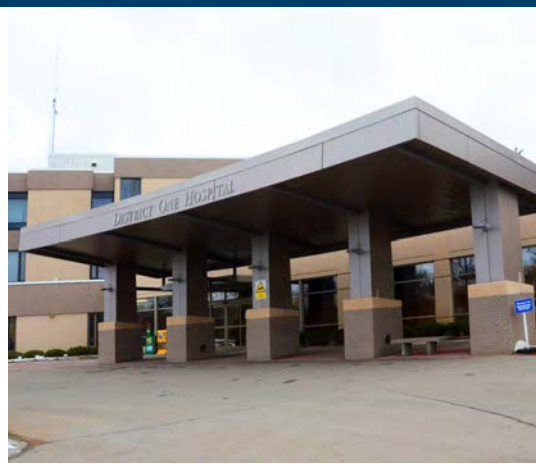
ALLINA HEALTH

Community Hospital Trustee Summit:

Spotlights in Innovations



Allina Health

BOUNCE BACK

promoting health through happiness

INTRODUCTION

The Bounce Back project is an initiative born at Buffalo Hospital. It is a unique collaboration of physicians, nurses, hospital leaders, and staff who have come together for a single purpose – to impact the lives of individuals, communities, and organizations by promoting health through happiness.

PROJECT GOALS

The Bounce Back project was developed with the following goals in mind:

- Provide tools, resources, and opportunities to foster resilience for individuals through the Bounce Back website.
- Engage local businesses, schools, and government agencies as partners in promoting evidence-based principles of resilience into their culture.
- Provide support and information to the health care community to address personal burnout.
- To collaborate with members of the health care community to use information and resources available on resilience in their practice.
- Engage in research with Allina Health's Division of Applied Research and organizations who support this work.
- Develop connections and collaborate with other researchers and organizations who are successful in promoting resilience.

PARTNERSHIPS

Multiple community partners have joined in the journey towards a healthier, happier community. Major partners include Allina Health, CentraCare Health of Monticello, employees of Buffalo Hospital, and over 40 community businesses and organizations.

KEY TOOLS

Bounce Back initiatives are based on research which demonstrates the effectiveness in decreasing rates of depression and improving levels of happiness through employing simple tools to help people focus their mind on the positive aspects of life. These tools further open individuals up to the possibility of greater social connections, improved sleep, enhanced memory, and stronger immune system function. It's simple, healthy, and life-changing.

Tools which have been shared by Bounce Back to help improve health and happiness are easy to use, and make a difference. Many of the tools are free and require few resources. Some examples include:

- **Random Acts of Kindness**—The Bounce Back website offers plenty of inspiration, including ideas such as buying a stranger coffee, or leaving a snack and nice note for your mailman.
- **Three Good Things**— This tool involves simply writing down three good things every night for two weeks. It has been proven to improve happiness, with results lasting up to six months.

OUTCOMES

Bounce Back partnered with the Patient Safety Center at Duke University to do a study in the Buffalo community around the "Three Good Things" happiness tool. Over 2,800 community members participated in the study, revealing that Buffalo experiences high burn-out and depression rates. Post-implementation of the Bounce Back project, depression and burn-out rates have decreased, and happiness and work/life balance has improved.

ADVICE TO OTHER LEADERS

Bounce Back project leaders have the following advice for other communities looking to implement similar projects:

- Build a team of hospital leaders and community members to be your innovators and implementers.
- Know that people are thirsty for this information. Everyone is chasing happiness, and it is scientifically proven that happy people live healthier and longer lives.
- It's not free! There are costs (staff time, printing, website, social media, etc.).
- It can be supported by philanthropy.
- This is good for Allina Health. It feels good to people, and helps us be the trusted partner they are looking for.

Questions? Contact Corey Martin, MD, Medical Director of Buffalo Hospital at ***corey.martin@allina.com*** or 701-527-4540. Or, learn more by visiting the Bounce Back website at ***bouncebackproject.org.***

District One & Health Finders Collaborative (HFC) Partnership

INTRODUCTION

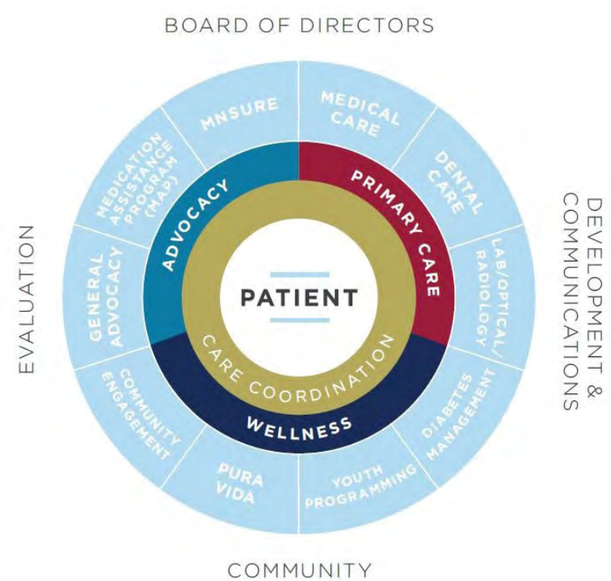
HFC is a community health center which provides a primary access point to health services for the marginalized individuals of Rice County. Through primary care, medication assistance, patient education and advocacy, and community-based wellness programming, HFC works across the continuum of wellness to engage individuals in their own health. Since the inception of HFC, District One Hospital (DOH) and Allina Health-Faribault Clinic staff have been involved, serving as board members and as HFC volunteers.

