

HEALTHPARTNERS

*A case study series on disruptive innovations
within integrated health systems*

A HEALTH CARE CASE STUDY

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EXECUTIVE SUMMARY

HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation. It serves 1.25 million medical and dental health plan members, has 10,000 employees, and brings in annual revenues of \$3.1 billion. It began as an insurance plan and later became a fully integrated finance and care-delivery organization. Today, HealthPartners employs a blended model: some patients and physicians are in the integrated care system, but the health plan also works with other contract care providers, while the medical group also works with other payers.

Growing a co-op takes time

Congress recently discussed whether the United States could grow enough co-ops fast enough to compete with private insurance companies. But policy makers, employers, and consumers will need time to become comfortable with the integrated care model. In the early days of HealthPartners, many viewed anything other than fee-for-service as socialist. Physician recruitment was low because doctors were unwilling to stake their reputations and earnings on a move to the new system. HealthPartners began to thrive only after highly credible institutions, like the University of Minnesota and Mayo Clinic, put their doctors on salary.

Physicians need to trust the numbers

Sound metrics and data are the foundation for evidence-based medicine and performance-based compensation. At HealthPartners, trustworthy data required considerable investment in internal platforms and collaboration by regional players to create impartial standards including Minnesota's ICSI, which functions at a "level above" any of its member organizations.

The cost of medicine is lowest with full integration

National health leaders often point out Minnesota's cost of care, which is 30% below the national average in medical costs. Medical costs for patients treated by HealthPartners Medical Group, however, are even lower than Minnesota's state average and measure 38% below the national average. According to HealthPartners' leaders, most of the 8% differential derives from practices attributed to their integrated system, rather than lower prices paid to physicians or hospitals. Of the plan's nearly one million members, more than 30% remain in the "core" staff model—users of HealthPartners Plan, Medical Group, and Hospitals.

Primary care can be redesigned to reduce cost and improve care

HealthPartners aims for its doctors' offices to book half as many patient visits a day to enable longer visits with sicker patients. The plan promotes retail clinics and e-visits, as well as the delivery of basic care at clinics based in the workplace. Plan administrators are discussing how to change compensation as doctors begin to see sicker patients in expanded visits.

Technology can be leveraged so everyone can practice to the top of their license

HealthPartners invests in sophisticated diagnostic tools like a diabetes wizard that enables nurses to manage and monitor diabetic patients. Many procedures have been moved out of the hospital owned by HealthPartners and into lower-cost health specialty centers that are equipped with advanced equipment. The ability to fully utilize various medical technologies and shift work between health care providers requires the crucial support of regulatory groups and credentialing organizations.

Consumer perceptions affect the rate of innovation

Many states are facing a potential reprise of the negative effects of capitation and HMOs in the 1990s, but Minnesota has been comparatively progressive. Yet even in this market, employer groups and individual customers purchasing insurance typically value choice. They perceive changes in insurance premiums designed to drive them toward the lower-cost integrated model as a reduction in choice. Also, several care providers mentioned that the care team approach employed at HealthPartners works best when customers understand that the doctor is not the only credible source of care. One practitioner pointed out that politicians, including those supporting health reform, actually hamper the use of care teams when they avow that “no one should get between you and your doctor.”

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This case study unfolds in three parts. The first section considers HealthPartners' path to integration and the critical steps to becoming a successful, integrated health care system. The second section examines the present-day systems and highlights practices and disruptive innovations¹ that are often dependent on integration. The third section presents learnings for other health care systems that are attempting to move toward integration and considers policy and payment reforms that would most effectively stimulate the spread of integrated systems.

I. HISTORY AND BACKGROUND

Developing the prepaid medicine model (1930s–1950s)

Group Health Mutual (Group Health), the predecessor to HealthPartners, was a health insurance plan that was founded in Minneapolis in 1938 by four men who were new to both health insurance and medicine. The founders' primary motivation came from seeing families pushed into great debt by medical expenses. Some families required bank loans for unexpected illnesses or injuries. Others fell into poverty because ailments in working adults who could not afford medical treatment went untreated.

State laws initially obstructed the establishment of a prepaid health plan, in large part because the concepts of both prepaid and consumer-owned health care delivery were new. One law had been created to stop exploitation of the learned professions by banning the corporate practice of medicine. The plan's status as a nonprofit did not shield it from likewise being prohibited under the statute. The local medical societies and the American Medical Association (AMA) considered anything other than traditional fee-for-service as "socialist" and therefore did not want the law overturned. In the interim, Group Health contracted with established clinics to provide care to members in exchange for insurance payments. The company ran into financial troubles as it worked out appropriate benefits and pricing strategies, but by 1951 it had grown to become the

¹ *Disruptive innovation* is a term coined by Harvard Business School professor Clayton Christensen and describes changes that improve a product or service in ways that the market does not expect, typically by lowering price or designing for a different set of consumers. It contrasts with *sustaining innovation*, a process of incrementally improving existing processes in ways that only serve the interests of existing customers.

Signing up members
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fourth leading seller of accident and health insurance in Minnesota, with well over 100,000 members.

By 1955, Minnesota's political climate had perceptibly changed. The governor, lieutenant governor, and state treasurer were all members of Group Health. The attorney general overturned earlier opinions and declared that the prepaid health plan could be incorporated legally.

Group Health's first medical clinic opened in August 1957, with 2,100 members. Signing up members—its own insurance customers included—to a new, untested idea proved daunting, however. Recruiting physicians who would risk their reputations was also a challenge. A turning point in hiring occurred when Maurice Visscher joined Group Health. An internationally renowned scientist and head of a medical department at the University of Minnesota, Visscher built relationships with local medical societies and helped bring other University of Minnesota physicians onto a board that monitored quality of care.

Group Health made prepaid medicine less disconcerting by giving customers choices and by proving its plan could provide a low-cost, high-quality approach. In the 1960s, Group Health offered a product called Instant Choice that combined the prepaid plan with indemnity insurance for out-of-network physicians. The new product was revolutionary at the time and helped dispel fears among employer groups and individual consumers that they would lose choice. Instant Choice also opened consumer decision-making to market forces. Now, consumers had to consider seriously their willingness to pay to see a doctor who might cost more than those in the core plan. Customers responded favorably, and Group Health won key contracts for state and university employees in the 1960s. At that time, hospital coverage through Group Health cost between 27 to 40% less than similar benefits at Blue Cross in Minnesota.²

Considering costs differently from traditional providers (1950s–1970s)

From the beginning, the plan's managers aimed to reduce cost by minimizing both hospitalizations and overhead. They reduced the number of hospitalizations by taking the unusual step of setting up a small operating room in a clinic. They avoided referrals by having the clinic doctor treat fractures and tonsillectomies in

² Philip K. Strand, *An enduring mission: The story of Group Health*, 1991, p. 43.

the outpatient setting, which resulted in a hospitalization rate less than half that of Blue Cross.³ They were also careful about considering which equipment was really worth the price. Management drove the savings from these policies into better medical services and lower rates.

By the late 1960s, Group Health had 19,000 members and needed to expand to new clinic sites to attract and better serve members from the suburbs. Each clinic's opening created pressure to absorb new operating expenses with sufficient growth. The plan had been using four hospitals, and Group Health's leadership sought to negotiate a discounted services agreement. The contract called for fixed rates for activities such as appendectomy or gall bladder surgeries rather than itemized charges for every procedure and drug. Many hospitals balked, but in 1971 Group Health signed an agreement with Fairview Hospital to provide the hospital with a steady flow of patients in return for lower, fixed service rates.

In the 1970s, Group Health started a nurse-clinician program and a nurse-midwife program. Some nurses in surgery and pediatrics were trained to provide additional services like applying casts and stitching lacerations under the supervision of doctors. Group Health also began the practice in the early 1970s of hiring a retired nurse to answer the phone at night to facilitate after-hour coordination with physicians on call.

In the 1980s, there was some tension between administration and physicians. The centralization that had worked well for two clinics was less effective for a dozen, so leadership worked on decentralizing clinic administration. By increasing local physician control and starting care units composed of physicians, nurses, and receptionists, Group Health reduced the need for outside intervention. A new quality assurance effort encouraged physicians to set guidelines for treatment and initiate their own programs to improve care. One of these programs—the first preterm birth program in the Twin Cities—lowered Group Health's preterm birth rate to half the national average.

Managing competition and growth (1970s–1980s)

In the mid-1970s the idea of for-profit health maintenance organizations became popular. Group Health advocated for state legislation requiring HMOs to be

During the 1970s, HealthPartners began contracting with hospitals at fixed rates for activities like gall bladder surgeries rather than itemized charges for each procedure.

³ Strand, p. 45.

nonprofit to avoid the onerous regulations the government was planning. Several other nonprofit HMOs started, and though Group Health continued to grow through the 1970s, the overall market grew faster, which left it with a market share of just 35% in 1980. The plan tried to maintain low prices and kept rates flat in 1980 even though costs were anticipated to rise by 10%. Group Health attracted many new members, but began to run into challenges, notably by pricing premiums too low to cover the services provided. New budgeting processes and management information systems were installed to refine pricing and benefit options. The plan also focused on improving productivity. In the dental program, for example, dentists began working with multiple chairs and using dental assistants and hygienists for minor procedures.

In 1985, Group Health's leadership targeted Omaha, Neb., as the plan's first site in a national network of staff-model HMOs. They ended up contracting with physicians, but the model was too different from what Group Health knew how to manage effectively. Group Health sold the HMO at a small loss.

