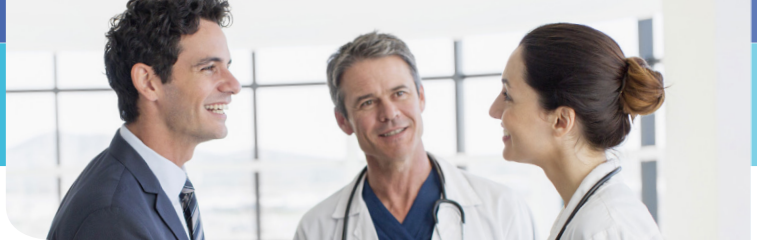

# New partnerships, new metrics for better population health

## Lessons emerge as Minnesota executives discuss health care

Throughout Minnesota, a variety of delivery system reform initiatives are targeted at integrating the full spectrum of care and improving care transitions, and they all have a common element: Collaboration and partnership among distinct entities.

## Achieving better population health

As the U.S. healthcare system becomes more complex with only modest gains in outcomes and quality, the industry is focusing on improving population health through new delivery models designed to place the patient at the center of care. States are becoming laboratories for these new models by developing policy and legislative initiatives that impact the health of populations and cost of care.

While no definitive strategy exists for "what works" in a patient-centered care model, states are beginning to discuss the lessons they've learned in the trenches of redesigning the way health care is delivered and paid for.

These lessons were shared during a recent healthcare executive discussion in Minnesota. Leaders from health plans, hospitals, government, and non-profit organizations talked candidly about the challenges, roadblocks and victories each is facing as they pursue improved population health outcomes. The discussion resulted in many personal, first-hand stories, from which two core themes emerged:

1. New and unconventional partnerships are developing to effectively manage population health, and
2. New metrics and measures are essential for success in population health management.

## New partnerships for person-centered care

Better population health requires a transition from exclusive attention on individual disease management to a focus that incorporates the social determinants of health. Factors such as a person's socioeconomic status, genetics, physical and social environments, and level of self-efficacy all have a deep impact on overall health outcomes. This is especially true of those with multiple chronic diseases.

Putting this approach into practice calls for a wider definition of health that extends beyond traditional care resources. Throughout Minnesota, a variety of delivery system reform initiatives are targeted at integrating the full spectrum of care and improving care transitions, and they all have a common element: Collaboration and partnership among distinct entities.

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## Payer-provider partnerships for personalized care: The creation of BluePrint by Blue Cross and Allina Health Network

Two important leaders in Minnesota's healthcare market, **Blue Cross® and Blue Shield® of Minnesota (BCBSMN)** and **Allina Health**, a not-for-profit healthcare system, recognized significant care challenges within their community and decided to work together in a different way to create change.

Like most health plans and providers, BCBSMN and Allina Health had a traditionally tense, negotiation-driven relationship. But they realized that their oppositional goals could actually be complementary—they could reward each other for collectively managing the total cost of care and clinical outcomes for the population using Allina Health's physicians and facilities.

The first step they took was to employ multi-year contracts so that there was less focus on negotiations and more on aligning economic incentives. Although they didn't completely remove fee-for-service elements, they were no longer the center of discussion. Their new focus was on transparency, which meant sharing data and strategies to better care for the Allina population.

"Clinical data and claims data doesn't automatically tell you where the cheese is. You really have to try and work together to figure out what those unique opportunities are," said *Garret Black*, senior vice president, Provider Collaboration and Network Management at BCBSMN.

In 2012, BCBSMN and Allina Health took their cooperative relationship to the next level by creating a new accountable care product, **BluePrint**, which is differentiated by its personalized member experience and affordability. It was the first time BCBSMN co-designed a product with physicians who gave input on which features were needed to improve access and care, such as chronic condition packages. Armed with a list of thoughtful, innovative benefits, actuaries then analyzed what was required to make the product economically sustainable. This forced physicians to give serious consideration to precisely which benefits would be most effective at driving better outcomes, enhanced health, improved access and reduced costs.

