Transforming Primary Care for Population Health

The Leadership Institute Horizon Group

April 7, 2017

OSF HealthCare

Where We Serve

Central Region Hospitals
1. OSF Saint Francis Medical Center
2. OSF St. Mary Medical Center
3. OSF Holy Family Medical Center
9. OSF Saint Luke Medical Center

Eastern Region Hospitals
4. OSF Saint James – John W. Albrecht Medical Center
5. OSF St. Joseph Medical Center

I-80 Region Hospitals
6. OSF Saint Elizabeth Medical Center
11. OSF Saint Paul Medical Center

Northern Region Hospitals
7. OSF Saint Anthony Medical Center
8. OSF Saint Francis Hospital & Medical Group

Alton
10. OSF Saint Anthony's Health Center

Centers for Health
- OSF Center for Health – Belvidere – Belvidere, IL
- OSF Center for Health – Fort Jesse – Bloomington, IL
- OSF Center for Health – Glen Park – Peoria, IL
- OSF Center for Health – Morton – Morton, IL
- OSF Center for Health – Nord Farms – Bloomington, IL
- OSF Center for Health – Rock Cut – Loves Park, IL
- OSF Center for Health – Route 91 – Peoria, IL
- OSF Center for Health – State Street – Rockford, IL
- OSF Center for Health – Streator – Streator, IL

- Other OSF HealthCare Facilities

Independent Affiliates
Illinois Valley Community Hospital – Peru, IL
Memorial Hospital – Carthage, IL
Perry Memorial Hospital – Princeton, IL
Rochelle Community Hospital – Rochelle, IL
St. Margaret's Hospital – Spring Valley, IL

serve. connect. transform.

Northern Region

I-80 Region

Central Region

Eastern Region

Alton

Michigan

115
OSF Locations Including Hospitals

738
Employed Physicians

335
Advanced Practitioners

18,127
Employees

200,381
Home Health Annual Visits

1,469,492
Outpatient Visits

1,626,748
Physician Enterprise Office Visits

63,501
Inpatient Admissions

2,652
Hospice Patients Served

700,316
Number of Persons Served

$2.3 billion
Net Revenue

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OSF HealthCare & OSF Medical Group

- CMS ACO (Pioneer, NextGen, MSSP-3) since 2012
- BC/BS ACO relationship
- Over 60 NCQA recognized Level 3 PCMH since 2012
- Embedded and centralized Care Management resources
- Multiple markets with significant variability
  - Urban, suburban, rural
- Epic EHR since 2008
  - Single instance across entire ministry
- Robust EDW driving predictive analytic capabilities

The One OSF Journey - Cultural Transformation – Care Transformation

1

Vision of Population Health- time to focus

- OSF has multiple initiatives dating back several years- aligned but not yet fully integrated

- Physician Enterprise, Pioneer ACO

- EMR build out, System service lines

- Creation of Clinical Agenda and Clinical Excellence

- Transitions of Care

- Cutting edge Value based contracts

- Through a Ministry led Initiative Creation of a multi-year roadmap, enabling OSF to align, coordinate and integrate initiatives leading its shift to value

2

Reinforce Elements of the Clinical Strategy

- Existing elements of the clinical roadmap were captured and integrated into an overall clinical roadmap

- The team also considered **new clinical care models to be introduced to accelerate clinical transformation and enable greater performance on OSF's risk-based contracts**
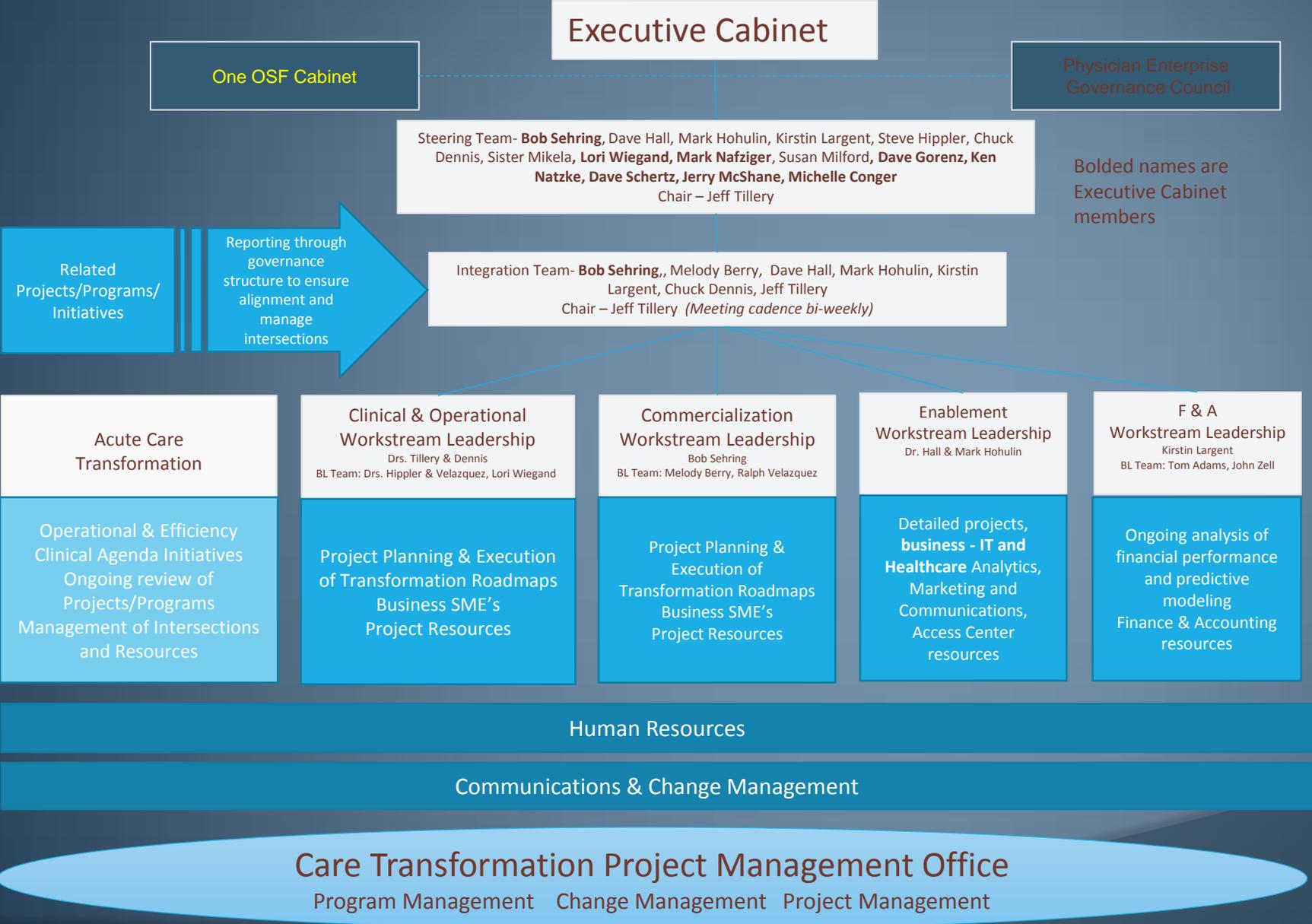
3

Map Efforts to a Comprehensive integrated financially sound plan

- The transformational plan was tested through a financial model that projects the impact of the shift from volume to value

- The staging and sequencing of initiatives can then be adjusted/ optimized based on the financial outlook

