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## ACO Collaboration with Health Plans Moving Beyond the Clinic Walls

AMGA Sept 2011

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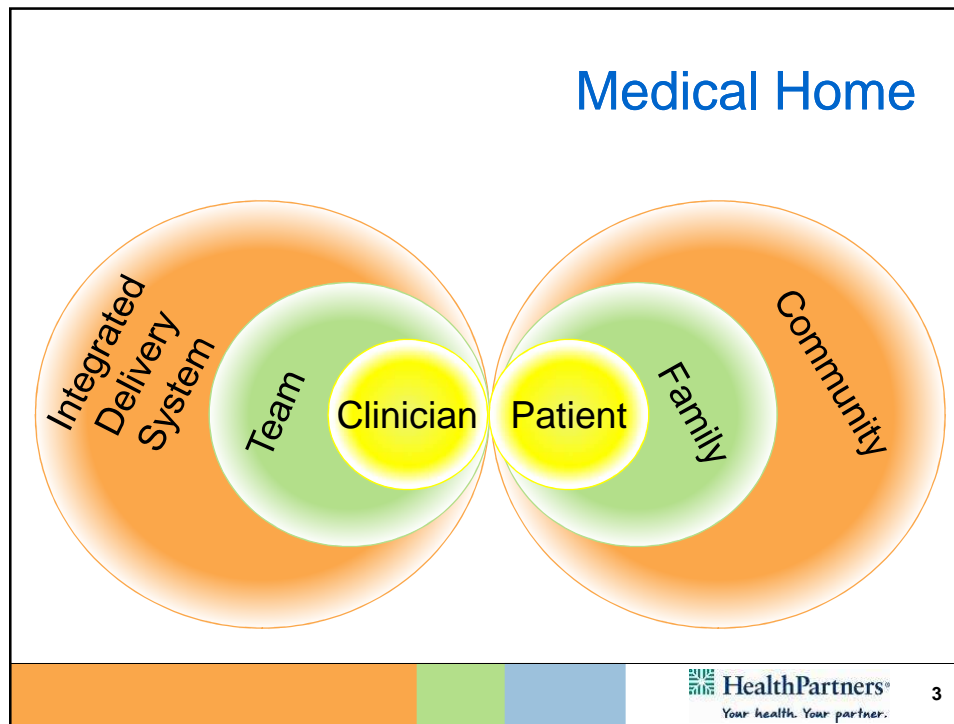
## HealthPartners

- Integrated Care and Financing System
  - 10,300 employees
  - Medical Group – 400,000 patients
    - Nearly 700 physicians
      - Primary Care
      - Specialty Care
    - 35 medical and surgical specialties
    - Multi-payer
  - Hospital: 435 bed level I trauma center urban teaching hospital
  - Non-profit health plan: 1.5 million members in Minnesota and surrounding states
  - Consumer governed
- Mission: To improve the health of our members, patients and the community.



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## Accountable Care Organizations

- Goal – improved health, better experience of care and lower costs
  - Optimizing health and preventing complications
  - Care coordination and seamless transitions
  - Removing waste but not withholding needed care
  - Putting the patient at the center

## Putting the Patient at the Center “The Visit”

Some numbers to consider:

– 3.36

– 83

– 58

– 0.07

» [cdc.gov](http://cdc.gov)

## Supporting patients at home and at work

### “In-Between Visit”


99.93% of their time

**Care Design Strategy**

**Hope & Good Intent**


or

**System Development**  
Process, People (culture), Tools





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**Culture**



- Leadership**
- Aligned purpose**
- Partnership**
- Complementary Skills**
- Systems & Teams**
- Patient centered**



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## Care Design Principles


- Assume good intent
- Assess current capacity
- Start small, spread to all
- Condition neutral
- Right person doing the right work
- Support patient-provider relationship
- Involve patients and families

## Care Design Structure

- Cross functional team
- Complementary data
  - Claims
  - Clinical
- Project management
- Senior Leader sponsored

## Convenient Services and Patient Choice Call, Click or Come In






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### Health & Wellness

Get and stay healthy with your one-stop spot for health and wellness resources.



**2010-11 Flu Season**  
Get important updates on the flu and flu shots.






#### Save


**Frequent Fitness**  
Save \$20 on your gym membership every month.

**GlobalFit**  
Save up to 60% on monthly dues for gym memberships nationwide.


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**Eat smart**



**Be tobacco free**



**Get moving**



**Rethinking drinking**


If you have a special health need or condition, your most powerful tool for managing it is reliable information and quality care. Find special programs to support you in managing your health needs:

<a href="#">Asthma and COPD</a>	<a href="#">Disease management</a>	<a href="#">Low back pain</a>
<a href="#">Behavioral health</a>	<a href="#">Diabetes</a>	<a href="#">Pregnancy</a>
<a href="#">Child and teen health</a>	<a href="#">Depression</a>	<a href="#">Weight control</a>
<a href="#">Case management</a>	<a href="#">Heart health</a>	

#### Resources

- [Virtual coach](#)
- [Health Information Library](#)
- [Decision support tools](#)
- [Health classes](#)
- [Preventive guidelines](#)
- [Advance directives](#)