PROJECT GOALS

A collaboration between DOH, HFC, and other caregivers in Rice County has begun a long-term project to improve management and prevention of diabetes and cardiovascular disease. The innovative and collaborative project seeks to unite a diverse care team that goes beyond the clinic and into the community. The objective of this project is to increase management and control of cardiovascular disease and/or diabetes for the underserved population in Rice County by 25 percent on or before July of 2018.

PARTNERSHIPS

HFC has established front-line health workers, advocates, care coordinators, and more who connect patients with the clinical care team by utilizing the care coordination hub. The program structure also consists of DOH staff, Allina Health-Faribault Clinic staff, and community paramedics and wellness programs. Work groups include a steering committee, front-line health workers, information technology, quality improvement/assurance, and communications. This project is funded by the Medtronic's Healthrise Program.



UNIQUE ELEMENTS

This program is unique due to the availability of a referral to community paramedics for in-home follow-up and community health workers who are able to do home visits to ensure that the patient has adequate education regarding managing their chronic condition. This includes diabetic education such as blood sugar checks, administering insulin, and dietary education. In addition, the program assets uninsured patients with checking on insurance eligibility, and connects them with a primary care provider for continuity of care.

A word of advice to other leaders: Seek and lead community-based health and wellness initiatives.

Questions? Contact Stephen Pribyl, President of DOH at ***Stephen.pribyl@allina.com*** or 507-332-4733

Commission on Cancer Accreditation of Virginia Piper Cancer Institute – Faribault

INTRODUCTION

The structure outlined in Cancer Program Standards: Ensuring Patient-Centered Care ensures that each cancer program seeking accreditation provides all patients with a full range of diagnostic, treatment, and supportive services either on-site at the facility or by referral to another location, including community-based resources.

ACCREDITATION GOALS

Commission on Cancer accreditation encourages hospitals, treatment centers, and other facilities to improve their quality of care through various cancer-related programs and activities. These programs are concerned with the full continuum of cancer, from prevention to survivorship and end-of-life care, while addressing both survival and quality of life. There are approximately 1,500 CoC accredited cancer programs in the U.S. and Puerto Rico.

BENEFITS OF COC ACCREDITATION

Patients who obtain care at a CoC accredited cancer program experience the following benefits:

- Quality cancer care
- Comprehensive care and state-of-the-art services and equipment
- A multidisciplinary, team approach to coordinate the best cancer treatment options
- Access to cancer-related information and education
- Access to patient-centered services such as psychosocial distress screening and navigation
- Options for genetic assessment and counseling and palliative care services
- Assessment of treatment plan based on evidence-based guidelines
- Information about clinical trials and new treatment options
- Follow-up care at the completion of treatment, including a survivorship care plan, a cancer registry that collects data on cancer type, stage, and treatment results, and offers lifelong patient follow-up

ACCREDITATION PARAMETERS

CoC accreditation is granted to facilities that are committed to providing the best in cancer care and demonstrate compliance with the CoC eligibility requirements and standards. Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, cancer programs must undergo and on-site survey review every three years.

CURRENT STATUS

Virginia Piper Cancer Institute-Faribault survey was completed on August 10 and subsequently received notice of receiving Full Accreditation with mention of several "Best Practices".

A word of advice to other leaders: Be aware of and seek appropriate certifications and accreditations that distinguish our programs as the gold standard.

Questions? Contact Lynette Dickson, Patient Care Manager of VPCI – Faribault at ***lynette.dickson@allina.com*** or 507-333-5557

Specialty Consolidation at St. Francis Hospital

INTRODUCTION

Specialty consolidation is a strategic initiative that has helped to engage physicians, increase volumes, reduce sources of frustration, and develop viable clinical programs at St. Francis Hospital. The purpose of the strategy was to create viable surgical practice who feed off the referrals of Allina Health and Park Nicollet primary care clinics in the St. Francis primary service area.

BACKGROUND

Over the last two decades, it has been shown that splitting the specialty referrals between Allina Health employed/oriented groups and Park Nicollet-employed/oriented groups is counter-intuitive to building and maintain a viable clinical practice that promotes quality, safety, and patient experience. It lead to meager clinic and surgical volumes, resulting in frustrated and unengaged surgeons, and frustrate hospital staff and primary care physicians as they did not know who to call or who to refer to at what times.