In summer 2013, BluePrint was launched, with some key aspects that make it uniquely person-focused:

1. **Personalization.** BluePrint was built with special attention to a comprehensive on-boarding process so that the plan could get to know its new members by discovering details, such as their health risks and whether or not they have a primary care physician. All members received a welcome kit and a follow-up phone call to ensure they received it and understood all of the benefits.
2. **Guided care.** The concept of guided care gives BluePrint members the tools they need to independently navigate the healthcare system with mobile technology, but it also integrates care managers and care navigators at the points where members need to have a live person walk them through a process.
3. **A network of excellence.** Allina Health's clinically-integrated network collaborates with a number of independent physicians and hospital systems. Marked by the tenet of trust, the network shares data across specialist groups, instead of only within Allina Health's own physicians, hospitals and clinics. This transparency gives the network access to robust clinical information, which enables powerful insight into factors that can drive change.
4. **A strong value proposition.** By incorporating feedback from a number of stakeholders (consumers, employers, brokers, and most importantly, physicians), BluePrint offers attractive features, such as its resiliency training by the Penny George Institute for Health and Healing. It is also 5–10 percent more affordable than other products and features a chronic condition package that pays at 100 percent, including maintenance drugs.

BCBSMN and Allina Health are positive about both the benefits and challenges of collaboration. As they look ahead, they want to improve access and convenience by "meeting consumers where they are" through e-visits and online care. "Will this have an impact? We hope so. We're going to get some traction and data to understand it, but that's what we're striving for as a collaborative," says *Brian Rice*, MHA, vice president, Network/ACO Integration at Allina Health.

## Combining resources statewide to reduce readmissions: The Minnesota RARE campaign

Minnesota's **RARE (Reducing Avoidable Readmissions Effectively)** campaign, launched in 2011, is an initiative among hospitals and care providers across the state to aggressively lower readmissions. Participating hospitals commit to the goal of reducing readmissions by 20 percent through partnering with care delivery organizations and focusing on the five key areas known to reduce avoidable readmissions: Comprehensive discharge planning, medication management, patient and family engagement, transition care support, and transition communications.*

### Integrating community resources

RARE is the essence of collaboration because it encourages hospitals to work with a range of community partners in long-term care, home care, primary care, and health plans to provide integrated, person-centered care. *Kathy Cummings*, RN, MA, project manager, The Institute for Clinical Systems Improvement, describes how Park Nicollet Health Services in St. Louis Park, Minnesota, uses local firefighters to perform post-discharge visits by applying their EMS skills: "The firefighters are excited because they want to prevent 911 calls for re-hospitalizations." Cummings says the core of the campaign "is about looking broader than just within our walls, and I think that's one of the things that we have opened up [people's] eyes to—it is about the community and where we can spend our resources more wisely."

*Source: www.rareadmissions.org

### RARE by the numbers

The Minnesota RARE campaign engages hospitals, providers, and all those involved in the complete continuum of care to reduce readmissions. To date, the program has witnessed impressive results:

- **7, 975** readmissions have been prevented as of the fourth quarter of 2013.
- Patients spent **31,900** nights at home instead of in the hospital.
- Minnesota hospitals reached a collective **19 percent reduction** in readmissions.
- Participating hospitals and health systems represented more than **80 percent of the state**.
- The program reduced healthcare costs by more than **$55 million**.

Sources: www.rarereadmissions.org; *Patient Safety Monitor Journal*, Volume 15, Issue 5: pp1, May 2014.

> "We're going to have tough conversations, but we have been building the trust and have the transparency necessary for open dialogue. That's going to be critical."
>
> — Brian Rice, MHA, vice president, Network/ACO Integration, Allina Health

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### Reinvigorating existing resources

The RARE campaign represents multiple layers of cross-functional collaboration. In addition to several care providers working together to reduce readmissions, the program's operating partners (the Institute for Clinical Systems Improvement, the Minnesota Hospital Association and Stratis Health) also function under the guiding theme of collaboration. They have worked with many people throughout Minnesota, such as representatives from the Minnesota Medical Association and Minnesota Community Measurement, to bring the program to fruition.

In fact, the program was conceived when the three partners convened for a discussion about reducing readmissions at a Minnesota Council of Health Plans meeting. Cummings recalls, "Each of our three organizations were starting to develop a strategy, when somebody brilliantly said, 'Why don't we work together and see how we can empower even further the resources that we each have?'"

Collaboration has proven effective at reducing readmissions. The RARE campaign exceeded its original goal of 4,000 fewer readmissions by December 31, 2012. It has prevented more than 7,000 readmissions to date.*

> "We have worked as a collaboration to look at creating a backbone for change."
>
> — Kathy Cummings, RN, MA, project manager, The Institute for Clinical Systems Improvement

## Health care alone cannot fix health care: Collaboration and policy

Collaboration for better population health is also taking place at the regulatory level. According to *James Koppel,* Minnesota Department of Health deputy commissioner, "We must think of health in all policies, from transportation to health care," emphasizing that the answer to improving care requires partnerships that extend beyond health care.