Group Health set itself apart from other HMOs by investing in customer service training and member surveying. In 1985 it had the lowest rate of written complaints of any HMO in Minnesota. Customer complaints from all other HMOs increased by 57% within the following year, but Group Health's complaint rates decreased.⁴ Notable steps in the mid-1980s included significant investments in new financial and planning systems and the decision to affiliate with private medical groups in order to quickly increase the number of service locations in the St. Paul/Minneapolis area. In conjunction with the federal government, Group Health also started a pilot social HMO for older adults called Seniors Plus. The program extended the range of services typically provided by Medicare, and aimed to delay the onset of chronic conditions by helping these older adults stay active and take other preventative measures.

Group Health realized it needed to update its systems when rapidly rising health care costs led many employers to demand more detailed reporting from health plans. The creation of a new IT system called JANUS made Group Health the HMO with the most comprehensive utilization reports available. Because insurer and clinic were combined, administrative costs were 30% lower than those of competing plans.⁵

⁴ Strand, p. 85.

⁵ Strand, p. 89.

Sustaining culture and core philosophy during mergers (1990s)

Group Health was aware during the 1990s that growth would require a more systematic focus on building a culture that in a small enterprise had developed naturally. Management focused on revitalizing the drive for quality improvement and innovation. Continued consumer control of its board meant Group Health stayed mindful of its roots. Mary Brainerd, the current CEO, took over in 2002 from George Halvorson, who left to run Kaiser Permanente. Several managers pointed to her commitment to the quality goals of “Pursuing Perfection” as a key turning point in driving a common culture and leveraging the investment in electronic medical records Halvorson had made.

The 1990s also brought two significant mergers. In 1992, Group Health merged with MedCenters to become HealthPartners. MedCenters was based on a contract model, so from that point forward the health plan started taking patients from other networks, and care delivery started accepting other payers. There would continue to be a core group of members in an entirely integrated plan (see Appendix A), but the merger diversified membership beyond the labor, community, and university groups that had long been its base and brought the total number of members from around 300,000 to more than 500,000. Most leaders at HealthPartners pointed to the inclusion of a contract model as necessary to be competitive and responsive to employer preferences.

The merger required former MedCenters staff to acclimate to the Group Health culture. When the former CEO made a presentation to Group Health’s consumer board about how well the company had been doing because of rising premiums, a board member interrupted him to say, “I don’t want you to feel good when premiums are going up.”

In 1993, HealthPartners acquired Regions Hospital, which had previously been the county hospital for the east side of the Twin Cities metropolitan area. “I can remember George Halvorson calling me on the phone and saying, ‘Guess what, we’ve got a hospital,’” said Kathy Cooney, chief administrative officer. It took time to assimilate a hospital with a large charity care load and a different physician culture. “We made the classic mistake of assuming there would be synergy,” said Brainerd, “and we found doctors with small separate business units within the hospital who didn’t want to integrate into the system. I regret not dealing with that early enough. It took us a good three years to build a shared vision and engage our organization fully.”

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As of 2009, HealthPartners Medical Group costs were at 38% below the national average.

Creating state and national models (1990s and 2000s)

In 1993, HealthPartners joined Mayo and Park Nicollet in co-founding the Institute for Clinical Systems Improvement (ICSI). ICSI became a statewide collaborative to improve health care quality by establishing and promoting best-practice guidelines. Standards of care and agreed-upon approaches for quality reporting enabled further innovations. One example was Minnesota's first tiered plan—which HealthPartners introduced in 1996—that identified which hospitals and doctors delivered the most cost-effective and high-quality care. They also introduced one of the first pay-for-performance systems that compensated providers at the group level for providing the best care. ICSI provided a foundation for a second unique collaborative organization co-sponsored by HealthPartners called Minnesota Community Measurement (2004). This was the first program in the nation to create transparency for consumers in quality of care metrics for medical providers.

HealthPartners, as well as the broader Minnesota region, continued to be notable in providing models for health care reform discussions in the 2000s. HealthPartners was the first health care organization in the nation to refuse to pay for “never” events, the 27 preventable medical errors the National Quality Forum said should never occur in hospitals. Political leaders and policy makers often point out that Minnesota's medical costs are 30% below the national average. As of 2009, HealthPartners Medical Group costs are even lower, at 38% below the national average. Cooney said most of the 8% differential is derived from more effective clinical practice patterns, rather than lower prices paid to physicians or hospitals. Of the plan's nearly one million members, more than 30% remain in the “core” staff model—users of HealthPartners Plan, Medical Group, and Hospitals.

HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation. It serves 1.25 million medical and dental health plan members, has 10,000 employees, and brings in annual revenues of \$3.1 billion. *U.S. News & World Report/NCQA* rated HealthPartners among the top 50 best commercial health plans in the nation for four years in a row. *Modern Healthcare* named HealthPartners one of the best places to work in health care.

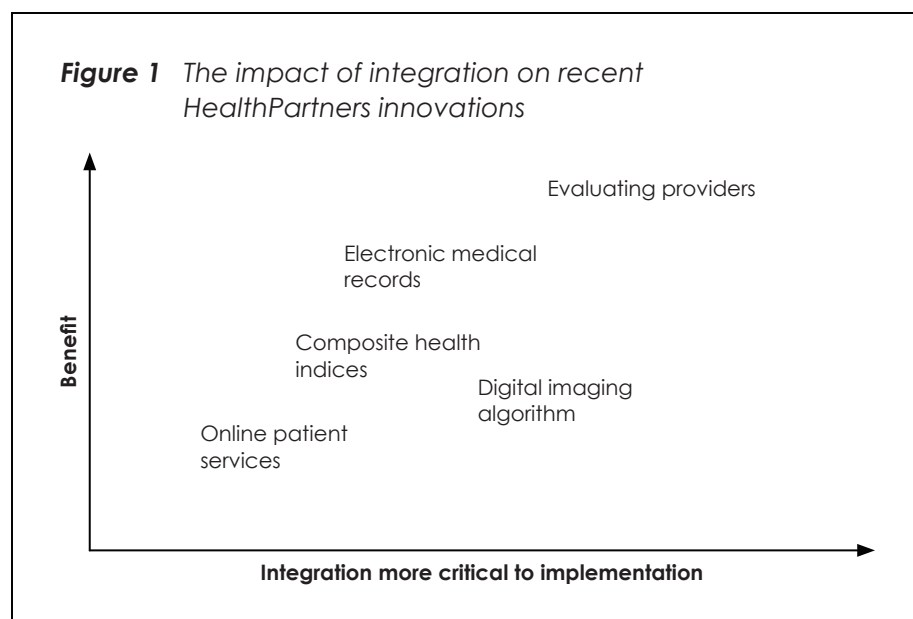
II. DISRUPTIVE POTENTIAL OF THE PRESENT-DAY SYSTEM

Enablers of innovation

Since the mid-1990s, when the organization committed to participating in the “Pursuing Perfection” initiative with the Institute on Healthcare Improvement, HealthPartners has made differentiating technology investments in areas including medical records, quality measurement, and care guidelines.

HealthPartners highly values collecting and using good data. The two leaders charged with recommending the health-related goals of the strategic plan are the vice president for health informatics, who possesses great expertise in analytics and metrics design, and the chief health officer. “We can only improve what we can measure,” said George Isham, the health plan medical director and chief health officer. “And we can only exercise the capabilities of integration if we provide the infrastructure for it.”

Some of the most important technological investments made by HealthPartners are shown in Figure 1, which maps these investments based on beneficial impact on quality and cost and the role of integration in allowing these investments to come to fruition.



Evaluating quality results and agreed-upon outcomes requires standardized care approaches.

Evaluating providers

Brian Rank, medical director of HealthPartners Medical Group, said consistent guidelines are critical to improving health outcomes. “In the past, diffusion of new knowledge might be considered facilitated Brownian motion—each physician doing his best, but little agreement and support for care standards,” Rank said. “Customization of care for every patient without an underlying standard is chaos.” Evaluating quality results and agreed-upon outcomes requires standardized care approaches. This eventually allowed health plan tiering, which classifies clinic systems based on use of quality and efficiency outcomes. Providers are rated in three tiers based on a combination of quality and cost of care. If consumers chose providers in the top tier, they paid less. “When we moved to tiering, parts of the organization that weren’t in tier one were motivated to improve,” associate medical director Beth Averbeck said. The care standards ultimately influenced the plan, but they started with the care system and considered factors such as cost, safety, efficiency, and patient experience.

Composite health indices

Another enabling innovation was the design of composite indices for health. For several key areas like chronic heart failure, diabetes, and smoking cessation, HealthPartners used a single metric—much like a credit score—that often incorporated dozens of care activities to assess whether the clinics were providing high-quality, effective treatment. “Of course building the metrics is just a start,” said Sue Knudson, vice president of informatics. “We also have the culture and values aligned at HealthPartners to really use the technology that we have built.”