PROGRAM GOALS

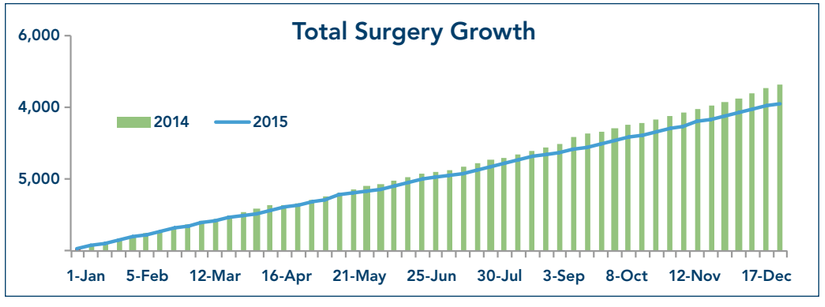
The program's goals were spread across orthopedics, urology, ear, note & throat, and gastrointestinal specialties:

- Develop a core group of on-call physicians who knew St. Francis, knew the hospital's staff and hospitalists, and were engaged around building a service line program
- Build volumes by incorporating self-referral patients, Allina Health primary care referrals, and Park Nicollet referrals (leveraging St. Francis' tri-ownership structure)
- Eliminate confusion by hospital staff related to constantly changing on-call groups
- Grow surgical volumes and case complexity by utilizing surgeons who are productive, invested in, and proud to be at St. Francis
- Enhance physician engagement by keeping surgeons productive and challenged as well as dedicated to quality and patient experience outcomes
- Allow patients to receive their care locally
- Develop a joint 24/7 GI coverage program with Ridgeview Medical Center

OUTCOMES

Specialty consolidation outcomes include the following:

- 12.3% growth in total surgeries between 2014 and 2015
  - ENT surgeries grew 22.9%
  - Urology surgeries grew 21.2%
  - Ortho surgeries grew 18.8%
- Ortho continues to grow, with volumes through June of 2016 being 25% ahead of 2015
- GI program is building momentum, but staying on pace with 2015 numbers, despite some challenges.



PARTNERSHIPS

Senior and mid-level leaders at St. Francis have been key drivers of this program, as have Allina Health, Park Nicollet, HealthPartners, and Ridgeview Medical Center. Several collaborative partners (including physicians and leaders from these groups) have been utilized in the specialty consolidation strategy, and vary by each service line:

- Orthopedics: Allina Health, Park Nicollet, HealthPartners, St. Francis
- ENT: Minneapolis Otolaryngology, Allina Health, Park Nicollet, HealthPartners, St. Francis
- Urology: Urology Associates, Allina Health, Park Nicollet, HealthPartners, St. Francis
- GI: Ridgeview Medical Center, Allina Health, Park Nicollet, HealthPartners, St. Francis

UNIQUE ELEMENTS

The uniqueness of the specialty consolidation strategy is centered on Allina referring patients to Park Nicollet orthopedic surgeons, Allina Health and Park Nicollet referring ENT and urology patients to independent groups, and Allina Health and Park Nicollet referring GI patients to Ridgeview Medical Center. St. Francis and Ridgeview are working together to build a GI program that will serve both hospitals with 24/7 GI coverage.

The most replicable element of this is collaboration with independent groups and competitors. It may seem counterintuitive to partner with competitors, but makes sense when the best interests of the patients are put forward.

A word of advice to other leaders: Open the door and have an "unthinkable" conversation. Other clinics and hospitals are likely struggling with similar issues.

Questions? Contact Michael Morris, Director of Business Development at St. Francis Hospital at ***michael.morris@allina.com*** or 952-428-2404.

Honoring Choices: Partnership between Owatonna Hospital and District One Hospital

INTRODUCTION

Owatonna Hospital has recognized difficulty in its service area of people struggling with end of life decisions. Hospital readmission rates are adversely affected by people near end of life who may be better served, medically and emotionally, by palliative and hospice care. The length of stay for hospice patients in the local market is very short; as little as one or two days for some patients. Short length of hospice stay significantly diminishes the value and effectiveness of hospice care to both the patient and surviving family members.

Honoring Choices®
MINNESOTA
An initiative of the Twin Cities Medical Society.

BACKGROUND

End of life planning is a topic that has been discussed extensively among Owatonna Hospital medical staff, Hospital ethics committees, and employees. The Respecting Choices advanced care planning programs developed by Gunderson Lutheran in La Crosse, WI, were reviewed and telephone consultations occurred. Respecting Choices is a national model for communities addressing the community attitude about end of life planning, decision making, and passing from this life with dignity during the final days of a person's life. While evaluating the end of life program options Owatonna Hospital became aware that District One Hospital in Faribault was having similar conversations, which led to a partnership between the hospitals (The Partnership).

PROGRAM GOALS

The Partnership is in the process of implementing the Honoring Choices Minnesota advanced care planning program in Owatonna and Faribault. The Honoring Choices Minnesota program was developed by the Twin Cities Medical Society. The purpose of the program is to make advanced care planning the collaborative standard of care for adults and to ensure every person's healthcare choices are clearly defined and honored. Honoring Choices is a base level program for all ages regardless of health condition to understand end of life choices, implications, and personal family discussion well before the need to confront end of life. Once the program reaches its potential, a growing number of people in the region will have been introduced to the topic, participated in education sessions, and hopefully have a signed personal advanced healthcare directive for inclusion in their permanent medical record.