The Minnesota Department of Health (MDH) is putting this concept into practice by partnering with other state departments to implement changes that will impact the health of all populations. For example:

- MDH partnered with the Department of Economic Development to increase the **minimum wage**, which has a strong impact on the health of citizens; a recent study shows the life expectancy of a low-income Minnesotan is eight years less than the average.*
- Another state initiative that integrated resources outside of health care involved adding stops on the Twin Cities' **light rail system**, providing those living in lower-income neighborhoods access to the state's downtown neighborhoods with higher quality grocery stores and medical care.

*Source: Minnesota Department of Health, "Whitepaper on Income and Health," March 2014; posted as of October 2014, at www.health.state.mn.us/divs/opa/2014incomeandhealth.pdf

## Potentially preventable metrics across the country

3M™ Potentially Preventable Readmissions (PPRs) and 3M™ Potentially Preventable Complications (PPCs) are widely used in measuring healthcare delivery reform.

- **14 states** use 3M PPRs in hospital and/or health plan performance management.
- **Illinois, Massachusetts, New York, Texas and Ohio's** Medicaid programs adjust hospital rates based on 3M PPR and 3M PPC performance.
- 3M PPRs are core metrics in both the **Texas and New York** Medicaid Delivery System Incentive Reform Programs (DSRIPs).
- **Maryland's** All Payer Hospital Acquired Conditions program uses 3M PPCs.
- **Minnesota** and Wellmark® Blue Cross® Blue Shield® use 3M PPRs and other potentially preventable events in their ACO contracts with their major health systems.

# Choosing the right metrics for population health

In addition to new partnerships and collaboration, another element on the minds of healthcare executives is choosing the right measures or metrics to ensure that a population health program meets its goals. The problem is that while the concept of population health is gaining traction, the metrics to measure it are lagging behind.

Traditional quality metrics tend to track processes rather than outcomes, with the drawback that process measures inherently focus only on sick care, excluding the core tenets of wellness and health. "Don't measure processes if you really want to have an impact," says *Jim Chase*, President of Minnesota Community Measurement, a nonprofit organization that aims to drive improvement in health care through measurement and reporting. "Measure some outcomes that you're looking for and then people will find the processes that help get to the end point."

While the executives at the Minnesota meeting all agreed that metrics should focus on outcomes, they arrived at three key attributes of metrics that effectively support population health efforts.

> "Metrics provide a language and a goal for people to work towards. Metrics become the reality of policy. Without metrics, we can't really know where we're at and whether or not the systems are in place and the populations are being served in the way we want."
>
> — Herb Fillmore, vice president, Strategic Innovation, 3M Health Information Systems

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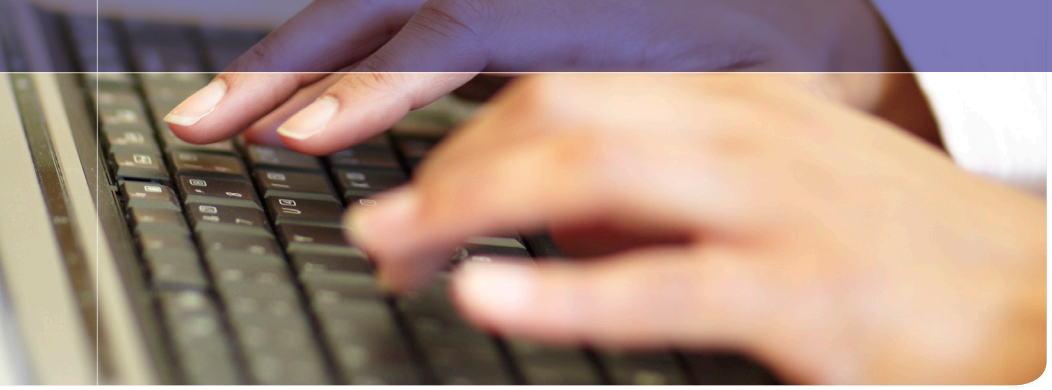

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1. **Measures that align cost and quality.** Measures that effectively link to payment and quality are most effective at achieving policy goals, in part because financial incentives get the attention of those at the executive level, along with practitioners and health systems. This shifts the focus to how well the system achieves outcomes, such as population health improvement and reduction in total cost of care.