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Primary Care Model Transformation Approach

- Ministry working sessions to understand and define scope and goals
- Identification of key levers and definition of expectations
  - Population growth
  - Increased spend capture
  - Cost impact for risk based populations
- Development of governance structure and accountabilities
- Identification of outcome metrics

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Program Governance and Working Teams

Executive Cabinet

One OSF Cabinet

Physician Enterprise Governance Council

Steering Team- **Bob Sehring**, Dave Hall, Mark Hohulin, Kirstin Largent, Steve Hippler, Chuck Dennis, Sister Mikela, **Lori Wiegand, Mark Nafziger**, Susan Milford, **Dave Gorenz, Ken Natzke, Dave Schertz, Jerry McShane, Michelle Conger**
Chair – Jeff Tillery

Bolded names are Executive Cabinet members

Related Projects/Programs/ Initiatives

Reporting through governance structure to ensure alignment and manage intersections

Integration Team- **Bob Sehring**,, Melody Berry, Dave Hall, Mark Hohulin, Kirstin Largent, Chuck Dennis, Jeff Tillery
Chair – Jeff Tillery *(Meeting cadence bi-weekly)*

Acute Care Transformation	Clinical & Operational Workstream Leadership Drs. Tillery & Dennis BL Team: Drs. Hippler & Velazquez, Lori Wiegand	Commercialization Workstream Leadership Bob Sehring BL Team: Melody Berry, Ralph Velazquez	Enablement Workstream Leadership Dr. Hall & Mark Hohulin	F & A Workstream Leadership Kirstin Largent BL Team: Tom Adams, John Zell
Operational & Efficiency Clinical Agenda Initiatives Ongoing review of Projects/Programs Management of Intersections and Resources	Project Planning & Execution of Transformation Roadmaps Business SME's Project Resources	Project Planning & Execution of Transformation Roadmaps Business SME's Project Resources	Detailed projects, **business - IT and Healthcare** Analytics, Marketing and Communications, Access Center resources	Ongoing analysis of financial performance and predictive modeling Finance & Accounting resources

Human Resources

Communications & Change Management

Care Transformation Project Management Office
Program Management   Change Management   Project Management

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A number of key principles are guiding the development of the clinical transformation roadmap

	Principle	Summary
1	**Person-centered**	Our clinical journey will be transformative and rigorously centered to sustain or enable the health of the people of our communities – and will address the needs of both our patients and those who have yet to present in our sites of care
2	**Staged to Match Risk**	Clinical changes will be implemented in concert with our acceptance of risk – this will ensure that we are prepared to succeed under risk contracts, but also to ensure that we garner fair value for the solutions we create.
3	**Cognizant of Innovators**	The journey toward clinical transformation will need to start with those providers willing to innovate, test and share learnings and insights – they will be our catalysts for change
4	**Methodical in Inspiring Broader Change**	Recognizing the difficulties inherent in change, our approach and process must consider real-world challenges, provide focused support, convey a multi-stakeholder value proposition, and operate at a pace to create and sustain change
5	**Commitment to Change**	Leadership's messaging, funding and behaviors will play a key role in conveying OSF's commitment to the transformation; it must anticipate and mitigate resistance and show the organization the future state vision and the course to reach it

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Understanding and building models that support teams to achieve key results are critical

	Outcome Metric	Impact
1	**Patient Experience**	Creating a differentiated experience for our patients, families and communities through ease of access, integration of services, and improved knowledge and management of their needs as measured by traditional surveys and new tools
2	**Population Growth**	As broad initiatives are deployed to better manage our panels and populations, thereby reducing traditional levels of acute care and ancillary services, sustainability will require growth of populations served. Targets developed at market levels over 5 years
3	**Cost of Care Impact**	Impact on the historic rising trajectory of health care costs is critical to assure more timely and affordable access for services for all patients, simultaneously focusing on high utilization patients to align necessary services and team members to better manage their care in ambulatory settings
4	**Share of Spend Capture**	Better utilizing the full scope our integrated services is critical for managing care across the continuum, while maximizing necessary service utilization within the healthcare system
5	**Mission Partner Engagement**	Development of extended team based models of care that encourage and demand full utilization of talent and scope of service, while supporting each other in the delivery of care

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Primary Care Model Transformation Approach

- Identification of Wave 1 sites
  - 6 adult primary care practices in 3 markets
  - ~100,000 patients
  - >20% of primary care adult patients for OSF Medical Group
- Deliberate engagement of practice representatives
  - All care team roles represented from each site
  - Multiple dedicated sessions to define care team roles and refine overall approach
 - Patient segmentation approach to understand consumer needs

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Design Session Outputs

The shift to team-based Primary Care is not incremental, but transformative…

Core Team

Physician

APN / PA

RN

Medical Office Assistant

Office Staff

Extended Team

Care Manager (Embedded, Virtual)

Social Worker

PharmD

Behavioral Health (Mental health, behavioral health)

Key ancillaries (smoking cessation, PT/OT)

- Care team design must work "from the patient in" – starting with needs, extending to required actions, and then aligning skills, roles, etc.
  - Titles, disciplines, designations are important, but secondary to the activities required to realize the desired patient experience

- In real time, patient needs must be identified and triaged such that team's efforts are efficiently aligned to produce the best patient outcome (right care team member aligned to patient need)

- The model must encourage coordination that enables members to operate at the "top of their competency within the context of their license"
  - There is an opportunity to evaluate RN roles to maximize their contribution to the care team
  - Care team staffing will flex to address each practice's patient mix (e.g. Medicare, Medicaid, etc.)

- Beyond addressing the needs of sicker patients, the primary care team must also incorporate aspects of 'wellness' for their people

- These changes portend a significant change in operating model, but should create leverage that allows for significantly larger panel sizes – making a focus on growth critical to success