UNIQUE ELEMENTS

End of life decision making is an emotional topic often delayed until times when stress levels are high and decisions must be made quickly. Honoring Choices is designed to make decisions and declare choices at a time when careful consideration can be given to the topic. This program is unique in its approach to education, coalition building and bringing this important emotional topic forward for discussion and consideration by families earlier in life.

PARTNERSHIPS

The partners engaged in this project include Owatonna Hospital, District One Hospital, and Honoring Choices Minnesota and the Minnesota Hospital Association. The Owatonna Hospital Foundation and District One Hospice Foundation have contributed funding to hire a full time advanced care planning coordinator to implement the program in both communities. A community advisory council, made up of people from both communities, is charged with overseeing the program, directing the work of the advanced care planning coordinator, and program implementation. An executive from Honoring Choices Minnesota provides guidance based on similar programs developed in the Twin Cities market.

Honoring Choices resources are funded by a grant from the State of Minnesota for the purpose of assisting outstate communities to implement the program. The Partnership has submitted a market readiness assessment to Honoring Choices Minnesota and has been selected as a participating market in the first outstate cohort. The plan is for an early 2017 community launch.

ADVICE TO OTHER LEADERS

This program is supported by The Partnership hospital's medical staff members and senior administration. To ensure success, it is recommended that the topic be discussed with local medical staff identifying a few physician champions who will participate on the community advisory council. Senior administrative support and participation are necessary to push this program as a priority. Honoring Choices Minnesota highly recommends a paid advance care planning position to advance and sustain the program. Funding for the position needs to be secured before moving the project ahead. Other partnership relationships need to be considered, including senior groups, clergy, community leaders and the legal community. This program is easily replicable using the structures described above and the assistance of Honoring Choices Minnesota representatives.

Questions? Please contact David Albrecht, President of Owatonna Hospital at ***david.albrecht@allina.com*** or ***(507) 977-2323***.

The Heart of New Ulm Project

INTRODUCTION

The award-winning Hearts Beat Back: The Heart of New Ulm Project is a collaborative partnership of the New Ulm community, the Minneapolis Heart Institute Foundation and New Ulm Medical Center. The entire community is working toward a common vision — to support a culture of wellness in the community and help people make the healthy choice where they live, learn, work and play. This project has been recognized with the Minnesota Hospital Association's Community Benefit Award as well as the American Hospital Association's Nova Award.

hearts beatback®
THE HEART OF NEW ULM PROJECT

PURPOSE

Through activities, education, policies and environmental changes, people who live or work in New Ulm are supported in their efforts to get more physically active, eat more fruits and vegetables, lose weight, quit smoking, manage stress and make other healthful lifestyle choices. Efforts involve the entire community — from health care organizations, providers and individuals, to schools, worksites, public health, local government, and civic groups and organizations.

PROGRAM GOALS

The goal of the Heart of New Ulm Project is to eliminate heart attacks in the 56073 zip code by addressing the modifiable risk factors of blood pressure, cholesterol, BMI, blood glucose, medication adherence, smoking, physical activity, fruit and vegetable consumption and triglycerides.

COLLABORATIVE PARTNERS

This project has been successful thanks to the broader community partners of restaurants, grocery stores, schools, city and county government and employees, New Ulm Park and Recreation Department, and New Ulm Chamber of Commerce.

The Heart of New Ulm Leadership Team is comprised of representatives from the following organizations: New Ulm Medical Center, Minneapolis Heart Institute Foundation, City of New Ulm, New Ulm Public Schools, Brown County Public Health, New Ulm Medical Center Foundation, Chamber of Commerce, Turner Hall, Hy-Vee, Firmenich, Alliance Bank, and Martin Luther College. There are also five action teams that complete project work and report back to the leadership team. They include:

1. Coalition for Active Safe and Health Streets
2. Safe Routes to School
3. Worksite Wellness
4. Health Equity
5. Community Health Challenge

UNIQUE ELEMENTS

The Heart of New Ulm Project is a comprehensive community health program that reaches people where they live, work, learn and play. The Project started out being very program-focused and has now shifted to focusing on policy, systems, and environmental changes while implementing programs that support efforts in the community. It includes a comprehensive communications strategy to keep the community informed of the various initiatives and to provide education on adopting healthy lifestyle behaviors.

The Project has assessed all aspects of the community to identify opportunities for change, and worked to meet the organizational partners and helped them to move along the continuum to help improve the health of their employees, customers, students, etc. Trainings have been provided and capacity has been built to allow the community to make changes within their own organizations rather than making changes for them.

REPLICABLE ELEMENTS

Developing a local leadership team that provides the direction and guidance for the improving community health is replicable. Action teams are created to do the work that has been identified as a need by the leadership team. The creation of action teams allows more people to get involved in the work, increases community engagement and allows them to work on something short term that they may be passionate about.

- Local restaurants participating in the Heart of New Ulm Project have committed to serving the same great-tasting food with fewer calories and more fruits, vegetables, whole grains and healthier fats. The level of participation (Bronze, Silver or Gold) is set by the number of healthy practices offered at the restaurant.
- Concession stands at school events are providing healthier options for students and spectators.
- The Complete Streets initiative is aimed at improving safety on roadways to encourage increased walking and biking for all residents.