   Texas is one state that realized the benefits of linking quality and payment within its Medicaid managed care program. *Billy Millwee*, managing principal at Sellers Dorsey and former Texas Health and Human Services Commission deputy executive commissioner and Texas Medicaid director, shared how the program believed the more quality measures it held its plans to, the more it would witness reduced costs and better quality. However, this approach led to significant variance in cost and quality among the plans, with no concomitant strategy for improvement.

   Once Texas implemented a review of preventable admissions and put up to four percent of premium at risk for HMOs, the managed care program started seeing better results. "By focusing on [metrics] that are measurable, directly related to payment, directly related to quality, and are around preventables, that is moving the program further now than it ever has in the past," says Millwee.

2. **Measures that empower physicians.** While metrics should provide clear goals for physicians, it's important that they also allow for some creativity. *Carolyn McClain*, MD, emergency physician at Methodist and Unity Hospitals in Minnesota, prefers the readmissions metric because it gives her the freedom to use her clinical judgment within the confines of a broader goal (e.g., reducing readmissions by five percent).

   She described a hypothetical situation where in order to meet the strep pharyngitis HEDIS test, she must spend money on ordering a strep test despite her confidence that her patient will test positive because his four siblings have already tested positive for strep. "That does not allow me any freedom as a physician to use my clinical judgment, but the readmissions measure is broad enough."

3. **Measures that are scalable.** Equally as important as choosing the right measures is obtaining buy-in from the providers who will actually be using the measures to make a difference. Agreement among one plan or one physician group typically isn't enough; it's necessary to provide "enough critical mass for providers that they will pay attention," says *Jennifer Vermeer,* vice president of Medical Affairs at University of Iowa Health Care and former Iowa Medicaid director.

When Iowa Medicaid created the opportunity for providers to build health homes, they didn't get the participation among larger systems that they expected. The program decided to revise its strategy and collaborate with Wellmark® Blue Cross® and Blue Shield®, the state's largest commercial insurer, and adopt the measures the plan had already implemented as part of its accountable care organization (ACO) strategy. Aligning with Wellmark not only captured the attention of providers, but by using the same metrics and methodologies, with some extra requirements for the Medicaid population, the program allowed providers to focus their efforts around common goals, without disruption to the work they began as part of the ACOs.

Along with measures that possess these qualities, it's important for someone to be held accountable for using metrics to achieve better results. Collecting data and creating measures can only take reform initiatives so far. As *Jim Chase* notes, the healthcare industry has a great love of data, and while it has information that supports where improvement is needed, "We also need to have some ideas about what [we] are doing to make the change."

# Conclusion

Putting the concept of population health into practice isn't a straightforward task; the right formula for success varies incredibly state to state, region to region. But by convening health leaders from various perspectives, some guiding lessons emerge for improving population health that transcend local differences:

- New partnerships are necessary for delivering care that is person-focused and meaningfully impacts outcomes
- These new delivery models require new metrics that align cost and quality, and garner acceptance and buy-in from physicians and other providers essential to delivering care

This report, developed by 3M Health Information Systems, offers a better understanding of the new requirements needed in a healthcare world that is moving toward evaluating success by population health outcomes, rather than disease-specific results. For more information on how 3M is helping payers, providers and government agencies navigate the healthcare landscape, please visit **www.3Mhis.com**.

# About the contributors

This document would not have been possible without the generous contributions of the leaders at the Minnesota healthcare executive discussion. Their willingness to share experiences, insights and lessons learned has shed light on the complexities of re-engineering the U.S. healthcare system to focus on population health. This document contains only a sampling of the many perspectives represented at the event.

### Garret Black, senior vice president, Provider Collaboration, Blue Cross Blue Shield of Minnesota

Garrett leads Blue Cross' initiative to create a high-performing healthcare system for Blue Cross members by offering affordable, high-quality care and optimal customer experiences via new forms of provider collaboration. These collaborations will result in new products, innovative care delivery and payment models, and integrated care management and health and wellness programs.

Prior to Blue Cross, Garret served as chief strategy officer for Children's Hospitals & Clinics of Minnesota. Before his work at Children's, he was system director for strategic development at Allina Health. His experience also includes seven years in consulting, where he advised hospitals, physician practices and integrated care delivery systems across the country on strategy, service development and financial planning.

Garret earned his bachelor's degree from Marquette University in Milwaukee and holds both an MBA and an MHA from the University of Minnesota.

### Jim Chase, president, Minnesota Community Measurement

Since 2004, Jim has been the president of Minnesota Community Measurement—a non-profit organization with the aim of improving health, reducing cost, and enhancing the patient experience through measurement and reporting.