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...and will be designed to build the person-centered primary care ecosystem fully oriented to best meet community needs
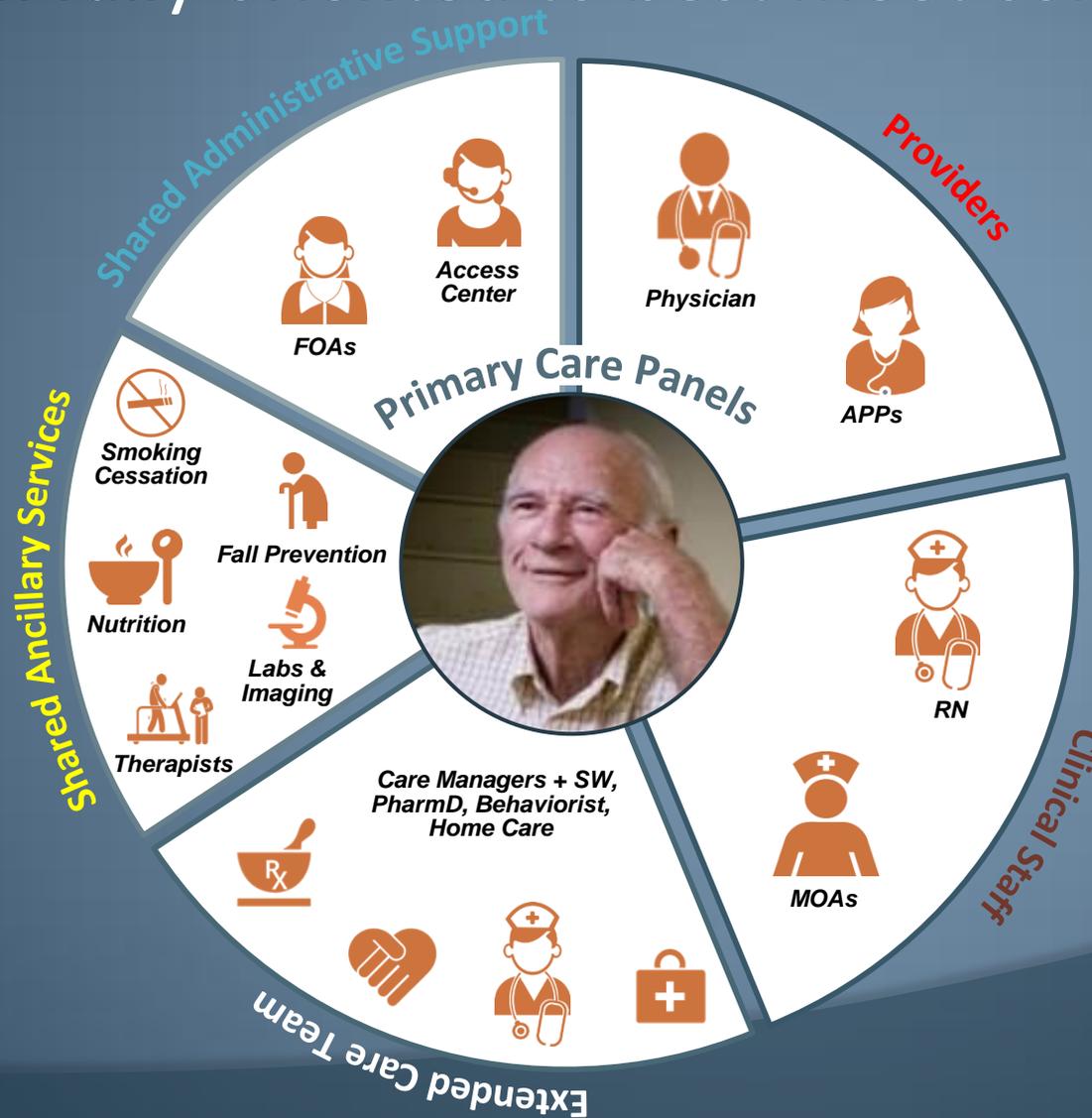
…and will build toward a next generation model that applies the many known solutions and interventions to drive a comprehensive change in the patient experience
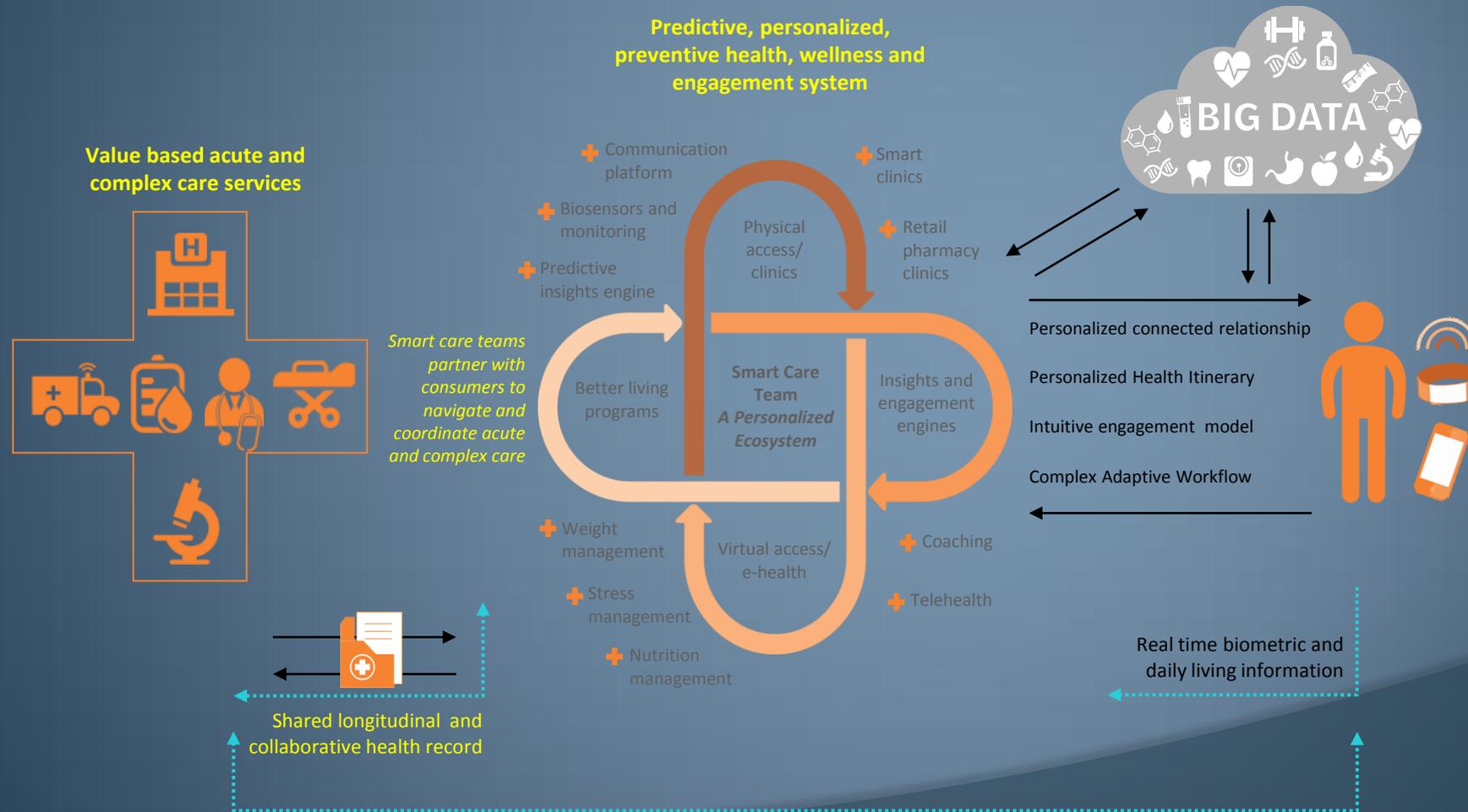
Design Session Outputs

- Principles for highly functioning care teams
  - Use of morning brief to review patient list, align appropriate care team members per patient need, review utilization scoring tool inputs, and share stories and outcomes while building culture
  - Improved same day access through multiple channels
    - 25% same day open appointments for physician / APP
    - Nurse clinic with same day / walk-in availability
  - Shift of care to most appropriate team member when appropriate
    - Development of standing orders for RN clinic
    - Linkage of care team nurse to clinician In-Basket to expedite and prioritize work, reduce inappropriate work

Design Session Outputs

- Development of Pre-Visit planning tools within Epic to flow into office visit
  - Identify and pend orders for Health Maintenance Alerts
  - Medication reconciliation / pend medication refills
  - Targeted chronic disease care gap closure for appropriate studies or documentation in advance of visit
    - Diabetes mellitus
    - CHF
    - Chronic lung disease

Design Session Outputs

- Development of alternative visit options
  - Pilot of primary care e-visit via Epic
  - Development of eQuestions / eConsults within Epic linked to specialty care knowledge and patient management
  - Dedicated RN clinic
    - Low acuity acute care visits with standing order guidance
    - Chronic disease education
    - Follow up visit opportunities for disease management and monitoring
- Distinct "Small and Rural" practice model
  - Unable to support full embedded extended team
  - Virtual support