The turn-key SWAP IT to DROP IT social marketing campaign is available for communities and organizations to license and use. SWAP IT to DROP IT is a proven-effective, eight-month social marketing campaign that The Heart of New Ulm Project conducted in New Ulm, Sleepy Eye and Springfield. The campaign is designed to deliver monthly nutrition messages that encourage people to save 100 calories or more each day for weight loss. The campaign combines paid advertising, marketing strategies and partnership efforts to reach consumers where they are making food and beverage selections.

Safe Routes to School is a national program which has been adapted to a local context. The lessons learned in New Ulm can help other similar communities create the partnerships necessary to adapt the program for their own context.

ADVICE TO OTHER LEADERS

To truly impact community health, the hospital cannot do all of the work and in some cases should not be the lead organization. It is important to tap into key local leaders from diverse backgrounds to provide guidance and increase community engagement. It must be a community-based project and not something the hospital is doing for the community. The hospital is a key partner at the table, but it may have to set aside some of its priorities in order to gain the community ownership which helps ensure long-term sustainability.

Heart of New Ulm vs. National Health & Nutrition Examination Survey Changes (at 5 years)

	NHANES 2009-10	NHANES 2011-12	**NHANES Change**	HONU 2008-09	HONU 2012-13	**HONU Change**
Systolic BP (mean, mmHg)	122.8	124.2	-1.4	125.5	124.2	+1.3
BP at goal (<140/90 mmHg)	83.1%	82.5%	-0.6	79.3%	86.0%	+6.7
BP medication	35.2%	36.8%	+1.6	38.3%	47.6%	+9.3
LDL at goal (< 130 mg/dL)	64.3%	63.7%	-0.6	68.0%	72.0%	+4.0
Cholesterol at goal (<200 mg/dL)	47.5%	46.9%	-0.6	58.3%	65.1%	+6.8

Questions? Contact Cindy Winters, Business Consultant for HONU at ***cindy.winters@allina.com*** or *507-217-5548*.

A Novel Approach to Community Health Needs Assessment at River Falls Area Hospital

INTRODUCTION

Healthier Together Pierce and St. Croix Counties is a community coalition in western Wisconsin working to create and maintain healthy communities and provide strategic framework for local health improvement activities. Healthier Together is currently leading a two-county, four-hospital community health needs assessment (CHNA) process. River Falls Area Hospital played a key role in advancing the proposal for this collaborative CHNA, with Allina Health providing much support for the process.

COLLABORATIVE PARTNERS

The primary collaborative partners with River Falls Area Hospital (Allina Health) on this effort are Hudson Hospital (Health Partners), Westfields Hospital (Health Partners), Western Wisconsin Health (formerly Baldwin Area Medical Center), the Pierce County Public Health Department and the St. Croix County Public Health Department.

PROJECT GOALS

The goal of the collaborative CHNA is to bring together a wide range of people from across the two-county region to identify and address health priorities. The intention is to create an action plan with the community, including and expanding on the work that will be done by the local hospitals and public health departments.

BACKGROUND

In our two-county region, where (1) four hospitals' primary service areas overlap, (2) many stakeholders serve more than one hospital community – and often, the entire two-county region, and (3) the health issues identified by past CHNA processes were very similar, we believed a collaborative two-county CHNA process would be the most efficient and effective use of everyone's investments, resulting in more impactful community health improvement work in our region. We were already part of county-wide collaborations in both St. Croix and Pierce County. We therefore recommended to the executive leadership of the four hospitals and two public health departments that the two county-wide collaborations merge into one entity, Healthier Together Pierce and St. Croix Counties, and that we collaborate on a two-county CHNA process. Our recommendation was endorsed by the executive leadership and we launched the joint CHNA process in mid-2015, with extensive support from the staff at Allina Health who were supporting the CHNA processes at all other Allina Health hospitals.

UNIQUE ELEMENTS

While we believe this is likely the CHNA model of the future, there are not yet many hospitals or health systems participating in this type of multi-health system, multi-county CHNA.

CURRENT STATUS

We have finished Phase 1 (COLLABORATIVE ASSESSMENT AND PRIORITIZATION) and nearly finished Phase 2 (COMMUNITY INPUT AND ACTION PLANNING) of the process. The report documenting the process has been drafted and will be ready this fall for approval by local hospital and public health boards. The resulting report will be designed by Allina Health but headed "Healthier Together Pierce and St. Croix Counties" with the logos of all four hospitals and both public health departments. Action Teams are convening around each of our three priority issues (mental health, obesity/overweight and alcohol abuse) and will be writing the detailed action plans to support our high-level goals and strategies. Working under this umbrella, each of the six entities will then be able to build their own internal work plans that support the goals, strategies, objectives and activities reflected in the joint community health improvement plan.

A WORD OF ADVICE

While we believe this approach is the right approach, it is definitely more complicated. Take the time at the beginning of the process to ensure that roles and responsibilities – including funding for the process – are defined and questions are answered. Ensure that those at the table include not only top organizational leadership (hospital presidents and public health directors), but also those staff responsible for leadership of the CHNA process, as they will bring different knowledge and perspectives and raise different questions.

Questions? Please contact Heather Logelin, Director of Foundation at River Falls Hospital at ***heather.logelin@allina.com*** or ***715-307-6001***.