Previously, Jim worked for the Minnesota Department of Human Services, health plans and provider organizations in the state. He is the past chair of the Network of Regional Healthcare Improvement, a group of leading regional health initiatives working to improve the quality and value of health in their communities. He also serves on the boards of the Institute of Clinical Systems Improvement and Apple Tree Dental.

Jim has a master's degree in health administration from the University of Minnesota.

### Kathy Cummings, RN, MA, project manager, The Institute For Clinical Systems Improvement (ICSI)

Kathy joined ICSI in early 2009 and is now the ICSI project manager for the RARE campaign. Kathy started her career as a staff nurse at the VA Hospital. Seeing the importance of staff development for improved care, she moved to Methodist Hospital to become an educator and eventually the director of performance development resources for Park Nicollet Health Services.

Throughout her career, Kathy has seen the importance of continually improving the work and services an organization provides. As a Lean expert, she developed the first inpatient Lean office at Methodist Hospital in St. Louis Park, Minnesota, overseeing the integration of Lean improvement principles into patient care and supporting processes.

### James G. Koppel, deputy commissioner, Minnesota Department of Health

As deputy commissioner, James serves as the chief of staff of the Minnesota Department of Health (MDH), the state's leading public health agency. MDH operates programs in disease prevention and control, health promotion, community public health, environmental health, healthcare policy, and regulation of healthcare providers.

Prior to his appointment, Jim served as executive director of Children's Defense Fund Minnesota and regional director of Children's Defense Fund Upper Midwest Region. Previously, he was the vice president of policy for the Minnesota Hospital and Healthcare Partnership for ten years.

Jim received his bachelor's degree from Mount Union College in Alliance, Ohio, and his master's in social work from Howard University in Washington, D.C.

### Carolyn McClain, MD, emergency medicine doctor, Minnesota Medical Association

Carolyn is a practicing emergency physician at Methodist and Unity Hospitals in Minnesota, as well as for The Urgency Room. As a partner with the Emergency Physicians Professional Association (EPPA), she is the assistant director of The Urgency Room and the assistant director for quality and education for her group of 140 physicians.

Carolyn has lectured on emergency medicine topics throughout the Twin Cities as well as internationally. She also developed and teaches an educational course to help nurses achieve their certification in emergency nursing.

Additionally, Carolyn is on the Executive Board of Directors for the Twin Cities Medical Society and is the chair of the Minnesota Medical Association Quality Committee. Carolyn graduated from Johns Hopkins Medical School and completed her residency in emergency medicine at Hennepin County Medical Center.

### Billy Millwee, managing principal, Sellers Dorsey

As managing principal with Sellers Dorsey, Billy works with clients on assessing new healthcare markets and products. His expertise includes the design, implementation and evaluation of Medicaid programs.

Prior to joining the Sellers Dorsey team, he served as the Texas Health and Human Services Commission deputy executive commissioner and Texas Medicaid director. In this role, Billy provided operational and programmatic leadership for the $30 billion Texas Medicaid and CHIP programs.

Billy holds a bachelor's degree in business administration from the University of Maryland, a master's degree in healthcare administration from Central Michigan University, and a master's degree in sociology from Texas State University.

### Brian Rice, MHA, vice president, Network/ACO Integration, Allina Health

Brian has been with Allina Health for 12 years. His current focus is leading the development of Allina Health's clinically integrated medical network that will support Allina Health and its independent provider partners to collaborate and align incentives for the successful delivery of market-leading quality, access, affordability and community health.

Brian's background has included performance improvement consulting services for hospital operations and leading strategic planning and business development efforts across the healthcare provider and payer settings. He received his master's degree in healthcare administration from the University of Minnesota and his bachelor's degree from St. John's University.

### Jennifer Vermeer, vice president, Medical Affairs, University of Iowa

Jennifer joined the University of Iowa in August 2014. Previously, she was the Iowa State Medicaid Director, for which she managed Iowa's $4 billion Medicaid program. Before being named director, Jennifer served as the assistant Medicaid director for three years.

Before her work with Medicaid, she was a senior analyst for the non-partisan Iowa Legislative Service Agency for two and a half years, specializing in Medicaid and other Department of Human Services programs. Jennifer served for seven years at the Joint Legislative Budget Committee in the Arizona Legislature, the last three years as deputy director, before moving to Iowa in December 2002.

Jennifer earned her Master of Public Administration from the University of Arizona and is a graduate of Central College in Pella.

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