Tools / Outputs of Collaborative Work

- Maturity staffing model to enable and support the defined extended team based model and outcomes
  - Physician / APP resources defined by panel size
  - Care Team Nurse, Nurse Clinic staffing
  - Appropriateness of embedded Behaviorists, dedicated Nurse Clinic, Care Managers
- Definition of "Access Guidelines" for hours of operation, work effort
- Development of Standardized Scheduling Template
  - 4 visit types
  - Removal of artificial blocks and holds for schedules

Tools / Outputs of Collaborative Work

- Crosswalks from model design to training and educational curriculum
  - Development of robust on-line, didactic/in seat, and simulation based training using standardized patients
  - Inclusion of clinical playbook education for clinicians with inclusion into in-situ simulation patient scenarios
- Development of OSFMG Care Transformation "Rewards & Recognition" program
  - Celebrates adoption and utilization of model, challenges broader use and movement to Care Transformation 2.0

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Tools / Outputs of Collaborative Work

- Integration with IT, Analytics, Managed Care, MarComm, and other resources to build enabling, supporting tools as defined by outcomes focused model

- Inclusion of Wave 1 sites for early adoption of enabling technologies (Innovation Pilots)

- Dashboard development for usable, transparent data cascading from provider-team-practice-market-region-ministry

Tools / Outputs of Collaborative Work

Tools / Outputs of Collaborative Work

Care Transformation Population

Traditional Office Face-to-Face
E&M coded visits

Non-E & M visit encounters within PCMH (phone, myHealth, eVisits, Tele-Health, etc)

E & M visit encounters in Non-Traditional settings (PromptCare, Specialty, SNF, Palliative Care, etc)

Attributed lives without OSF interaction

Unactivated / Deactivated
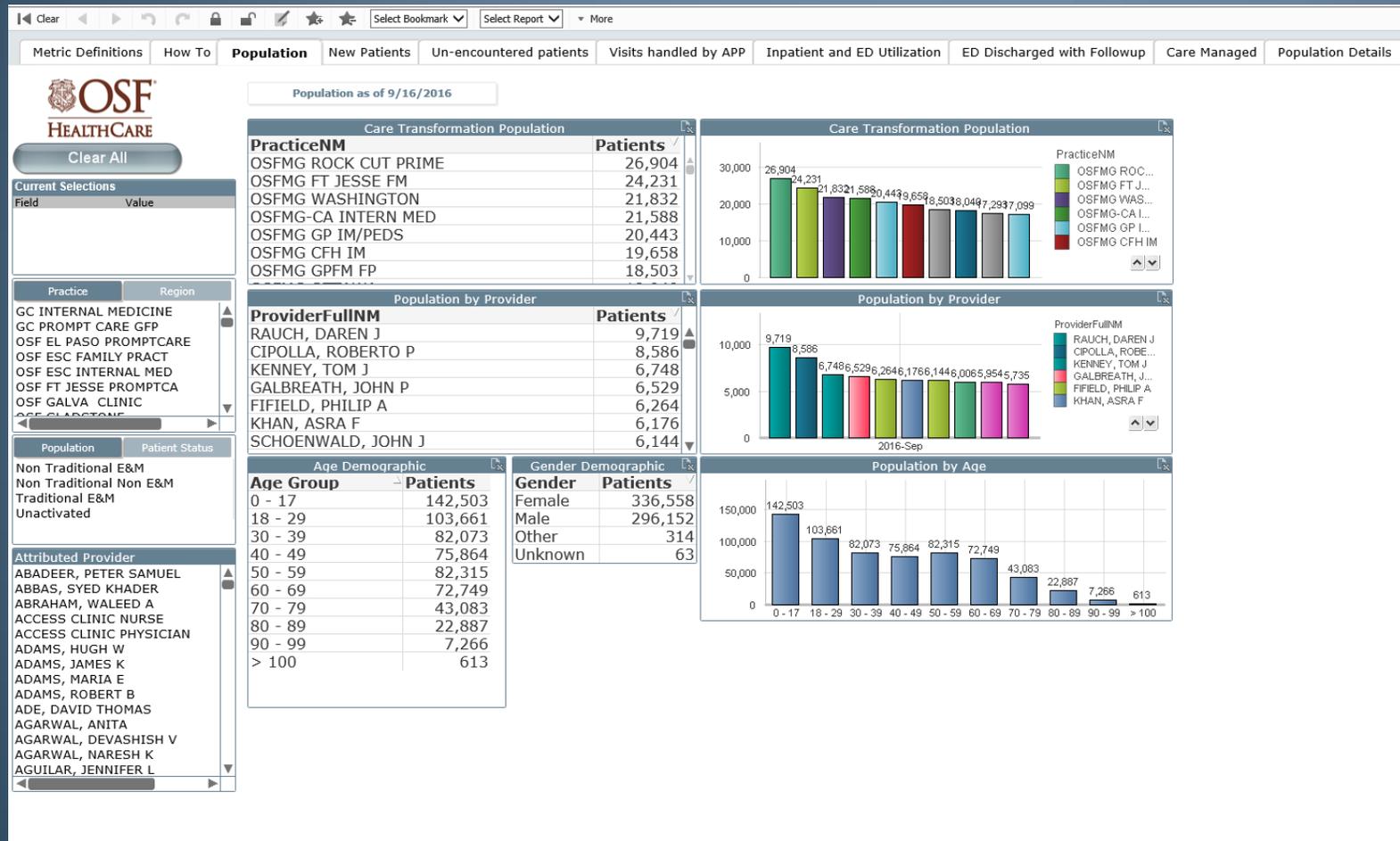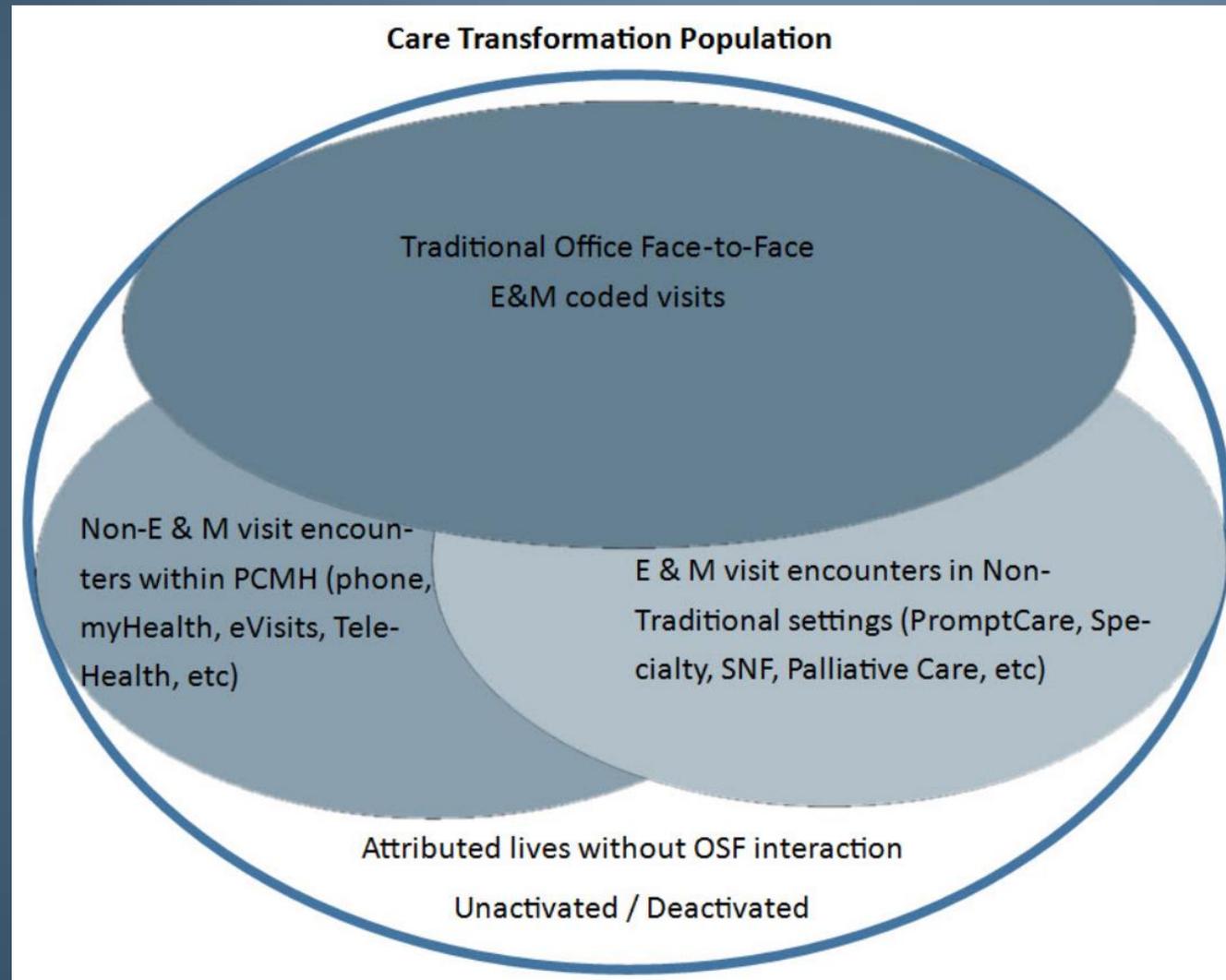
Encouraging Early Results