Electronic Medical Records (EMR)

In 1996, HealthPartners began to create an electronic medical records (EMR) system based on the Epic system core that many other health organizations use. Over the next decade, HealthPartners invested \$80 million in its system, which included additional functionality oriented to accountable care. For example, care guidelines were built into Epic to increase consistency in using recommended care. Epic also included mechanisms that enabled specialists to recommend preventive care normally directed by primary care practitioners—for example, informing a cardiologist that her heart patient is overdue for a mammogram. “The specialists may be the only touch point for the patient, and they can refer to their primary care

Figure 2 *Accountable care principles shape EMR design at HealthPartners*

Elements of system design	Who benefits
Evidence-based care guidelines built into system	Patients, employer, plan
Specialists prompted to recommend preventive services and primary care	Patients, employer, plan
Decision-making at the point of care enabled by prompts for digital imaging	Patients, employer, plan, providers

colleagues, too, rather than always the other way around,” said Kevin Palattao, vice president of clinic patient care systems.

Diagnostic imaging algorithm

Since costs for diagnostic imaging (particularly CT scans, MRIs, and nuclear studies) were escalating rapidly, employers around the country were depending upon health plans to control these costs, and many were moving to the use of prior authorization/ notification to manage appropriate utilization. This placed a significant burden on providers whenever they ordered an imaging study. By working collaboratively, HealthPartners health plan and care system developed an algorithm based on American College of Radiology and American College of Cardiology standards that fit with the Epic system. The algorithm enabled providers to answer a series of questions together with the patient at the point of care and efficiently obtain the right study for the right patient. It effectively negated the need for authorization. “The outcome was more provider satisfaction and ultimately lower utilization for imaging,” Averbeck said. Though this may have reduced radiologists’ income to some extent, radiology groups actively helped shape the recommendations and process.

Although the algorithm was originally built for HealthPartners, the medical group gave away the approach and software to other systems in Minnesota that were using Epic EMR, as well as to those using different EMRs. “The medical group is our laboratory, but it’s good for everyone, and we can still differentiate ourselves by our execution,” said Nancy McClure, senior vice president of HealthPartners Medical Group and Clinics. Others, however, raised the issue of how to distribute the costs of technology investments appropriately. “Most investments are done by ambulatory care physicians, but the algorithm for diagnostic imaging benefits both employers and the health plans so there have to be ways to share expenses

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appropriately so that doctors don't have to pay for everything," said Beth Waterman, vice president of health improvement and care innovation. "That's easier to deal with in HealthPartners because we have both care and financing."

Online patient services

The move to a more patient-centric model included online and advanced access scheduling. These immensely complex systemic changes included cutting more than 800 appointment types in the system to just a few dozen. HealthPartners also reengineered workflow so that doctors could move away from the typical practice of booking appointments six weeks out. Instead, doctors could see patients the very same day or week they called in for an appointment. Appointment waiting time was reduced by 350%. Since 2004, HealthPartners espoused the principle that "records belong to patients, and we are the custodians." In accordance with that principle, test results began to be shared directly with patients in 2005. Previously, patients had to wait several days or weeks for doctors and nurses to interpret and send the results. In more than 93% of the tests today, patients receive their results at the same time as the doctor, and turnaround time is generally 12 hours.

HealthPartners also focused on developing a robust website with rich educational content. Members of HealthPartners Medical Group used both the website and the telephone care line significantly more than non-members. "Online patient services can become a big non-financial lever to steer people to our medical group," said Andrea Walsh, chief marketing officer. "We simply can't offer something as integrated to those who are only in our health plan," Cooney said. HealthPartners took the big step of posting prices online for many medical services. Although they have measured a fair number of hits to the pricing pages, leaders were aware of only a few people anecdotally who used the pricing list to make a different choice about doctors or services than they would have otherwise.

Setting stretch goals

In 1995, under Halvorson's leadership, HealthPartners set dramatic health and organizational goals, called Partners for Better Health. The current version was called Health Goals 2010 (see Appendix B). The goals align with the Institute of Healthcare's Triple Aim—improving the care experience, improving health outcomes, and reducing cost (see Appendix C). Cooney said Brainerd encouraged senior management to set goals that were truly tough to attain. For example, on

one scorecard measure, HealthPartners aimed to have 75% of members undergo health assessments, even though the current rate was 16%. Another stretch goal was 75% performance, up from 35%, in optimal vascular care outcomes. Leaders who came to HealthPartners from other high-performing companies had to adapt to the idea of not achieving a goal and instead demonstrate considerable progress and formulate workable plans to move beyond incremental gains.

“Creating mountains to climb gives people momentum to focus on how to get there,” said Calvin Allen, senior vice president of strategic planning and human resources. For diabetes, all providers within the medical group received monthly data on their patient panel. The Epic medical record was reviewed for potential changes that would make it easier to manage diabetes and now has several new data prompts. Pay-for-performance (which many leaders agree is more about pride than money) added diabetes outcomes to its goals. The optimal diabetes measure included all the modifiable factors involved in care delivery to create systematic change so that providers were thinking beyond managing only blood pressure or LDL cholesterol levels.

Donna Zimmerman, vice president of government and community relations, pointed to another situation where stretch goals motivated distinctive action at HealthPartners. “Four years ago we became the first organization to start collecting information on race and language to try to reduce racial and income disparities in health outcomes,” she said. “Even in our clinics, there were potential concerns about the sensitivity around doing this. We are still the only organization in the state doing this—and in the country.” Training and consistent workflows were developed so that care team members could ask questions about race/ethnicity and language preference while meeting with the patient in an exam room. Interventions based on these surveys were being tried in primary care specifically for diabetes and breast cancer. For example, HealthPartners guaranteed certain populations mammography on the day of an acute care visit or ensured they had a woman technician. “Because of these interventions, we are seeing improvements in our service level that no one else can match,” Zimmerman said.

Stretch goals that were essentially impossible to achieve inspired HealthPartners to experiment with pilot programs and segmentation to reach breakthroughs. “Trying to reach a goal of 75% of our patients having advanced directives is so daunting—but we can target a certain population, like chronic heart failure patients and make progress there and learn how to improve and expand our efforts,” Waterman said. In a pilot to optimize phone visits, the participating doctors were put on salary to

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counteract the income risks of trial-and-error. This pilot allowed management to gather learnings before trying to implement the new approach on a large scale.

Brainerd was intent on fostering these types of innovations. “I try to use ‘no’ as sparingly as possible. I don’t want to kill good ideas for innovation wherever they are in the organization,” Brainerd said. “Maybe two will develop top-down, like use of information technology or our use of the Triple Aim to frame our work, but many more will come bottom up.” The one downside to a culture of many initiatives, she said, was the difficulty of sometimes distinguishing which ones should be prioritized.

Disruptive practices made possible by integrated care model

Primary care

HealthPartners has already begun a primary care redesign aimed at reducing costs and prices. “In the future, our doctors’ offices should have half as many patient visits and enable longer visits with sicker patients,” Averbeck said. “Retail clinics and e-visits are promoted by the plan, and our providers support it but are also concerned,” said Bob Van Why, senior vice president of primary care and clinic operations. “We also take basic care out to clinics at employer sites. Our hope is to ultimately get standard care out of the primary care physician’s (PCP) office, so they can be freed up to schedule 30 minutes with chronic care patients, where we could work on goals and real behavior change with patients. We need to re-conceptualize what the care team does, what panels look like.” The primary care redesign may also

Figure 3 *Re-conceptualizing primary care at HealthPartners*

Current use of PCP time	Future model of PCP time allocation
22% follow-up/documentation	25% phone and e-care visits
45% face-to-face	45% face-to-face
25% managing phone calls, e-care, test results for patients not in clinic	20% attending to test results, managing chronic care patients and panel management with added nursing support
3% lunch/break	10% lunch/break

include a better approach to compensating doctors for seeing mostly sicker patients during expanded office visits.

E-visits

Professionals in clinic patient care systems are developing a structured online interview to help narrow the diagnostic field and reduce the time patients spend with clinicians. “We know good history-taking is critical, and we are trying to come up with reliable diagnostics and algorithms,” Palattao said. He estimated that seven out of 10 PCPs see the merit, including several in the contracted groups—“but the other three are really loud” in voicing their opposition. Many details of the e-visit model had yet to be resolved. “A patient who has not gotten rid of his strep throat—what constitutes follow-up communications versus coding for a new visit? Do we have co-pays on an e-visit? How quick are we guaranteeing we will respond?” Van Why said. “We also have to address cross-border issues, prescription-writing capacity, and privacy and security.” HealthPartners was already using e-communication with about 300,000 patients on email lists. “When *The New England Journal of Medicine* came out with a warning on a widely-used diabetes drug, we knew we would get thousands of patient calls. We pushed out email and paper mail, and only ended up with two hundred extra phone calls,” Rank said.

Team-based approach

Averbeck credited the care team approach with putting HealthPartners “in a better cost position.” The goal was to put the right people in the right roles. “We want everyone to practice up to the top of their license or training,” Averbeck said. HealthPartners had standing orders for the suite of services offered at most retail clinics so most nurses could handle acute patient needs over the phone. At the centralized appointment center, customer representatives were trained to proactively check patient records for preventive care opportunities. “If someone called in with the flu, our rep checks if they are overdue for preventive services. Then, they ask if you need to schedule a mammogram as well and schedule it right on the same call,” Waterman said.

The redesigned primary care model required solidifying team-based relationships. Patients would ideally view nurses as true extensions of the doctors. Nurses would help manage panels of up to 4,000 people and reach out to case managers, travel medicine specialists, or social workers for certain patient groups. The new model also envisioned more primary care doctors doing some of the work that historically was

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sent to specialists. “Most pediatric acne shouldn’t need a referral to dermatology,” Averbeck said. “And some of our pediatricians do a lot of behavioral health themselves.” To that end, HealthPartners was developing information and decision-making tools to make nurses and providers more capable. A diabetes wizard, a diagnostic tool to let nurses manage and monitor diabetic patients, was about three years away from rollout. In the meantime, leaders were considering other similar tools, including *Archimedes*, which could potentially identify and recommend best care for individual patients (as opposed to “one size fits all” recommendations for populations of patients) and could interface with Epic. Ultimately the goal would be to transfer some of these tools to patients, but management believed that step was several years away.