Mental Health Boarding in the Emergency Department at Cambridge Hospital

INTRODUCTION

Mental Health Boarding in the Emergency Department (ED) is an Allina Health system-wide initiative. Cambridge Hospital was the pilot site, but the initiative has extended to Buffalo, Unity, and United Hospitals as well. The purpose of this program is to provide quality care to the mental health population by increasing the consistency of care being delivered. Eighteen care standards were tested and implemented that were developed by a multidisciplinary group that included Emergency Medicine Practice Council (EMPC), Mental Health (MH) service line, regulatory, security, pharmacy and Assessment and Referral (A&R).

PROGRAM GOALS

The initial goal was to improve care provided to boarding mental health patients as emergency departments were not designed to hold patients for days at a time. Simple things like showering, brushing teeth, home medications, and other activities were not consistently provided to boarded mental health patients. This initiative has proven effective in decreasing the number of code greens and restraints, which thus will help decrease workplace violence, staff and patient injury, and length of stay.

COLLABORATIVE PARTNERS

Partners include emergency room providers and staff, A&R, and psychiatry, security, and pharmacy staff members.

RESOURCES

Resources utilized in this successful initiative were system resources that included EMPC, mental health service line, and performance improvement.

UNIQUE ELEMENTS

This was a multidisciplinary project that required many stakeholders coming together and trying something different. There was also not a lot of information on best practice so innovative standards of care and measurement systems were developed. Now, the focus of this initiative will shift towards ensuring sustainability across the organization.

Questions? Please contact Autumn Hanes, Patient Care Manager at Cambridge Medical Center at ***autumn.haynes@allina.com*** or ***763-688-6432***.

Regina Foundation Development Council

INTRODUCTION

The development council is a foundation model comprised of a series of interdependent, function-specific committees of community volunteers. These committees typically include employee participation, community relations, business relations, annual giving, major and special gifts, and planned giving.

PROGRAM GOALS AND OUTCOMES

This model builds employee and community relationships through activities and personal involvement that establishes and maintains donors at all giving levels. Effectively implemented, the development council model significantly increases the number of people that interact with the hospital, building awareness, trust, and likelihood of choosing the hospital for services and as a philanthropic priority.

COLLABORATIVE PARTNERS

Each committee in this model is stronger when creating collaborative relationships to achieve its purpose. For example:

- The employee participation committee of this model is a group of influence leaders whose initiatives build organizational spirit and likelihood of employee participation in the hospital's philanthropy effort. High employee participation levels energize the community volunteers that comprise the remaining foundation committees.
- The community relations committee in this model often partners with outside organizations with related missions to host or partner in its health promotion programming.
- The planned giving committee of this model often engages community financial advisors, trust officials, lawyers,

Events sponsored by committees throughout this model often partner with outside organizations / individuals as hosts for recognition or membership events.

RESOURCES

Hillary Lyons Associates of Dimondale, MI started this model nearly 50 years ago and provides consulting support of our approach. We operate this model in alignment with Allina Office of Philanthropy resources and strategy.

UNIQUE ELEMENTS

- Volunteers drive the model's success. Staff provide direction and organization, but otherwise focus on supporting the volunteer's success.
- The model is a community relations model that builds philanthropy. It cultivates potential donors at all giving levels and maintains those relations over time with its recognition and other programming.
- The employee committee within this model breaks down barriers between departments and engages employees in the organization's greater mission.

REPLICABLE ELEMENTS

The model is low tech; it is completely built around community influence leaders who can recruit other community influence leaders. All elements are replicable and adaptable to meet organizational interests.

A WORD OF ADVICE

Often, hospital relationships with their associated foundations is very distinct. Hospital leaders appreciate the special event efforts and annual campaign efforts that periodically attach donors to the organization's Mission.

The development council approach makes the organization's foundation a key strategic partner in the organization's community relations strategy. A half-hearted attempt at this approach will yield half-hearted results. The approach takes a lot of energy to support the volunteers and the committees' varied efforts. Ensure alignment with the tremendous tools of the Allina Office of Philanthropy. Leadership support and involvement is critical to success.

Questions? Thomas Thompson, President of Regina Hospital, ***Thomas.thompson@allina.com***, **651-404-1450**.

Cambridge Hospital Concussion Program

INTRODUCTION

In 2007 Cambridge Medical Center, in combination with its Sports Medicine department, committed to developing a comprehensive concussion diagnosis and management program to address a growing community need for concussion care. The program was initially funded by donations from the local community and has grown exponentially in both volumes and level of care delivered. The program is completely physician driven, making it unique in its design.

PROGRAM PURPOSE

The purpose of the concussion management program is two-fold. First, it serves to provide baseline ImPACT™ screening to local high schools and youth sports organizations that can then be used as a management tool in the event a concussion occurs. Second, it identifies patients who have sustained a concussion by providing them with the correct diagnosis and then giving them prompt access to a multidisciplinary team of concussion specialists for treatment in a safe, successful and sustainable manner.