- Panel size / Population growth of 6 Wave 1 practices
  - 11% over first 9 months (5.5 – 20.1% growth)
- > 6,000 RN clinic visits
  - ~ 55% immunization, 20% acute illness, 25% chronic / other
- Increased referrals to Care Management / Behaviorist
- Positive cultural feedback results from team surveys
- Requests to accelerate implementation calendar for remaining markets
- Significant decline in "no-show" rates for PVP patients

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Lessons Learned

- Time necessary for adequate recruitment / staffing of team roles
- Challenge to drive change influenced by clinician adoption, support
  - Access Guidelines, Standardized Schedule, Reduced Visit Types
- Challenges with scalability of supporting operations
  - Staffing of Access Center
  - Adequate staffing of trainers / educators for more rapid implementation

Lessons Learned

- Earlier development of accountabilities/ responsibilities for Regional / Market leadership and management
  - Maintain prioritization of efforts
  - Accelerate implementation
  - Optimize model
  - Leverage operations / performance councils to drive results
    - Noun versus Verb
- Need for aligned value based / population health compensation models for clinicians

New Care Models for Rural Health
Leadership Institute Horizon Group

April 7, 2017

Challenges for Rural Health and Wellness

National Rural Health Snapshot	Rural	Urban
Percentage of population	19.3%	80.7%
Number of physicians per 10,000 people	13.1	31.2
Number of specialists per 100,000 people	30	263
Population aged 65 and older	18%	12%
Average per capita income	$45,482	$53,657
Non-Hispanic white population	69-82%	45%
Adults who describe health status as fair/poor	19.5%	15.6%
Adolescents who smoke	11%	5%
Male life expectancy in years	76.2	74.1
Female life expectancy	81.3	79.7
Percentage of dual-eligible Medicare beneficiaries	30%	70%
Medicare beneficiaries without drug coverage	43%	27%
Percentage covered by Medicaid	16%	13%

All information in this table is from the Health Resources and Services Administration and Rural Health Information Hub.

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Welcome to Streator, Illinois

Population – 13,710
        Peak – 16,868 in 1960

Industry
    Vactor Manufacturing (specialty trucks)
    Owens Glass (Miller Brewing vendor)
    Healthcare

Famous Citizens
    Burt Baskin –
    Co-founder of Baskin Robbins

Healthcare
    Saint Mary's Hospital – 251 bed
community hospital

Local Geography

Ottawa, IL - 18 mi N
    OSF Saint Elizabeth Medical Center – 97 beds

Pontiac, IL – 25 mi SE
    OSF Saint James Medical Center – 42 beds

Peoria, IL – 61 mi SW
    OSF Saint Francis Medical Center – 629 beds

Springfield, IL – 130 mi S

Most St. Mary's workers find jobs

David Giuliani, davidg@mywebtimes.com, 815-431-4041 Dec 15, 2015 💬 0

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Some of the last words spoken by Carol Biroschik, of Streator, to Dr. Glenn Aldinger as she was loaded into a Life Flight medical helicopter for an emergency transfer to a Peoria hospital Aug. 3 for heart treatment were, "Can I come back and hug you?" Recently, after surviving the major attack, Carold and her husband, Steven, returned to OSF Center for Health in Streator to personally thank her "saint" and others for saving her life. The couple praised Aldinger and the local medical facility for Carol's swift diagnosis and professionalism.

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RHIhub — Rural Health Information Hub | *The* RURAL MONITOR

FEATURES   RURAL SPOTLIGHT INTERVIEWS   AROUND THE COUNTRY   RURAL INSIGHTS

NOVEMBER 30, 2016

Freestanding Emergency Departments: An Alternative Model for Rural Communities

by Jenn Lukens

It was 2015 when St. Mary's Hospital of Streator, Illinois, announced its plans to close. The closure would soon leave the community's 13,700 residents with a 16-mile drive to receive emergency care. St. Mary's is just one of the 78 rural hospitals that have shut down across the U.S. since 2010.

OSF HealthCare of Peoria took an interest in the town's plight — soon the idea to introduce a different model started to take shape. An appeal was made to the Illinois General Assembly for an exception to the state law prohibiting the establishment of freestanding emergency department (FSED) in rural areas. Because of the town's dire circumstances, their request was granted. In August of 2016, the OSF Center for Health – Streator became the state's first rural FSED.