Patients could also access telephone care lines staffed by nurses who understood both clinical care and plan benefits. Some clinics used care lines only after hours, but HealthPartners staffed its care line 24 hours a day to “triage” care and answer basic questions from patients (“Should I come in to the doctor? Should I go to an ER? What signs should I look for if my condition worsens at home?”) “The difference between us and other organizations is we truly don’t think of this as a cost; it is a contributor to lowering overall cost of care,” Walsh said. A HealthPartners competitor started a care line a few years ago, but shut it down during a recent budget crisis. “They viewed it as a profit and loss (P&L) decision. We measure return on investment and contribution to cost of care rather than P&L,” Walsh said.

Dentistry

HealthPartners considered dentistry part of primary care and included dentistry in the articles of incorporation written at the inception of the organization. “We think of crowns like ‘hospital days’—the way to make money in other places,” former chief dental officer Craig Amundson said. “We don’t do unnecessary crowns.” HealthPartners was the first in the nation to offer sealants in the 1970s, which drastically cut down on the need for dental fillings.

Amundson believes that oral health instruction should not be covered by insurance only once in a lifetime and “shouldn’t be discussed by a dental hygienist for five minutes in the chair while she is trying to show you out.” Dentists and hygienists at HealthPartners sent educational materials on oral health to patients with chronic problems. HealthPartners covered fluoride treatments three times a year for patients who had active diseases and were on particular medications that caused the need for more fluoride. Traditional insurance only covered fluoride

once a year. The dental group encouraged patients who smoked to join smoking cessation programs and linked them to the appropriate care contacts. The group offered additional dental coverage to pregnant women and diabetics. Another program provided full dental coverage for children aged 12 and younger.

The dental group had multiple pilots underway that attempted to reduce overall cost of care. One pilot encouraged pediatricians to identify high-risk kids and also trained nurse practitioners to apply varnish in the doctor's office. "The dental group gives up a dental visit, but it's much better for overall cost of care," Amundson said. The group has moved to advising a dental visit every 12 to 18 months instead of every six months for low-risk kids.

Forays into disrupting hospital and specialty groups

In some cases, HealthPartners has tried to manage cost and price by disrupting revenue streams that typically accrue to hospital and specialty groups. One notable example was creating an ambulatory surgery center. "Being an integrated system and being nonprofit led us to do this even though it does disrupt the hospital," Allen said. Oncology practitioners did not share in chemo and radiation therapy revenue as most specialists in private practice do. "On the hospital side, we have tried to move orthopedics to a different, lower-cost venue. We are working on supply standardization, and providers are looking at each other's data to improve—really using EMR on diabetes, chronic heart failure and cost of care as a care improvement tool," said Brock Nelson, president and CEO of Regions Hospital. Some leaders questioned whether HealthPartners would be willing to make major changes that would result in a significant cost difference. "We haven't been able to get our GIs to agree on using the same prep tray; we are working on reducing down from five different setup trays. We've moved many procedures out of the hospital to a Health Specialty Center (HSC). But the real advance would come if we would move colonoscopies out to PCPs since we don't have enough GIs to do them, but I don't think we're ready for that," one leader⁶ said.

Spine management was an area where HealthPartners was attempting significant disruption. The plan had previously instituted care guidelines for acute back conditions and encouraged patients to go to physical therapy earlier and see a provider group that demonstrated good outcomes. "This was already a big advance

Spine management was an area where HealthPartners was attempting significant disruption.

⁶ This speaker asked to be anonymous for this comment.

Guidelines for care and prevention spread ideally from providers within the HealthPartners network to providers across the community and ultimately to patients in their own homes.

over other delivery systems where nothing is done for back problems until they are urgent,” Isham said. Now HealthPartners was going one step further by investing in an in-house spine management group that advocated appropriate treatment and further threatened group doctors that performed back surgery. “In situations like this, where we have tensions over revenues, doing what is best for patients becomes our basic value,” Waterman said,

HealthPartners’ willingness to disrupt hospital revenue was clear in some of the key statistics by which they measured progress:

- In HealthPartners’ post-hospital transitional care program, length of hospital stay was 30% less than the community norm, and re-hospitalization was 40% less than the community norm.
- Coordination of care between HealthPartners’ clinics and hospital reduced emergency room visits by 39% and hospital admissions by 24%.
- The outpatient case management program for behavioral health patients decreased inpatient costs by almost 20%.

Wellness programs

Tom Kottke, medical director of evidence-based health, left Mayo Clinic to join HealthPartners because he was attracted to its view of population health and wellness. “Mayo has chosen to define health as a purely individual experience. HealthPartners thinks about patients as members of the community. I was trained in epidemiology, and I came here because I wanted to have impact on the health of populations.” Nicolas Pronk, vice president of health management behavior, came to HealthPartners out of academia for the same reason. “We are trying to engage people in creating a social movement,” Pronk said. Pronk and Kottke were working on shaping population-based approaches in diabetes, heart disease, preventive services, and optimal lifestyle. HealthPartners referred to it as “taking health care outside the exam room.” Care and prevention guidelines ideally spread from providers within the HealthPartners network to providers across the community and ultimately to patients in their own homes.

Wellness was an area where partnering with employers showed immense benefits in health outcomes. “Working with employers has been the best way to get the reach and frequency of messages to patients that is needed,” Kottke said. “In a couple of key groups, more than 90% of employees are taking health assessments, and nearly 60% have been involved in prevention programs.” Employers seeking

to increase productivity and reduce medical claims worked with HealthPartners in a variety of ways. Offerings include Well@Work, onsite clinics at employers, some of which were open to family members of employees. JourneyWell, another sub-brand, focused on health and productivity coaching services, and included online education and check-ins. “We have been able to document that employer-based wellness programs, supported by strong communications and incentives, can make an impressive impact on healthiness, reduce cost, and increase productivity,” Pronk said.

Challenge of managing medical device costs

HealthPartners has not come up with any ways to markedly reduce the costs of investing in new and expensive medical devices and technology. “We have had to make big capital commitments in order to compete,” Brainerd said. “We have still not arrived at a good solution here.”

Several leaders said patients want the newest devices. If other hospitals have a novel technology, patients ask when HealthPartners will have it. Doctors are no different. “As Americans—both clinicians and patients—we seem to have an insatiable appetite for devices and technology,” Rank said. “The Da Vinci robot is being used for prostate cancer surgeries, hysterectomies, mitral valve repair. It’s an added expense, and who is to say it’s worth it? We can hold CT scan and MRI costs down, but expensive new procedures and technologies can overwhelm those savings.

Figure 4 *Common elements underlying innovative practices at HealthPartners*

- Move standard care to most cost-effective venues (e.g. retail clinics, employer sites, e-visits)
- Use effective case management to reduce illness and emergencies
- Build connections across continuum of care for better chronic disease management
- Allow caregivers to focus more on sicker patients
- Ensure everyone practices to top of license
- Cultivate shared belief in quality guidelines and evidence-based medicine
- Leverage information and decision tools, including EMR
- Manage cost of care, *not* P&L
- Think about health of populations rather than individuals
- Engage and incentivize consumers to take health care out of the exam room

Clinicians worked
for 18 months to
design a physician
compact.

The incentives need to change. For example, would we create a more efficient way to screen for colorectal cancer if we paid less for each procedure? Gastroenterologists are highly-trained specialists. They undergo four years of medical school, three years of residency, and at least three years of fellowship. Do we really need this amount of training to perform routine screening colonoscopies, or could a less expensive and more expandable resource be developed?”

“The Twin Cities community has been lousy at collaborating on shared use of technology,” said Brainerd, the CEO. “We are still faced with investing in facilities and technology for three pediatric hospitals rather than one because they couldn’t agree.”

In an encouraging development, HealthPartners and Allina (a large care system) recently announced an alliance in one suburb to focus on improved community health, more affordable care, demonstration of a new payment approach, and collaborative use of technologies and specialty resources. “We wanted to build this collaboration to deliver more affordable care and to share technologies and capabilities across systems. That’s going to offer real benefit,” Brainerd said.

Leaders did feel HealthPartners had effectively used make-buy analyses in managing new and expensive technology. Such an analysis resulted in HealthPartners purchase of transplant services from Mayo and some other services from the University of Minnesota. Doing so made more financial sense than offering these services in-house.

Recruiting and retaining physicians

The HealthPartners model fits with certain physician personalities and philosophies. “We don’t want the entrepreneurial high-fliers,” Amundson said. “Most of our professionals are glad we take Medicaid and feel strongly about our efforts on risk reduction and wellness. There was a time some doctors used to call us ‘Commies on Como’.⁷ We are past that now.”