PROGRAM GOALS

The program's goal is to provide concussed patients with access to an expert navigation team that can lead them through their injury and through the "system." We utilize the care model established at the leading concussion management program in the country at the University of Pittsburgh Medical Center (UPMC) under the direction of Dr. Micky Collins. Our program is based on MANAGEMENT of the concussion instead of simply MONITORING concussions. The care delivered is individualized to each patient. There is no cookie cutter approach. We believe that concussion management is done best when it is Patient-centered/Physician-driven/Athletic Trainer-sustained.

COLLABORATIVE PARTNERS

The program utilizes Athletic Trainers (ATs) who are integral to its success. They are the link to athletes in the local schools, to the Urgent Care and ED departments as well as primary care providers. They help facilitate timely access to the program for the patient and provide continuity of care after the patient has seen the concussion specialist. Our program prides itself on being a "clinic without walls," and our ATs make that all possible.

We have close working relationships with area schools including activities Directors, coaches and school guidance counselors and nurses. We have established a very successful pager system, run by our ATs, that is available 24/7 that makes the link between ED, UC, primary care clinics into our concussion management clinic, as seamless as possible.

Our ATs also are the contact point to do baseline computerized ImPACT™ testing for area youth sports organizations.

We have close working relationships with several concussion referral specialties including Physical Therapy, Occupation Therapy, Neuro-optometry, and Neuropsychology.

RESOURCES

Athletic Trainers are the most important resource for success. Without them, the program would not function. In addition, Cambridge Medical Center has paid in the past for maintaining our Credentialed ImPACT™ Consultant status and also for essentially free Baseline ImPACT™ testing to all of our athletes at Cambridge-Isanti High School and Braham High School. Orthopedic Sports Medicine cost center is now in process of transitioning payment for these issues.

UNIQUE ELEMENTS

In addition to what is stated above, our program is unique because there are very few concussion specialists in the region, and even fewer who will also manage adults with concussions. Our program is so well organized that we have demonstrated a 97% retention rate in the Allina Health system if a patient is seen within one of our ED, UC or primary care clinics in Cambridge. Compare that to metro data which only shows about a 55% retention rate. Concussion management is a huge void across the healthcare system. We are making a huge positive difference in returning patients to their pre-concussion lives.

REPLICABLE ELEMENTS

In trying to roll this program out over the past 2-3 years in the metro area, it is clear that there MUST be a central group that is guiding this program and it must be physician driven. The success of the program is contingent on having interested, motivated physicians and ATs who enjoy working with concussion patients. We have a Concussion Work Group which has been established as a subgroup of the Allina Health Oversight Committee. We help guide program rollout in various areas within Allina Health.

A WORD OF ADVICE

This is a program that has proven to be financially viable but more importantly, successful in providing patients with easy and seamless access to care that will maximize their potential for a positive outcome. We have learned over the years that if you are going to commit to such a program, you have to have all the pieces in place before you begin to see patients. This is NOT something you can just dabble in. Our Allina Health Concussion Work Group can be a great resource to help.

Questions? Contact:

- Dr. Budd Renier, Allina Concussion Workgroup – Physician Lead at ***george.renier@allina.com***
- Dr. Mike Patten, Cambridge Medical Center at ***michael.patten@allina.com***

Project SEARCH at River Falls Area Hospital

INTRODUCTION

Project SEARCH is a one-year transition program for young adults with disabilities whose goal is competitive employment. The program model includes total immersion of the interns in the workplace which facilitates the teaching and learning process as well as the acquisition of employability and marketable work skills. Interns participate in three internships to explore a variety of career paths. The interns work with a team that includes their family, a special education teacher and Rehabilitation Services Administration to create an employment goal and support the student during this important transition to work.

Project SEARCH was developed at Cincinnati Children's Hospital Medical Center in 1996. Since its inception, Project SEARCH has grown to more than 300 sites across the United States and Canada, England, Scotland, Ireland, and Australia.

BENEFITS OF THE PROJECT SEARCH MODEL:

Benefits to the Interns:

- Participation in a variety of internships within the hospital
- Acquire competitive, transferrable and marketable job skills
- Gain increased independence, confidence, and self esteem
- Obtain work based individualized coaching, instruction, and feedback
- Develop linkages to Vocational Rehabilitation and other adult service agencies

BENEFITS TO THE HOSPITAL:

- Access to a new, diverse, talent stream with skills that match labor needs
- Gain intern/employees with disabilities who serve as a role model for employees and customers
- Performance and retention in some high-turnover, entry-level positions increase dramatically
- Supports our mission of being a good community partner

PARTNERSHIPS

Multiple community partners support the program, including Allina Health, River Falls School District, Ellsworth School District, Wisconsin Department of Workforce Development, Bridge for Community Life, TMG, and ContinuUs.

OUTCOMES

Project SEARCH programs' average rate of employment exceeds 70% across all programs, and over 80% in Wisconsin. The 2015-2016 intern group at River Falls Area Hospital had a 73% employment rate prior to the program completion.

The magnitude of these results may be lost to those who aren't familiar with the employment statistics of individuals with disabilities. In 2014, 17.1 % of persons with a disability were employed as reported by the U.S. Bureau of Labor Statistics. In contrast, the employment-population ratio for those without a disability was 64.6 %.