OSF Center for Health – Streator campus

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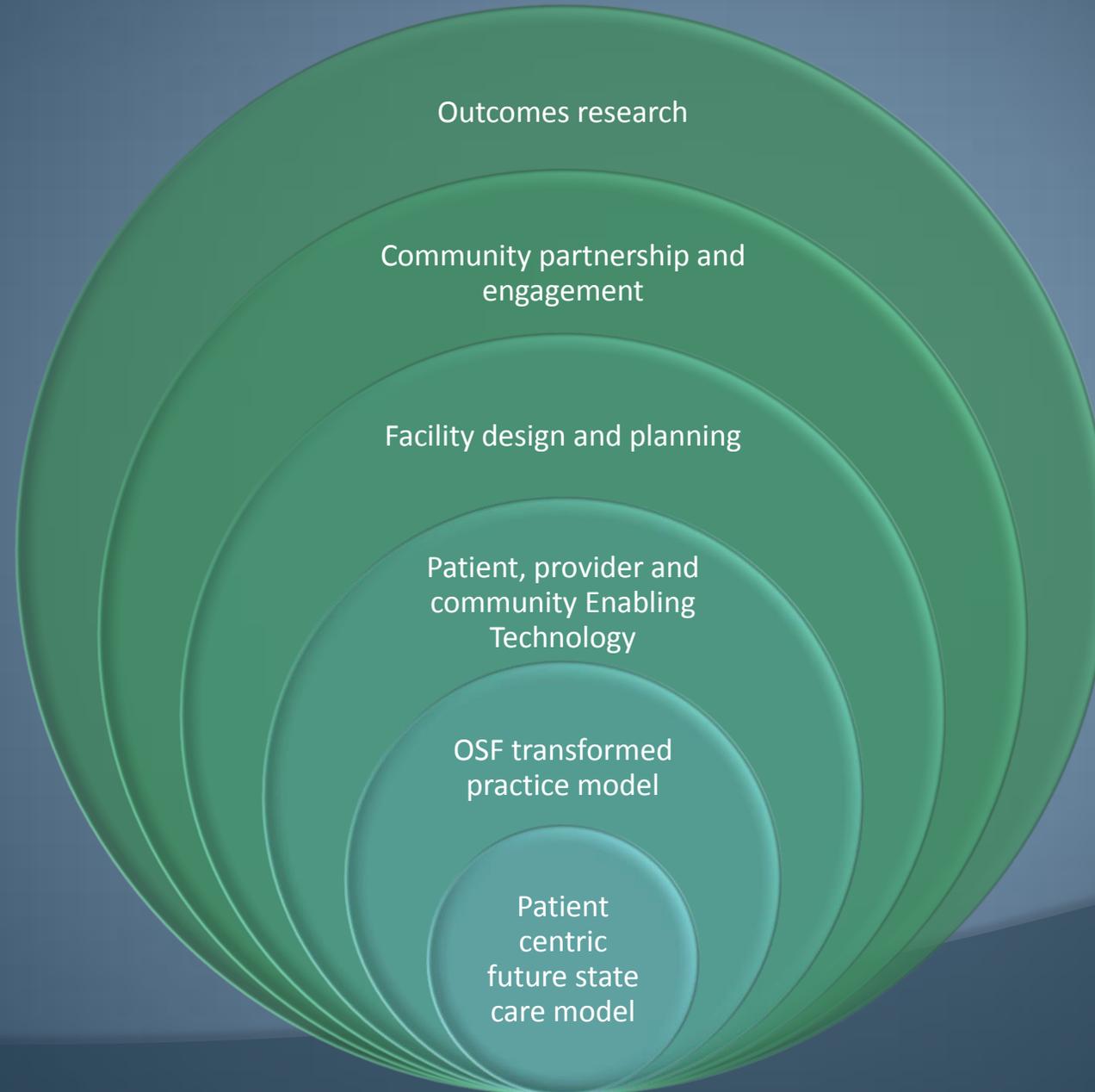
PATIENT SEGMENTS

OCCASIONAL   **75% of the population**

Patients with a condition that can be resolved within a short period of time and does not require substantial ongoing medical therapy.

ELECTIVE   **8% of the population**

Patients with a condition or disease that does not pose any significant threat of loss of life or substantial reduction in their functional ability if treatment is delayed

PERPETUAL   **20% of the population**

Patients with a disease that extends over a multiyear period and requires ongoing medical therapy

COMPLEX CRITICAL   **5% of the population**

Patients with at least one complex illness, multiple comorbidities, and psychosocial problems

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PATIENT SEGMENTS

OCCASIONAL

Patients with a condition that can be resolved within a short period of time and does not require substantial ongoing medical therapy.

ELECTIVE

Patients with a condition or disease that does not pose any significant threat of loss of life or substantial reduction in their functional ability if treatment is delayed

PERPETUAL

Patients with a disease that extends over a multiyear period and requires ongoing medical therapy

COMPLEX CRITICAL

Patients with at least one complex illness, multiple comorbidities, and psychosocial problems

-------------------------------------- **Population Health Goals** --

Encourage the balance of physical activity, nutrition and mental well-being to keep the body in top condition and help people lead healthy lives

- Keep patients healthy
- Build loyalty with our health system
- Collect data on patient's to treat them effectively when they do need care

Assist patients with understanding their intermittent condition or disease status, symptom management and improvement of their functional ability to quickly return them to daily activities and normal function

- Keep patients condition from becoming chronic
- Teach patients how to proactively manage their intermittent condition
- Avoid unnecessary spending

Assist patients with symptom management, monitoring, medication management, and ongoing treatment of their chronic condition(s). Enhance and extend these treatments with the use of provider-, patient- and community-enabling technologies

- Keep patients from becoming high-risk
- Manage in primary care
- Avoid unnecessary spending

Caring for patients with at least one complex illness, multiple comorbidities, and/or psychosocial problems requires the thoughtful development of systems of care to improve their health status and/or reduce their mortality risk

- Develop systems of care that trade high-cost acute care services for lower cost care management whenever clinically effective
- Deliver intensive, comprehensive and proactive management

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Reusable Framework
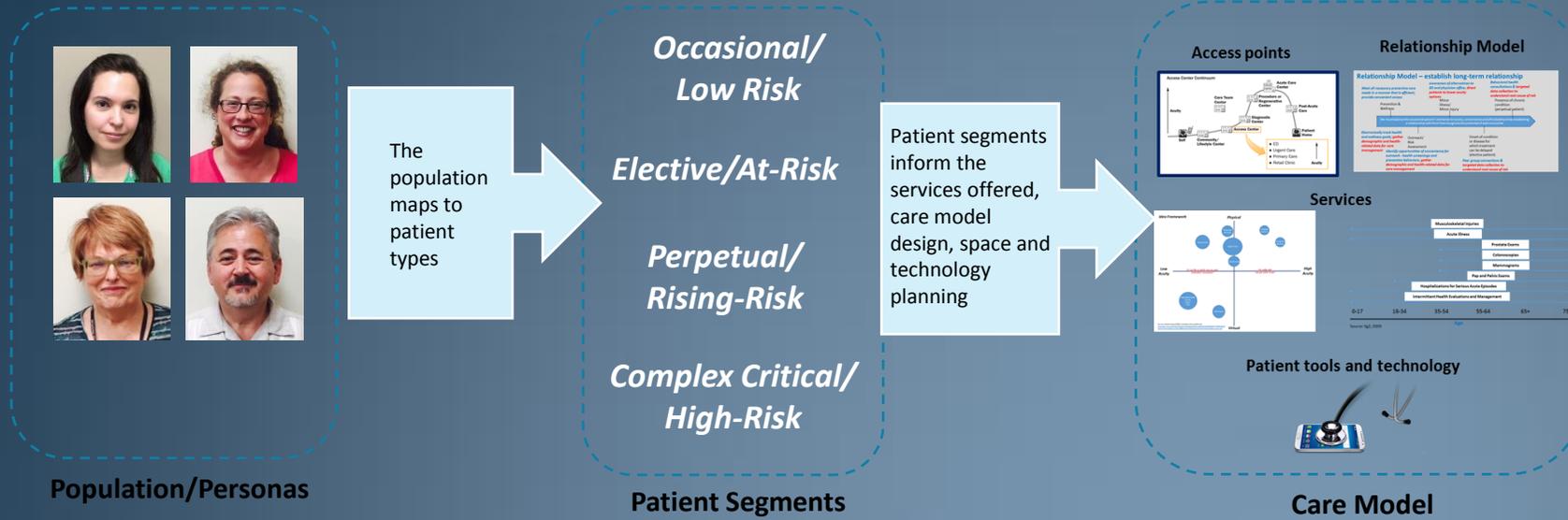
Population/Personas