HealthPartners physicians realized that different organizational and physician cultures would be necessary to transform the system and create care that was more reliably consistent with the IHI’s Triple Aim. Clinicians in the care system worked for 18 months to design a physician compact to identify and clarify behaviors and

⁷ The first HealthPartners clinic was located on Como Street.

principles they sought in each other and in the organization to create and sustain this culture (see Appendix D). “The process mattered as much as the outcome,” Rank said. “Clinicians from across our medical and dental groups want us to be delivering the absolute best care in the world and were willing to put in time and effort to describe the clinician and organizational culture that would support us to that end.” Rank thought HealthPartners could be a compelling proposition to doctors: “Most doctors in practice find that much of their time is wasted. I believe doctors are chomping at the bit to be part of a system that improves the efficiency of their practice along with the care of patients.” He thinks the way doctors are trained often runs at cross-purposes to the way HealthPartners practices medicine: “We need to change clinical education to focus more on how to reliably and measurably improve the care we deliver and understand the value of standardization, customization, and measurement and reporting of our results for our patients and public.”

Brainerd imagined attracting physicians could be more difficult in other states. In Minnesota, “Mayo made group practice safe for us,” Brainerd said. “Also, new medical graduates don’t want to go somewhere without electronic medical records. Some don’t want the administrative hassles of private practice. And they have a decent chance of work-life balance here.”

Physician compensation included a pay-for-performance component, with 85% based on productivity and 15% on improved quality experience results at the clinic level. But the range on the performance component was not wide, amounting to differences of perhaps two to 3% in pay. “If we put too much money at risk, the providers will start to complain their patients are different, start to patient-shift to get better incentives. And the key is to do rewards at the clinic level—not the individual provider level—which is a much better match for our culture,” Averbeck said. “Probably our providers don’t even know exactly what their pay differential is,” Waterman said. “But we do think it creates motivation for organizational leaders. Once we started tiering based on performance, ortho for example was motivated to climb a tier.”

III. LEARNINGS FOR OTHER HEALTH SYSTEMS

Benefits of partial integration

The medical group has driven overall quality ratings, often serving as a laboratory for innovations that HealthPartners has then rolled out across their affiliated groups.

“I believe doctors are chomping at the bit to be part of a system that improves the efficiency of their practice along with the care of patients.”

—Brian Rank, medical director, HealthPartners Medical Group

Partial integration is sometimes tricky, and staff attested to a range of challenges.

“It’s important that we continue to be a physician-driven organization and keep to our mission,” said Barb Tretheway, senior vice president and general counsel. “Acquisitions at other health delivery systems are tied to keeping hospital beds full. We take care of the ‘safety net’ role at our hospital, but we are generally looking to keep people out of the hospital.”

“It is a great strength to have the flexibility to use revenue streams differently,” Brainerd said. “The organization is structured to have accountability within business units, but ultimately we look for overall system success.”

The lowest total cost of care was recorded in HealthPartners’ Dental and Medical Groups compared to other large, multispecialty groups in the network. This lowered overall average cost for the whole Health Plan and enabled more competitive premiums. Integration, of course, depended on a long-term perspective on patient health to continue to keep patient trust. It was notable that at HealthPartners, the chronic care patients, who were the sickest and the biggest users of services, had the highest levels of satisfaction in the integrated system, according to Isham.

Why HealthPartners has not moved to full integration

Partial integration is sometimes tricky, and staff attested to a range of challenges. “There’s internal language and then the way we have to write our claims for employers—sometimes things feel real or not real for internal accounting purposes,” Amundson said. “We had a big discussion over whether we should open up to other Medicare plans. Sales didn’t want us to have Blue Cross in here—but it was better overall for the company so we did it,” Tretheway said. “It’s much easier to go through negotiations when everyone is in the same room, but there’s still tension around things like readmission initiatives, around disparities,” Isham said. “We want our own unit to do well, but then we know sometimes in the end there will be tradeoffs made for the larger system,” said Van Why. “Doctors from outside sometimes look at HealthPartners like ‘we lose money in our medical group.’ But we look at it as delivering a lower total cost of care.”

HealthPartners’ own medical group was included in tier one of the health insurance plan, along with other providers that likewise demonstrated high quality and low total cost of care. There was commonly a \$15 co-pay or \$250 deductible gap between tiers one and two—not enough to really change purchasing behavior. Some employers created larger differentials between tiers to drive selection, but many employers did not. “We feel we have to earn the business,” Cooney said.

“On 83 measures of quality, our group has to show quality as well as lower cost to rank in the first tier of our evaluation of medical groups, and that will hopefully attract patients.” The medical group is marketed to consumers and employers on its own merits, separate from marketing for the plan. Multiple leaders preferred using quality to attract patients versus blunt pricing strategies to force patients to choose HealthPartners. “Our health plan looks like choice, *not* like Kaiser,” Isham said. Tretheway concurred. “Our members want choice. When I look at California, people seem content with less choice,” she said. Cooney said Minnesota employers were more focused on economics than individuals were, but still wanted to preserve choice since their employees “just want to go to their doctors.”

An estimated 10% of members were in a high-deductible plan, and Cooney predicted the number could grow to between 25 to 35% in the next five years. As mentioned earlier, there was little evidence that disclosing pricing online was driving behavior thus far. HealthPartners was also investing in building a bigger platform of individual plans because an increasing number of smaller employers were no longer providing health benefits.

“We have zero momentum to move towards a full staff model,” Brainerd said. “The staff model can be a bad thing because it can bring a sense of entitlement. Many doctors in the later years of Group Health saw the plan’s role as delivering patients. That can lead to poor service orientation and reduce patient satisfaction.” At the same time, the medical group was fully owned within the system, and Brainerd saw that as unlikely to change. Kaiser, on the other hand, had a standalone doctor’s group, and Group Health Cooperative in Washington had also spun off their doctors 10 years ago.

Lessons from capitation in the 1990s

Several HealthPartners leaders agreed that integrated delivery systems fell apart in the 1990s because the HMOs were finance- and system-driven, not care-delivery-driven. “Providers had to accept far greater risk than they had control over,” Palattao said. “We didn’t have the tools to manage patient populations,” Zimmerman said. “When we signed our first capitation contract with the government for Senior Plus, we ended up attracting the frailest of the frail, and we hadn’t priced right to have the funds for community services.”

“The lessons from carrier-driven HMOs are to be really disciplined in identifying synergies across partnerships. We are now smarter about what works,” Brainerd

Leaders agreed that integrated delivery systems fell apart in the 1990s because HMOs were finance- and system-driven, not care-delivery-driven.

said. Brainerd believes most integrated care systems maintained a strong regional focus because “the relationship between caregivers and financing requires active management.” HealthPartners had expanded to a national footprint through partnership allowing access to the Cigna network, but had no plans to build out in entirely new regions.

Tretheway suggested that access to capital is another reason for the regional size of integrated care systems versus the larger HMO attempts in the 1990s. “Most health care is local, and most integrated systems are nonprofit, which means they can’t go and raise stock. They have to do bonding, which is less oriented to big expansions and growth. Also, the systems are regulated by the Department of Health rather than the Department of Commerce that regulates insurance companies, which might affect their business mindset, or lack thereof.”

External environment

The external environment sometimes constrained HealthPartners clinics’ ability to innovate. One example is e-visits. “Customers don’t want to pay a co-pay for e-visits, and, as a clinic system, we are willing to drop the co-pay,” Waterman said. But plan contracting and other rules may prohibit or limit dropping co-pays. “What the rules are limits us more than what we are willing to try,” Van Why said.

HealthPartners, like any integrated care system, maintained a delicate balancing act between its different units. HealthPartners had the technological capacity to merge EMR with claims data, but the law sometimes prohibited the utilization of this information, Knudson said. “Because of the health plan, we have a view of the whole population, though we have to be careful how we use it,” Isham said.

Self-funding introduced other complexities. “When some employers went self-funded, it became harder to be a prepaid plan,” Amundson said. “When the University of Minnesota wanted to go self-funded, we structured a monthly payment of hours of dental work, with a risk cap on top of that, to enable us to do some things that were health-oriented that were not necessarily invasive and traditionally reimbursable.” Even though HealthPartners had introduced total cost of care by contractual agreement with some customers, there was often an underlying fee-for-service structure where costs and rewards were shared on a quarterly basis.

Another challenge involved fighting the medical and dental guilds over some changes. When HealthPartners proposed a bill allowing advance practice nurses to perform some services formerly provided by dentists, controversy flared. “We and

Figure 5 *Accountable care organizations tend to overcome many systemic hurdles but not legal ones*

Values and culture
Organizational coordination/systems
Reimbursement/financial

Licensing/legal

the community doctors were the only major forces backing it,” Amundson said. “Even though we have a shortage of dentists, and non-DDSs can provide many services, we spent all our time fighting the dental guild.” Zimmerman recounted another example of trying to include advance practice nurses in the area of mental health. “Even if they have not been certified as psychiatric nurse clinicians, which requires another four years of training, we have very experienced nurses who we think can still collaborate with a psychiatrist, but we got lots of pushback.”

“We try to help patients value the whole care team. That is the only way we will make health care affordable,” Amundson said. “It’s a mistake for politicians to say, ‘We don’t want anyone to get between you and your doctor.’”

How payment reform can send the right signals

HealthPartners would like to see more policy and payment reform that better supports managing total cost of care and paying for results. Management calculated that if others took many of the steps that make HealthPartners cost 38% less than the national average, the federal government would far surpass its \$2 trillion target in cutting health care costs. Leaders at HealthPartners have spoken in Washington, D.C. in support of an accountable care model. “Medicare should get out of unit cost to total cost over the next seven years,” Cooney said. “The federal government needs to change payment signals,” said Babette Aplan, senior vice president for health and care management. “Not paying for ‘never’ events was a start, but they should also stop paying for readmissions. These are blunt tools, but they start to change behavior.” Cooney said Medicare and Medicaid severely underpay providers in Minnesota, which amounts to approximately half their cost of services. Meanwhile, Medicare payment rates for Florida and Massachusetts were set at double the amount paid to Minnesota providers. HealthPartners opposes the idea of a public

plan that uses similar cost controls as Medicare because many providers may simply opt out.