ADVICE TO OTHER LEADERS

Project SEARCH is a worthwhile endeavor which provides an opportunity to partner with community agencies and increase cultural competence while leading the community to help decrease the high unemployment rate among individuals with disabilities. In addition, by hosting the River Falls Project SEARCH program:

- Employees had the unique opportunity to provide an inclusive work environment for interns while discovering how accommodations to complete tasks can assist everyone increase productivity and performance.
- Employees who were not in traditional leadership roles had the opportunity to mentor and provide guidance to interns, resulting in increased pride and sense of worth in their own positions.
- Repetitive tasks such as bin cleaning, sorting, and stocking were completed on a daily basis contributing to both employee engagement and patient experience.

Questions? Please contact Cyndy Bayer, Manager of Quality/Risk at River Falls Hospital at ***cynthia.bayer@allina.com***, or **715-307-6079**.

Value-Based Care at New Ulm Medical Center

PROGRAM PURPOSE AND GOALS

While much of the nation is still primarily tied into a fee-for-service reimbursement system, New Ulm Medical Center has nearly 50% of its revenue in value-based reimbursement arrangements through Medicare, Medical Assistance, and Blue Cross. The purpose of the value-based reimbursement program is to achieve the Triple Aim—improve quality, improve health, and reduce the total cost of care. Through these arrangements Allina Health is rewarded or penalized financially based on its performance on quality, patient experience and overall cost of care measures.

To improve quality, NUMC focuses improving quality measures such as cancer screening rates and chronic illness management. NUMC has worked to decrease cost by reducing high-cost utilization (such as ED, inpatient admissions, swing-bed) and guide patients towards more cost-effective and care-effective services. Experience has been improved by providing care coordination services across partner organizations. When these three objectives are achieved, the patients receive better care and achieve better health outcomes and Allina Health is financially rewarded.

PARTNERSHIPS

Partners in our value-based strategies include: All local Allina Health services, Physicians Group of New Ulm, Allina Health Network Division (ACO & Care Management), South Country Health Alliance (Medical Assistance payer), Brown County Public Health, Brown County Family Services, and Minnesota Department of Health

RESOURCES/PROGRAMS

Social Workers/Care Coordinators – partnership with South Country Health Alliance (SCHA) where NUMC and SCHA share in the salary cost to employ a social worker in the emergency department aimed at reducing high cost utilization and improving care and experience. As a result of the first cohort group after three years of intervention:

- Total cost Per Member Per Month (PMPM) reduced by 41%
- ED utilization reduced by 53%
- IP admissions reduced by 89%
- OP visits reduced by 41%
- Clinic visits reduced by 14%
- 67% improvement in patient's rating of their overall health at the conclusion of services

Pay-for-Performance – SCHA offers financial incentives to achieve agreed upon quality and service goals.

Senior Care Model – Per Member Per Month (PMPM) payment arrangement for some SCHA members (instead of fee for service payments) that recognizes the value of the extended provider visits at the facility and leads to lower inpatient admissions and emergency department visits. Aside from the SCHA relationship, NUMC provides senior care services at many different long-term care facilities in our region with similar goals related to quality, experience and cost.

BluePrint – an Allina broad network health plan through Blue Plus which includes Allina and its partners. The product offers additional price discounts, chronic care packages, premiums generally 5-10% below open access products and has a shared collaboration in total cost of care goals.

Pioneer Accountable Care Organization (ACO) – CMS program focused on the Medicare population in achieving quality standards and total cost of care targets that share in savings or loss attributed to the population.

Integrated Health Partnership (IHP) – State of MN demonstration project focused on patients who are on medical assistance by improving quality outcomes and lowering cost. Much like the Pioneer ACO, the IHP has an upside risk in year 1 and upside and downside risk in year 2 depending on performance of the attributed population.

Accountable Communities for Health (ACH) and SCHA Grant – NUMC received over $600,000 to implement a care coordination initiative to reduce health care disparities that exist between patients who are on medical assistance and the general population in certain quality measures, such as cancer screenings, chronic illness management and utilization of health care services.

Data Analyst – NUMC has a high performing data analyst that supports our Value-based Population Health strategies.

REPLICABLE ELEMENTS

- Care coordination – ER and Clinic based social workers
- Care Coordination Partnerships with County Public Health and Family Services agencies
- Senior Care Model to improve post-acute transitions and management
- BluePrint/Allina Network Health Plans expansion to bring greater affordability and performance to commercial market in regional communities
- Data Analytics Reporting tools to measure quality and cost of care

A WORD OF ADVICE

- Pursuing value-based arrangements requires organizations to redefine measures of success, such as membership, care integration, affordability
- Pursuing value-based arrangements can have a negative impact on a local budget while potentially providing benefits to overall system financial performance
- Success in accountable care will be enhanced when local care is integrated, expertise and resources of the system are leveraged to expand and enhance local care, and health improvement is a priority for the entire community
- Data analytics should guide your strategy and inform your outcomes measurement.

Questions? *Contact Carisa Buegler, Director of Operations/Support Services at New Ulm Medical Center at* ***carisa.buegler@allina.com*** *or* ***507-217-5210****.*

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