- Demographics
- Commuter data
- Community Health Needs
- County Health Rankings
- Disease Burden
- Baseline and ongoing measurement and analytics for outcomes research and patient segment analysis

The population maps to patient types

Occasional/ Low Risk

Elective/At-Risk

Perpetual/ Rising-Risk

Complex Critical/ High-Risk

Patient Segments

Patient segments inform the services offered, care model design, space and technology planning

Access points

Relationship Model

Services

Patient tools and technology

Care Model

- Access points
- IT infrastructure
- Patient tools and technology
- Clinical technology
- Care processes
- Resource utilization
- Cost
- Patient engagement/ Relationship model

POPULATION AND HEALTHCARE ANALYTICS

Key Stakeholder Groups	Patients	Care team	Executive Cabinet	Board of Directors	Payers	Employers	Community Resources

Powered By

EMR	EDW	CRM

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PATIENT SEGMENT OVERVIEW

Description

Patients with a condition that can be resolved within a short period of time and does not require substantial ongoing medical therapy

Occasional patients:
- Interact with the health system sporadically. They have conditions that can usually be resolved quickly.

- Seek wellness and quick recovery from illness or injury.

- Span the entire age continuum.

- Utilize a range of access centers…

Persona

Devin

Age - 27

Location - Morton

Family status - single

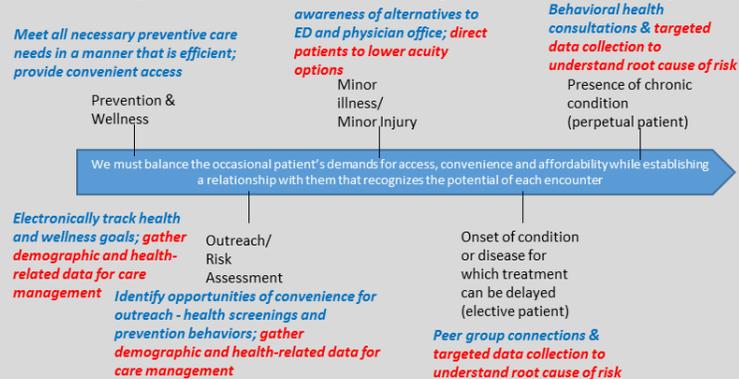Employment – Finance at a local parts distributor

Health insurance – BCBS IL through his employer

PCP – none

Health goals – "what's a health goal?"

Relationship Model

Relationship Model – establish long-term relationship

Meet all necessary preventive care needs in a manner that is efficient; provide convenient access

awareness of alternatives to ED and physician office; direct patients to lower acuity options

Behavioral health consultations & targeted data collection to understand root cause of risk

Prevention & Wellness

Minor illness/ Minor Injury

Presence of chronic condition (perpetual patient)

We must balance the occasional patient's demands for access, convenience and affordability while establishing a relationship with them that recognizes the potential of each encounter

Electronically track health and wellness goals; gather demographic and health-related data for care management

Outreach/ Risk Assessment

Onset of condition or disease for which treatment can be delayed (elective patient)

Identify opportunities of convenience for outreach - health screenings and prevention behaviors; gather demographic and health-related data for care management

Peer group connections & targeted data collection to understand root cause of risk

What they want from us

Access and Convenience
"Meet me when I'm available and where I'm at"
"I don't want to leave work, can we meet online"

Be efficient
"I'm busy, I can't fit long wait times into an already hectic day"
"I can't afford time lost from work, I need to get better quickly"

Be affordable
"My copays have gone up, is there a less expensive option?"

Know me as a whole person with individual needs
"Lets talk about the best treatment and services for me"

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CARE MODEL SUMMARY – OCCASIONAL PATIENT SEGMENT

Net New OSF Service

Existing OSF Service

WELLNESS

Partnership Opportunity – Streator YMCA

| Motion/ Fitness | Nutrition | Smoking Cessation | Preventive Screenings HRAs | Lifestyle Management Coaching |

Programming Notes and Enabling Technologies

Activity monitors, personal health goals, better living itinerary

MINOR ILLNESS/ MINOR INJURY

| Transformed Practice Model | Walk-in APN Clinics | Virtual Visits | Freestanding ED |

Programming Notes and Enabling Technologies

Transformed Practice Model + Extended Hours, Walk-In Availability and Same-Day Appointments

OSF OnCall
virtual urgent care, 24/7

Available 24x7 + Virtual Visit room near entrance of the building

+Same-day Appointments

Extended hours: 7:00 AM – 10:00 PM

RELATIONSHIP BUILDING

| Welcome Kiosks (2) | Epic Technology Bundle | Patient Feedback | Patient Portal | Social Media Mining | Advanced Care Planning | OSF Technology Bar |

Programming Notes and Enabling Technologies

Welcome Kiosks (2) – Clinics

Online Scheduling eCheck-In – Clinics Appointment Offers

OSF HEALTHCARE Listens

OSF MyChart

binaryfountain

WiserCare

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Objective / Purpose	Tool / Technology	Description	Status	Streator	Patient Segment(s)
Gather Patient Input	OSF HEALTHCARE Listens	**OSF Listens** provides a safe, private, online environment for patients to be able to freely share their opinions and input on various health care related topics	Implemented and production ready		ALL
Gather Patient Input	PatientWisdom	PatientWisdom efficiently collects, curates, segments, and shares patient stories to improve the experience and delivery of care.	Implemented and production ready		ALL
Chronic Care Management	care innovations an Intel·GE company	Remote patient monitoring technology to better manage the health of patients with chronic conditions. The telehealth technology used to deploy remote care management is expected to assist in reducing costs by better engaging and educating patients, promoting adherence to treatment and early intervention to keep readmissions at a minimum	Care Innovations is currently in use for OSF remote patient management of CHF; Diabetes and COPD management are extensions of these tools for the Streator / Rural care model		Perpetual / Complex Critical
Virtual Visits	OSFOnCall virtual urgent care, 24/7	**OSFOnCall** provides 24/7 urgent care services over the internet or phone. Patients can receive a diagnosis and treatment for a variety of conditions without having to leave your home or office.	Implemented and production ready		Occasional / Elective / Perpetual
Reputation Management	binaryfountain	Facilitates analysis and understanding of online presence to prioritize and respond to feedback and promote positive experiences. Allows improvement of transparency and trust by showcasing authentic patient reviews and turning our performance data into social & web based content - turning surveys into star ratings	Implemented and production ready		ALL

TOOLS AND TECHNOLOGY SUMMARY

Objective / Purpose	Tool / Technology	Description	Status	Streator	Patient Segment(s)
Behavioral Health	regroup	**ReGroup Therapy** provides an easy, secure, online platform for licensed mental health professionals to offer online therapy sessions	Implemented and production ready	🏥	Perpetual / Complex Critical
Behavioral Health	SilverCloud	**SilverCloud** offers effective, supportive programs for a range of mental and behavioral health issues. Our programs are designed in-conjunction with world leading partners from academic and medical institutions. The content is designed to be motivational, easy to use, and interactive with relevance to the unique requirements of the service user.	Implementation underway	🏥	Perpetual / Complex Critical
Patient Provided Data Collection	tonic	Medical data collection platform used to drive better engagement while improving access to information needed to complete patient intake, screening, academic research, clinical trials and evaluate patient satisfaction, patient reported outcomes, etc.	Implemented and production ready	🏥	Elective / Perpetual / Complex Critical
Patient Portal	OSFMyChart	**OSF myHealth** provides a web based connection to your doctor's office, allowing a patient to schedule appointments, request prescription refills, review their health history and more - online, any time!	Implemented and production ready	🏥	ALL