Because employer purchasers subsidized the underpriced cost of Medicare, they paid increasingly expensive insurance rates. “We need to protect the employer base for insurance; it needs to be affordable for the small and middle-size employers who are a good share of the insured market here,” Zimmerman said. “We don’t want insurance companies to start gaming risk to make the pricing work.” She also was concerned that individual insurance would not be cost-effective if purchased through an exchange that placed strict stipulations on minimum benefits, as in the Massachusetts model of health care reform.

HealthPartners would like the federal government to invest savings from cost-cutting efforts into a pay-for-performance reimbursement system; a Medicare distribution formula that rewards states that produce the best and most affordable care and eliminates cost-shifting; comparative effectiveness research; adoption and use of health information technology; and public health system improvements.

Recently, updated federal guidelines eased the integration of wellness incentives with product design. “The health care reform debate hardly even acknowledges wellness,” Aplan said. “Even creating accountable care organizations still suggests that ‘care’ is primary. We say that ‘health’ is primary, ‘care’ is secondary.” Pronk agreed. “If the government thought about wellness more, then health care reform would involve not just health services, but decisions on the farm bill and funding for mass transit.”

HealthPartners hoped its home state of Minnesota would help distribute uncompensated care more fairly. “Our hospital has trauma, mental health, and burn units that are used by people who are flown in from other communities—who we provide uncompensated care for,” Zimmerman said. “We need to build on the ‘Minnesota Care’ indigent care access fund. Or we could have a provider tax with a pool that would pay for uncompensated care. Or a care charity fee. Just because Regions Hospital used to be the county hospital, we can’t have all the burden of uncompensated care fall on our providers. It needs to be play or pay.”

Optimal organizational structure for innovation

“No one should underestimate how hard it is to get competing interests to maximize optimization,” Nelson said. He recalled his experience during a merger at another

hospital and medical group. Even consolidating the phone line for referrals caused arguments over whether to use a Minneapolis or St. Paul area code.

Some integrated care models operate without owning a hospital, but Rank points to the hospital as key to HealthPartners' leadership in influencing delivery of care. "[By] running a hospital as a cost center rather than a revenue center, we have the plan benefit because of lower cost to use hospital services, and medical group benefit because of access to specialists and the downstream revenue to ambulatory care and digital imaging," Rank said. "A hospital can also contribute to primary care referrals, which most hospitals won't do—it's really hard to get a hospital's attention when it's a revenue center. No longer does the hospital just view the medical group as a revenue source; it's also a testing ground for innovation."

Knudson believed that other health care players looking to move toward integration might find it equally productive to start with either the medical group or insurance as the integrator, but a hospital-driven process might be more difficult. "With a hospital, the focus is not necessarily on wellness," she said. "You could try starting with a multispecialty group that has a hospital that they are trying to use efficiently."

Van Why considered any health system that combined finance and delivery to be in a much better position than traditional competitors because they had resources committed to continuous improvement and technology. "We can invest in quality and experience, and that creates margin," he said. "Others are chasing margin to get the money to make the investments."

"What you need to create a system like ours is shared values between the hospital and medical group," Waterman said. "You need a culture that aligns incentives and that involves patients in designing care because they will have things they want and distinguish who they get it from."

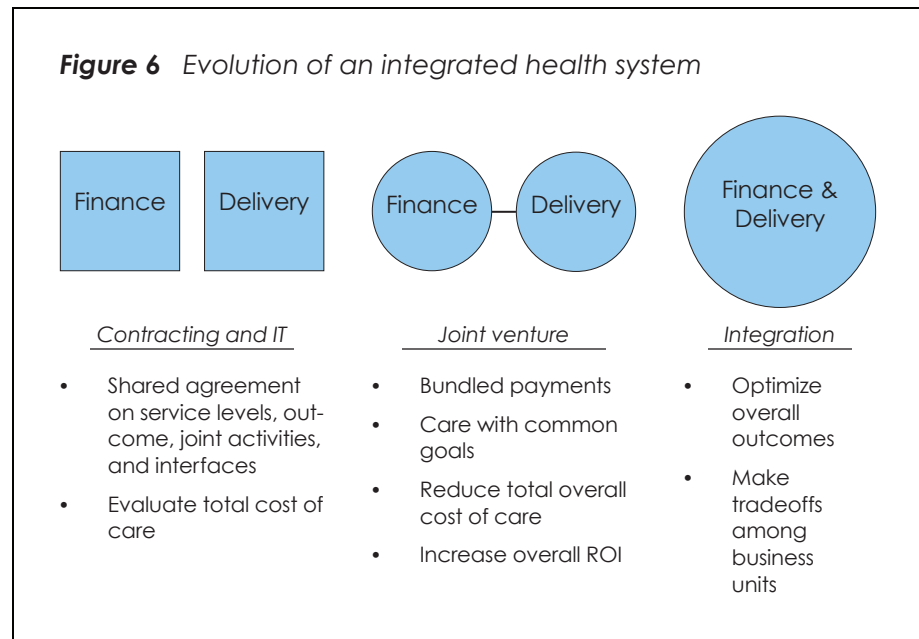
Several leaders thought integration could be an evolution, starting with contracting and IT to build common platforms, next moving to a joint venture, and ultimately creating a partnership. A culture of collaboration, rather than the significant hostility often seen between finance and delivery, was crucial. Many leaders also mentioned that status as a nonprofit could serve to build that culture, to stay focused as an organization, and to be trusted in the marketplace by customers. "Coming out of the cooperative movement of the 1930s, being consumer-governed, and being nonprofit, never focused on making more than 2%—all of that gives us a different level of trust than some integrated players would have," Tretheway said.

Integration could be an evolution, starting with contracting and IT to build a platform, next moving to a joint venture, and ultimately creating a partnership.

The consumer board, an historically important part of HealthPartners structure, had also remained critical to keeping the organization focused on quality, cost, and innovation. “They are the ultimate appeals forum for the health plan. They will occasionally agree with members pursuing alternative or non-proven therapies not covered by the health plan. But they clarify our mission, help the organization put consumer needs first, and stay focused on the right things,” Brainerd said.

HealthPartners leaders concur that, short of embracing integration, other health organizations could adapt elements of the HealthPartners model that would represent significant progress and set the stage for change. A bundled payment approach could allow doctors and hospitals to offer care with common goals; hospitals with health plan capacity could design a payment approach to create aligned interest with physician groups; or physician groups and hospitals could approach health plans to create innovative payment approaches supporting Triple Aim-like goals and innovations.

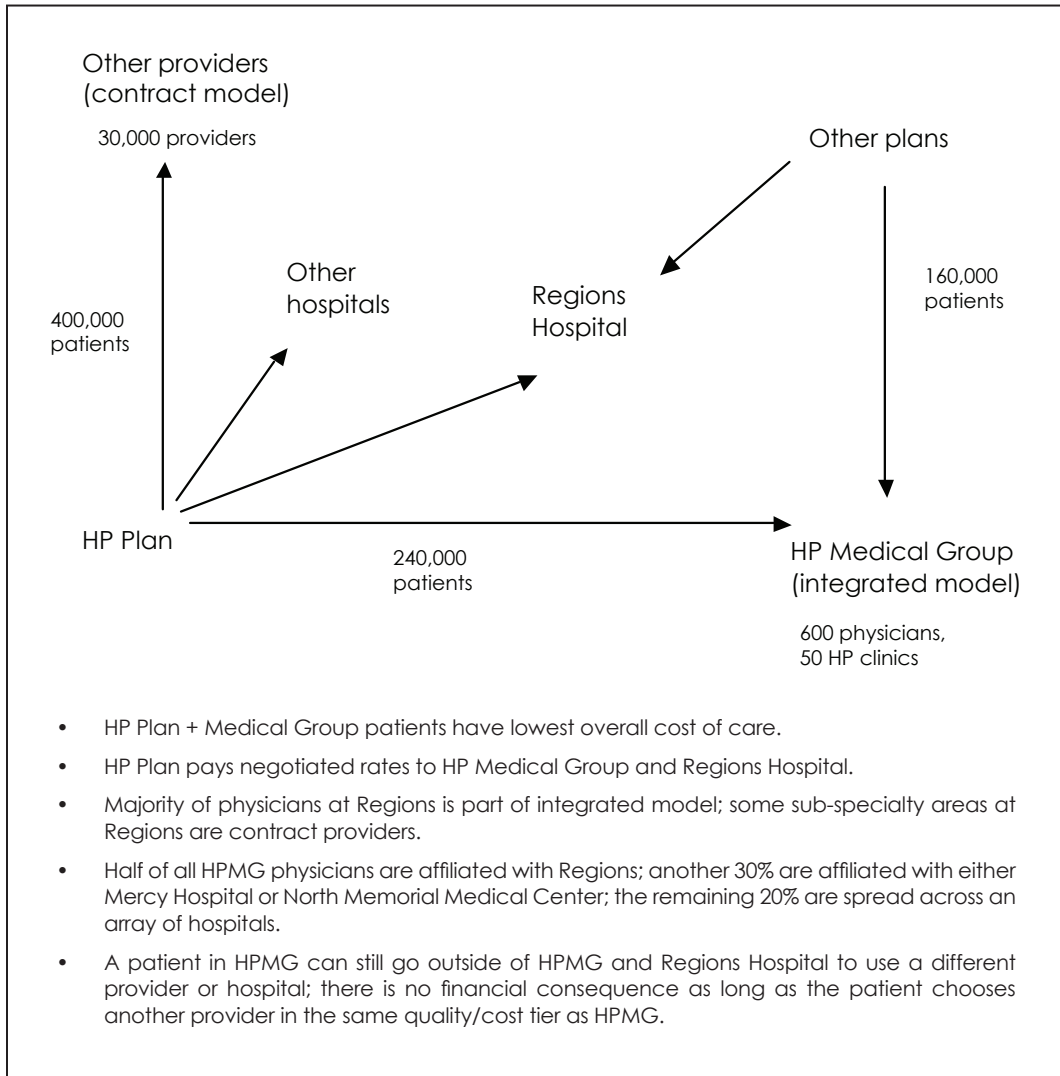
HealthPartners’ relationship with St. Paul Radiology has similar benefits to integration with a radiology group, Brainerd said. “We agree on service levels and outcomes. We have longstanding clinical relationships, some joint activities, some interfaces to support theirs. We are also looking at joining with another hospital where we both have primary care, but neither of us have a lot of specialty care. In both cases we look at total cost of care, rather than individual business unit P