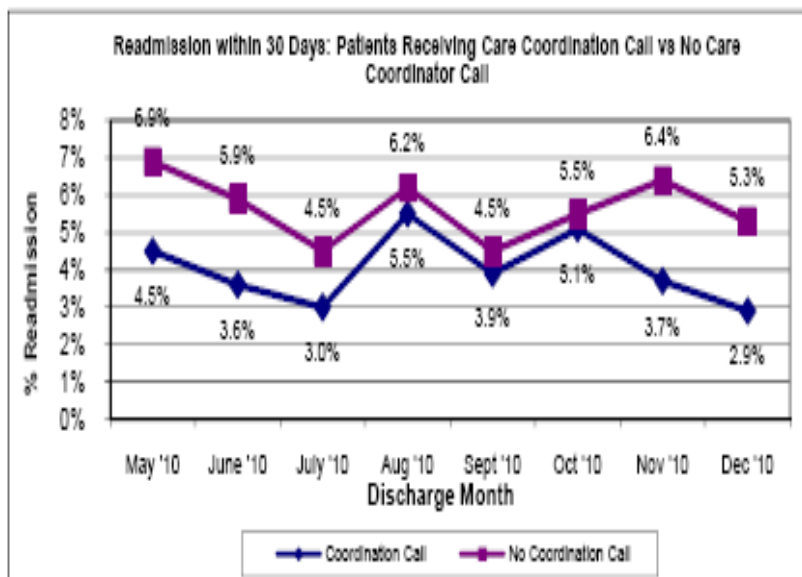
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## Care Coordination: Patient Transitions

- Urgent Care and ED to Primary Care
  - Scheduled orders for follow-up
- Home to Hospital
  - MD notified of admission
- Hospital to Home
  - Follow-up call within three (3) days
  - RN function



## Partnering with Community Hospital and Health Plans

- EHR view access
- Use existing case management at the hospital to do post-discharge call
- Hospital call center calls to ensure f/u appt – if no appointment, transfer to our clinic call center
- “transition” hotline – one number for 4 clinics, gets picked up 7:30 am each day and calls triaged to other clinics as needed
- Case management attends provider meetings
- Hospitalist attends clinic leadership meetings

## Care Coordination: Complex Medical Patients

- RN role
  - Care team based in clinic
  - Risk based registry
- Risk assessment
- Care plan development
- Shared visits
- Active referral to health plans and community resources

## Examples of Plan Coordination

- Optimize Care
  - Disease Management
  - Case Management
  - Outreach
  - Evidence based education
  - Alcohol and substance abuse
- Reduce high cost care
  - Decrease avoidable hospital & ER visits
- Increase MTM (Medication Therapy Management) and use of generics
- Decision Support
- Well@Work Clinics

## Total Cost of Care

**Professional Fees (Fee Schedule)**  
**Hospital (IP, OP, Pharmacy, Ancillaries)**  
**Pharmacy**  
**+ Referrals**

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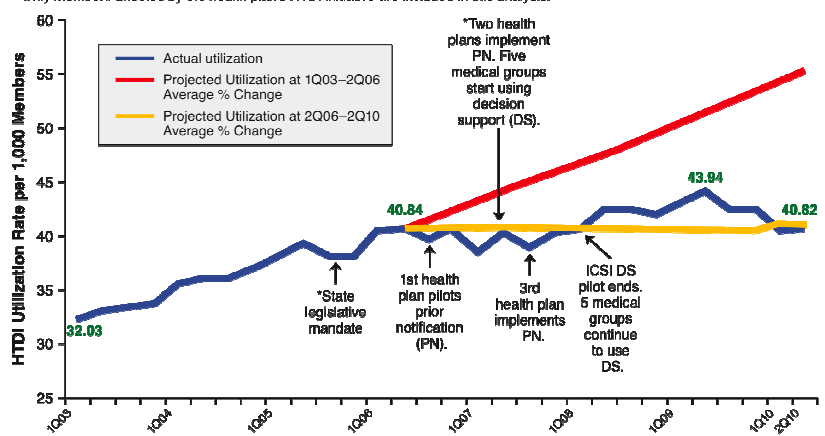
**Total Cost of Care**

## Improving TCOC

- Primary Care
  - Specialty referral preference
  - Standardized labs
  - Hospital choice
  - Screening test intervals
- Specialty Care and Hospital
  - Care pathways
  - Place of service
  - Consultation balanced with on-going care
- Medical Group
  - Generics
  - Fee schedule
  - Diagnostic imaging

### Aggregate HTDI Utilization Rate per 1,000 Members, 1Q03–2Q10 Aggregate Data Include: BCBS, HealthPartners, Medica, UCare and DHS Claims and Membership Data (Hospital Inpatient and ER Claims Excluded)

\*Membership profile differs across health plans.  
\*\*Only members affected by the health plan's HTDI initiative are included in this analysis.

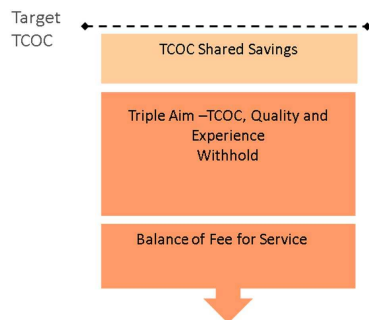


## Payment Reform to Support Value

- Take the emphasis off fee-for-service
- Pay for value (Triple Aim)
- Move to Total Cost of Care approaches

## HealthPartners Plan for the Future

### Our Current Model



### Our Future Model

- More global payment
- Less fee for service
- More TCOC risk and shared savings

## Key Learning's

- **Build reliable processes**
- **Partner operational experts across care settings**
- **Project management**
- **Stories to engage, data to inform**
- **Involve patients and families**