Objective / Purpose	Tool / Technology	Description	Status	Streator	Patient Segment(s)
Social Health Information Exchange	PIECES	**PCCI Iris** is a shared information exchange (IEP) for healthcare organizations, social service agencies and other community resources that are caring for a population of people. Integrating information from social and healthcare organizations will provide quality and safe healthcare for the broadest range of citizens in our communities. The IEP will provide a higher, more consistent level of healthcare to even the most vulnerable populations across the community, resulting in a more efficient, cost-effective use of resources and, most importantly, lives saved.	Implementation underway	🔴	ALL
Treatment Options	**WiserCare**	Online tool that helps guide people to the best treatment options that meet their own needs and preferences; **WiserCare** provides a platform that patients can use to share information with their care team electronically. Having this communication platform may increase the likelihood they will discuss those things that can sometimes be uncomfortable to talk about in person and therefore are many times avoided.	Implementation underway	🔴	Elective / Perpetual / Complex Critical

ENGAGING AS PART OF THE BROADER COMMUNITY – COLLABORATIVE COMMUNITY CARE MODEL

We recognize:

- that OSF Healthcare is part of a broader community
- we must be effective partners in improving the lives of the people that live there
- Health care alone cannot accomplish this
- We must also work together to address and influence the social determinants of health

OSF HealthCare is working with the Streator community towards a common goal – health improvement for the people that live there

Rural Community Benchmarking

- **New Ulm, MN**
  - New Ulm is a community of about 15,000 people located ~75 miles southwest of Minneapolis. Below are highlights of their current community health initiative, *Hearts Beat Back: The Heart of New Ulm (HONU)*
  - **Began in 2008 as a 10-year research project for intervening in regards to heart health**
  - Because 90% of people in New Ulm are with Allina Health, they were able to use EMR data to gather pertinent patient data and identify risk factors for heart disease
  - Although started with 36 stakeholders have now evolved to a 12-person team of key stakeholders that identify strategies that are implemented by action teams (of which there are currently nine)
  - Early hurdles included getting those involved with policy and public/private health to think about a much longer-term view and getting buy-in from worksite health plans
  - Keys to success include having a great program manager, an annual communication strategy with built-in goals/campaigns to build the brand, and involvement from the New Ulm Medical Center CEO
  - Highlighted results in 2016 included:
    - 86% of adults with normal blood pressure, up from 79% in 009
    - 64% of adults had their total cholesterol in recommended range of under 200, up from 59% in 2009
    - 50% of eating establishments in New Ulm partnered with HONU in 2016 to make it easier to eat well by eating out
    - 85 worksite wellness leaders from 37 different local employers attended three quarterly networking and training events in 2016 that provided an opportunity to learn, share and find solutions to help successfully build a culture of wellness at their worksites
  - Have an annual HONU event and publish yearly results

Rural Community Benchmarking

- **Algoma, WI**
  - Algoma is a community of about 3,200 people located 26 miles east of Green Bay on the coast of Lake Michigan. **The program is in its second year and started with a grant from the Robert Wood Johnson Foundation as part of the 100 Million Healthier Lives program. Algoma was selected as a "scale" community for the RWJF grant initiative**. Below are highlights of their *Live Algoma* initiative:
  - Have had success with partnerships, including a strong partnership with the school system
    - Have turned part of the school into a wellness center, which has successfully led to a lot of interactions amongst various generations in the community
    - One paid staff member that is currently employed by the school that also staffs the wellness center on a part-time basis
  - One of the primary tasks to date has been connecting resources and breaking down silos
  - Identified seven dimensions of health (Emotional, Environmental, Intellectual, Physical, Relational / Social, Financial, Spiritual) and ask every person to commit to improve one dimension of their wellbeing each year
  - Use self-assessments and check in with members of the community through surveys as measurement tools
  - Seems to be some uncertainty as to the sustainability of the initiative after the grant is completed, though they are a finalist for another RWJF grant.

Rural Community Benchmarking

- Cabarrus County, NC
  - Cabarrus County is made up of communities that are suburbs of Charlotte. The county has a total population of 192,103 (an increase of nearly 50% since the year 2000). The two largest cities are Concord (85,560) and Kannapolis (45,245). While not rural, the *Healthy Cabarrus* initiative is now in its 20th year. Below are highlights from the *Healthy Cabarrus* initiative:
  - **Started in 1997 when state of North Carolina began asking counties to complete health needs assessments very 4 years**
    - **Needs assessed by surveying 1% of the population**
    - **Form coalitions with existing community advisors to address identified needs**
    - **Focus on the top three issues and then choose three indicators to measure for each initiative**
  - Two staff (executive director and admin) that are employed by Cabarrus Health Alliance (local health department) but funded via a 50/50 split between Carolina's HealthCare System and Cabarrus Health Alliance
  - Executive Committee of six that meets monthly to discuss funding, projects, etc.
  - Advisory Board of 35 that meets every-other-month
    - Have a job description for members
  - Coalition meetings organized as workgroups – a tangible use of everyone's time
    - Have a job description for members
  - Utilize grant funding for various aspects, including operations
    - Have a full-time grant writer at Cabarrus Health Alliance that they utilize
  - Although they publish a yearly State of the County Health Report, they do not have an annual meeting or event. Highlights from the 2016 Report include:
    - Reduction in the rate of diagnosed diabetes (age-adjusted rate per 1,000 has dropped from 11.5 in 2006 to 7.7 in 2012) – though the age-adjusted death rate of diabetes mellitus has increased from 18.4 (2007-2011) to 21.4 (2010-2014)
    - Rate of substantiated reports of child abuse and neglect per 1,000 dropped from 14.08 in 2012-13 When the Positive Parenting Program was implemented) to 13.33 in 2014-15
  - Other reported progress focused on activities that were implemented or expanded in the communities (e.g. Safe Routes to School plans)

Rural Community Benchmarking

- Overall takeaways thus far:
  - Focus on a few key issues
  - Success is measured over the long-term
  - Community engagement at many levels
  - Have organizational leadership / structure (including executive director)
  - Supported by various grants
  - Celebrate wins / publicize results
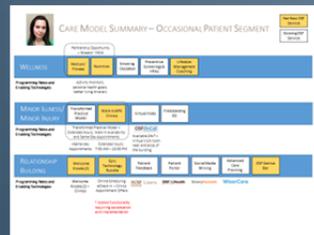
"Healthy Village" Concept

Broad range of **Ambulatory** services

Various **Social Service agencies** and **Community Resources**

Innovative **Care Models**

Patient, Provider and Community enabling **technology**

Key Takeaways

- Build trust and collaboration with the community
  - Follow through on commitments with timely execution
  - Engagement through governance <u>with</u> community members
- Be patient, but be bold
  - Share the vision of what can be
  - Invite broader initiatives
  - Continuously innovate
  - Coordinate, integrate, but don't suffocate
- Define goals and measure outcomes

OSF HEALTHCARE

Questions, Feedback, Collaboration

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