and Us.” Apland referred to other specialty group practices in the network that HealthPartners worked with on defining a clinical logic to reduce total cost of care. Knudson mentioned working with other partners, outside of the integrated group, on increasing overall return on investment.

“Ours is not the only structure that can achieve goals based on wellness and cost of care, take steps to redesign primary care, establish practice approaches with specialists or use mid-levels and pharmacists differently,” Brainerd said. “It requires not relying on production drivers, really relying on quality, and putting patients’ and members’ interests first.”

Appendix A Patient flows in integrated and contract model



Appendix B HealthPartners' strategic goals (2010)

		Health Goals 2010	
Innovate and simplify to deliver best health.	
<p>1. Customers receive amazingly easy-to-use care, coverage and service.</p>	<p>A. By 2010, HealthPartners health plan will score in the 90th percentile in each of the 10 key results for commercial CAHPS. B. By 2010, the HealthPartners dental group will achieve top decile performance for patients' willingness to recommend. C. By 2010, HPMG will achieve top decile performance for patients' willingness to recommend. D. By 2008, HealthPartners will define measures of access satisfaction that are inclusive of emerging alternatives to face-to-face visits. E. By 2008, HealthPartners will define measures of satisfaction reflecting efficient path to recovery from illness and will establish a goal for improvement. F. By 2010, Regions hospital will achieve top quartile performance among medical/surgical inpatients on willingness to recommend.</p>	Safe Equitable Efficient Effective Timely Patient/Member-Centered	Six Aims
<p>2. Customers receive maximum quality and affordability in health and care.</p>	<p>A. By 2010, HealthPartners health plan will achieve top decile performance on key HEDIS & CAHPS results. B. By 2010, HPMG will perform at the 90th percentile on HealthPartners quality of care index, and in the most favorable tier of providers in the Total Cost Index for tiered specialties. C. By 2010, Regions hospital will perform at the 90th percentile for HealthPartners hospital quality of care index, and in the most favorable tier of hospitals based on Total Cost of Care D. By 2010, HealthPartners in partnership with other stakeholders will develop an index of affordability and costs which is benchmarked to a multiple of the federal poverty level, or another publicly available benchmark. E. By 2007, HealthPartners will have a strategic approach to eliminate unwarranted variation in supply sensitive services.</p>		
<p>3. Patients and members receive equitable care and service.</p>	<p>A. By 2006, we will measure disparities in experience, preventive services and diabetes by race and financial class. B. By 2008, we will measure disparities in vascular disease care, pregnancy and asthma by race and financial class. C. By 2010, we will cut identified disparities by 75%.</p>		
<p>4. Customers feel they are treated as individuals.</p>	<p>A. By 2010, 90% of commercial members will say HealthPartners' customer service always treated them with courtesy and respect. B. By 2010, HealthPartners dental group will achieve top decile performance in patient's reporting that their dentist treated them with respect and dignity. C. By 2010, HPMG will achieve top decile performance in patients reporting that their health care provider treated them with respect and dignity. D. By 2010, Regions Hospital will achieve top quartile performance among medical/surgical inpatients reporting being treated with courtesy and respect.</p>		
<p>5. Patients and members have and understand the information they need to be effective decision-makers.</p>	<p>A. By 2010, 75% of CAHPS survey respondents will give an excellent rating to HealthPartners for how well the plan provided information and support to help make decisions about their health care. B. By 2010, HealthPartners dental group will achieve top decile performance in patients reporting their dental clinic provided them with information to make better decisions about their oral health. C. By 2010, HealthPartners dental group will achieve top decile performance with patient agreement that this information helped to make better decisions about your oral health and care. D. By 2006, HealthPartners will outline a formal process for supporting patient-decision making and health literacy. E. In 2008, the OB/GYN and Breast Cancer departments will implement patient decision making tools for those patients with benign uterine disease or breast cancer.</p>		
<p>6. Customers are incented and supported for self care and healthy behaviors.</p>	<p>A. By 2010, we will offer a Health Assessment to every adult member and medical group patient and we will have a 75% adult participation rate. B. By 2010, we will have 100% improvement in the comprehensive lifestyle behavior measure reported by our members and patients.</p>		
<p>7. Customers experience perfect transitions among clinicians, patients, family, payers and community support.</p>	<p>A. By 2010, HealthPartners medical & dental groups will achieve 75% of patients who strongly agree (top box) their care was coordinated well. B. By 2010, Regions hospital will achieve top quartile performance on satisfaction with transition of care questions. C. By 2010, HealthPartners plan will achieve 75% of patients who are very satisfied (top box) with how well specialty care and hospital care are coordinated with their personal physician. D. By 2010, HealthPartners will achieve __% performance for frail elderly/MSHO patients who experience nonelective rehospitalization for the same condition that prompted their index hospitalization.</p>		
<p>8. Customers receive evidence-based care, creating an efficient path to recovery.</p>	<p>A. By 2010, HealthPartners will achieve 60% performance on diabetes optimal care outcome measures and 75% performance on vascular optimal care outcome measures. B. By 2010, HealthPartners will achieve 90% performance on all optimal care process measures. [preventive services, community acquired pneumonia (CAP), congestive heart failure (CHF), acute myocardial infarction (AMI), ventilator associated pneumonia (VAP), central line (CLI) & surgical site infections (SSI), depression, and pressure ulcer prevention]. C. By 2010, double or triple the percent of health care costs and episodes assessed with optimal care approach. D. By 2007, HealthPartners will develop a strategic approach to reducing variation in supply sensitive services and create stretch performance targets for improvement.</p>		
<p>Lasted Updated: 3/11/2008</p>			
<p>Mission Vision</p>		<p>To improve the health of our members, our patients and the community. To be the best and most trusted provider of health care, health promotion, health care financing and health care administration in the country. We will transform health care by delivering outstanding care and service based on the six aims: Patient/member centered, Timely, Effective, Efficient, Equitable, Safe</p>	



Health Goals 2010

Innovate and simplify . . .

. . . to deliver best health.

9. Members and patients will have help to be healthy

- Optimal Lifestyle
 - Tobacco use and exposure
 - Nutrition
 - Obesity/weight management
 - Substance Abuse
 - Physical Activity
- A. By 2006, we will include Nutrition & Substance Abuse components into our Optimal Lifestyle measurement.
- B. By 2010, we will achieve 100% improvement in the Optimal Lifestyle behaviors measure reported by our patients & members.

10. Members and patients will have help with health/life transitions

- Pregnancy and childbirth
 - Palliative care
- A. By 2010, we will cut identified disparities in pregnancy treatment and outcomes by 75%.
- B. By 2010, 80% of HealthPartners members enrolled in complex case management programs, MSHO community based patients, HPMG stage IV CHF, and oncology patients engaged in disease management programs will have advanced directives.

11. Members and patients will live well with acute and chronic illness and disease

- Diabetes care
 - Vascular disease care
 - Cancer care
 - Bone and joint disease care
 - Depression care
 - Asthma care
- A. By 2010, HPMG total cost of care for patients with diabetes will be in the best 1/3 of providers.
- B. By 2007, HealthPartners will expand its Heart Disease programs to include other vascular conditions for which Optimal Care guidelines create improved care & health.
- C. By 2010, HealthPartners will achieve 75% performance on Optimal Vascular Disease Care.
- D. By 2010, HPMG total cost of care for patients with vascular care needs will be in the best 1/3 of providers.
- E. By 2010, HealthPartners will define measures of optimal cancer care and develop a benchmark for improvement.
- F. By 2010, HealthPartners Cancer Disease Management Program will achieve an engagement rate of 70% for high severity commercial members.
- G. By 2010, Regions Hospital will achieve top quartile performance among oncology inpatients reporting during their hospital stay, the doctors explained things in a way they understood.
- H. By 2010, HPMG will achieve top decile performance with oncology/hematology and breast center patients reporting they received as much information about their condition and treatment as they needed from their provider to make informed decisions.
- I. By 2007, HealthPartners will develop optimal care measures for supply sensitive services, and create stretch performance targets for improvement.
- J. By 2010, HPMG total cost of care for bone & joint disease care will be in the best 1/3 of providers.
- K. By 2010, 50% of newly diagnosed patients & members will have a 50% improvement in their symptoms as measured via PHQ9.
- L. By 2010, 90% of patients with persistent asthma will be on anti-inflammatory therapy.

12. Members and patients will be safe

- Rapid response teams
 - Medication reconciliation
 - Hospital acquired infections
 - Reduced harm in hospital and clinic settings
- A. By 2010, HealthPartners will reduce code II calls per 1000 patient discharges by 50%.
- B. By 2010, HealthPartners will decrease adverse drug events associated with harm by 75%.
- C. By 2010, HealthPartners will eliminate occurrences of hospital acquired infection related to Ventilator Associated Pneumonia (VAP), Surgical Site Infections (SSI) and Central Line Infections (CLI).
- D. By 2007, HealthPartners will identify measures of clinic and hospital safety and develop stretch targets for clinic and hospital.
- E. By 2010, the Regions Hospital Standardized Mortality Rate (HSMR) will be at or better than the actual to expected rate of 100% (e.g. lower than 100%).

Safe
Equitable
Efficient
Effective
Timely
Patient/Member-Centered
Six Aims

Last Updated: 3/11/2008

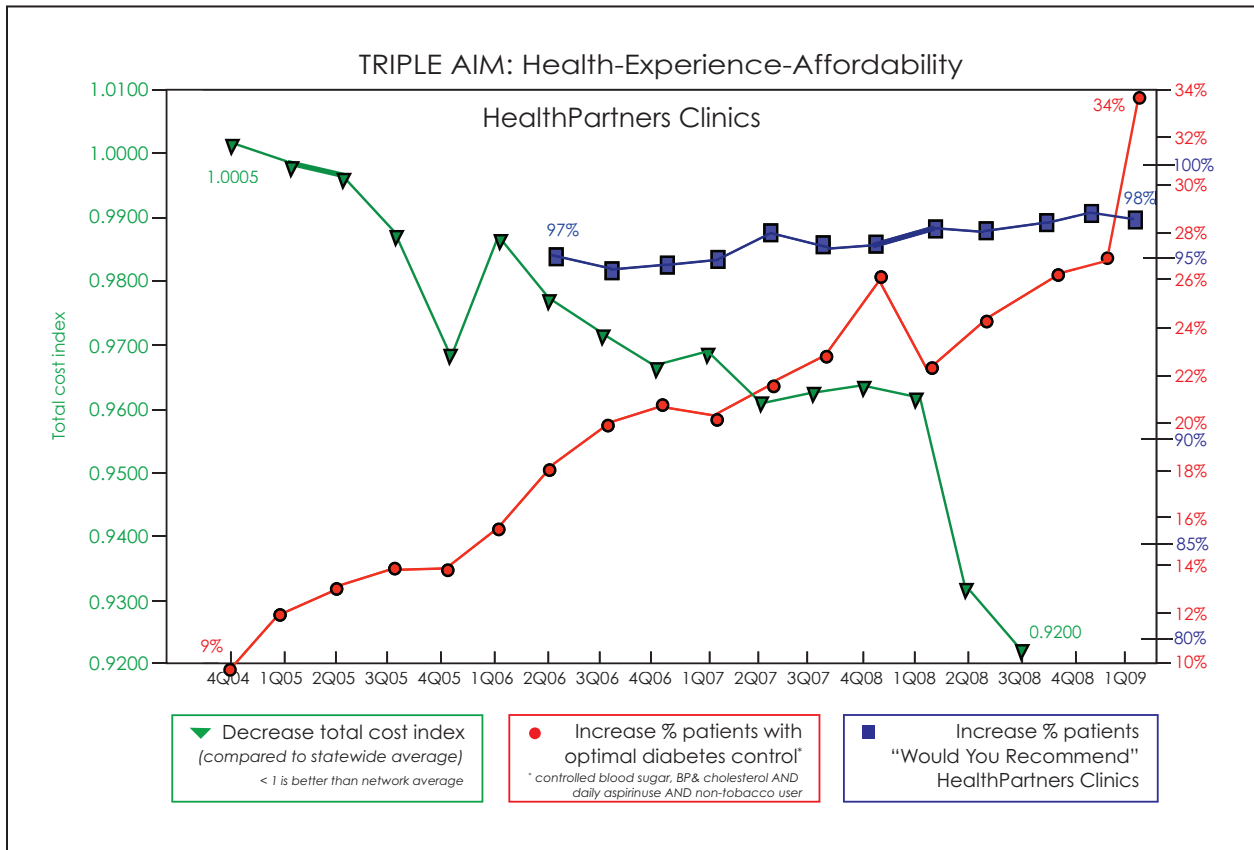
Mission
Vision

To improve the health of our members, our patients and the community.

To be the best and most trusted provider of health care, health promotion, health care financing and health care administration in the country. We will transform health care by delivering outstanding care and service based on the six aims: Patient/member centered, Timely, Effective, Efficient, Equitable, Safe



Appendix C Triple aim chart



Appendix D *Physician compact—HealthPartners physician and dentist partnership agreement*

Organizational gives	Physician and dentist gives
<p><i>Involve and engage doctors</i></p> <ul style="list-style-type: none"> • Involve doctors in strategy, business, and marketing • Include doctors in the development of patient-centered and doctor-efficient practices • Provide opportunities for leadership training • Promote partnership between doctors, staff, and organization • Listen to and be influenced by doctors, assume good intentions, and foster opportunities and forums for doctors to discuss and deliberate important issues <p><i>Support a practice that works for both patients and doctors</i></p> <ul style="list-style-type: none"> • Be patient centered • Support 6 Aims practice and remove barriers at the point of care • Provide an environment and tools to ensure satisfying and sustainable practices • Promote trust and accountability within teams and the medical/dental groups • Create opportunities to educate physicians, dentists and staff about 6-Aims-centered care • Provide support for a healthy and balanced work life for doctors • Respect physicians' and dentists' time to allow care of patients <p><i>Grow strong and sustainable clinical practice</i></p> <ul style="list-style-type: none"> • Recruit and retain the best people • Market HP's multi-specialty medical and dental groups aggressively • Provide market based, and performance linked compensation • Acknowledge and reward contributions to patient care and the organization's goals • Create an environment of innovation and learning • Support teaching and research <p><i>Demonstrate accessible, accountable, responsive and empathetic leadership</i></p> <ul style="list-style-type: none"> • Understand the complexity of health care delivery and apply best management practices • Seek to understand the clinical perspective • Communicate coherently our mission, vision, direction, and strategy • Help us to understand the complexity of our dynamic business challenges • Provide performance feedback communicated in the spirit of improvement and learning • Recognize the leadership, professionalism, and contributions of doctors • Resolve conflict with openness and empathy 	<p><i>Be involved and engaged</i></p> <ul style="list-style-type: none"> • Participate in departmental and medical/dental group meetings and activities • Engage and participate in partnership with practice teams and with clinical and administrative colleagues • Champion processes to improve care systems service and quality • Provide input to strategy, marketing, and operations development • Develop understanding of the business aspects of care delivery • Raise issues and concerns respectfully • Seek to understand the organizational perspective, assume good intent, and collaborate effectively • Demonstrate ownership of your practice and clinic <p><i>Excel in clinical expertise and practice</i></p> <ul style="list-style-type: none"> • Be patient centered • Pursue clinical practice consistent with the 6 Aims • Advance personal and care team expertise and excellence • Seek and implement best practices of care for patients • Reduce unnecessary variation in care to support quality reliability, and customized care based on patients needs • Create innovations for care and care delivery and be open to innovations and ideas for improvement needed in our environment • Show flexibility and openness to change <p><i>Support our multi-specialty group practice</i></p> <ul style="list-style-type: none"> • Demonstrate passion and commitment for your practice and our multi-specialty medical and dental group • Collaborate within and across disciplines and partners to improve patient care • Promote, refer and communicate with colleagues effectively • Use resources responsibly and support care delivery systems that improve care and reduce costs effectively • Participate in teaching and research <p><i>Be a leader</i></p> <ul style="list-style-type: none"> • Demonstrate commitment to the organization's mission and vision • Lead as a role model • Support colleagues and partners • Communicate respectfully and thoughtfully • Use a problem solving approach when identifying issues • Provide leadership to the care team and delegate effectively • Provide recognition and feedback to other doctors and staff • Participate in and support medical/dental group decisions • Seek ways to continually develop leadership and influence skills

About the case study series

Disruptive innovations in health care have the potential to decrease costs while improving both the quality and accessibility of care. This paper is part of a series of case studies that uses disruptive innovation theory to examine integrated delivery systems and aims to identify the critical factors necessary to achieve many of the desired quality, cost, and access improvements called for in current reform proposals. By providing a historical and strategic analysis of integrated fixed-fee providers, this project hopes to accelerate the adoption of disruptive innovations throughout the health care delivery system.

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pioneer

Robert Wood Johnson Foundation

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About Innosight Institute

Innosight Institute, founded in May 2007, is a 501(c)(3) not-for-profit think tank whose mission is to apply Harvard Business School Professor Clayton Christensen's theories of disruptive innovation to develop and promote solutions to the most vexing problems in the social sector. Innosight Institute's case studies are for illustrative purposes only and do not represent an endorsement by Innosight Institute.

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