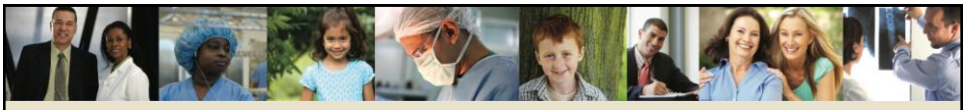
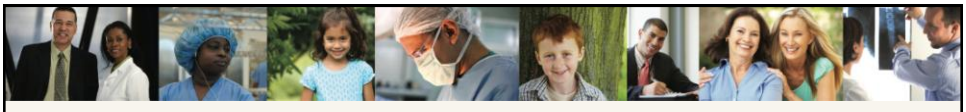


Reducing Preventable Readmissions: Fairview's Work

Mary Edwards, Vice President, Public Policy

August 2014

FAIRVIEW



Fairview Overview

- Not-for-profit established in 1906
- Partnership with University of Minnesota since 1997
- 21,000+ employees
- 2,300 aligned physicians
  - Employed, faculty, independent
- 7 hospitals/medical centers (1,475 staffed beds)
- 40+ primary care clinics
- 55+ specialty care clinics
- 53 senior housing locations
- 30+ retail pharmacies

2013 data

- 5.9 million outpatient encounters
- 1.5 million clinic visits
- 72,291 inpatient admissions
- 320,00 attributed lives
- $524 million community contributions
- 3 billion total assets
- $3.4 billion total revenue

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Taking partnership with U of M to the next level

Creating University of Minnesota Health

Co-managed facilities and services include:

- University of Minnesota Medical Center (UMMC) and Children's Hospital
- University of Minnesota Physicians services at UMMC
- UMP physician activity at other Fairview sites (e.g. NICU, ICU Hospitalists, specialty outreach)
- University-branded services at Fairview sites
- Associated services and tests provided at UMMC
- Fairview Maple Grove ACC specialty activity
- University ACC Joint Venture

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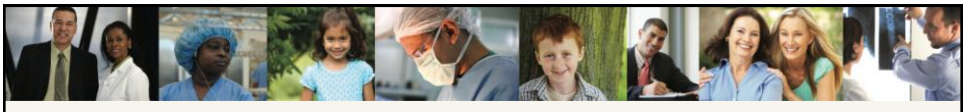

Overarching Goal:

Do the right thing for our patients

- Improve the quality of care
- Improve the patient and family experience
- Reduce the cost of care

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One Strategy: Reduce Hospital Readmissions

Why focus here? The numbers tell the tale…

1 in 5 — Medicare patients discharged from the hospital readmitted within 30 days*

836,000 — 30-day readmissions that could be prevented out of 7 million annually**

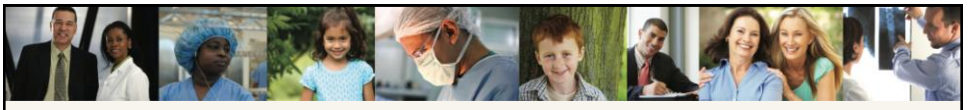
$25 billion — Estimated cost of preventable readmissions to the U.S. health system annually***

*Jencks, SF, Williams MV, Coleman EA, Rehospitalizations among patients n the Medicare fee-for-service program, New England Journal of Medicine, 2009;360(14):1418-1428
**National Priorities Partnership, Nov. 2010
***PriceWaterhouse Coopers' Health Research Institutes, The Price of Excell: Identifying Waste in Healthcare, 2008.

What Fairview is Doing

Testing ideas, putting them into action

Targeting Populations	Addressing Causes	Testing Solutions
Focus on populations of patients with the highest rates and risk for readmission, such as: • Heart failure • Heart attack • Pneumonia • Chronic obstructive pulmonary disease • Psychoses • Intestinal problems	• Inadequate discharge planning and follow up • Inadequate or ineffective patient and family engagement • Lack of transition support and communication	• Risk stratification to identify high-risk patients in real time and connect to resources • Follow-up appointments • Teach-back • After-visit summary improvements • One plan of care in electronic medical record



Meet Veronica

88 years old, chronic heart failure

Veronica was in the hospital for her heart condition

She was ready to go home on a Sunday

- Discharge instructions weren't very clear
- Left the hospital not certain of who to call with questions
- No scheduled follow-up appointment at her primary care clinic
- Managing multiple medications

Veronica was readmitted the next month for the same issues

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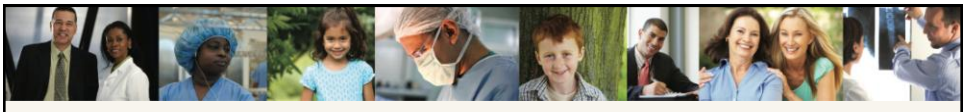

What Did We Do?

Developed a patient-centered disease management program

As part of our Chronic Heart Failure program, we created the Cardiomyopathy Optimization Rehabilitation and Education (C.O.R.E.) Clinic in 2003

Goal is to help patients:

- Better understand their condition, treatment and the importance of follow-up care and lifestyle choices
- Improve the length and quality of their lives (slow the progression with guidelines-based medicine)
- Detect future heart problems before they become life-threatening
- Avoid hospital admissions and readmissions

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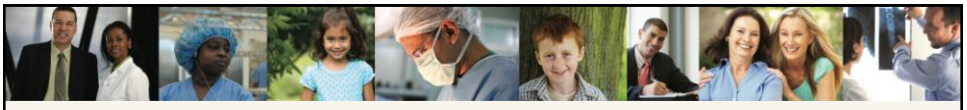

Where Do We Provide This Care?

University of Minnesota Heart

5 locations
- Fairview Northland Medical Center
- Fairview Ridges Hospital
- Fairview Southdale Hospital
- University of Minnesota Medical Center
- Fairview Clinics – Fridley

Clinic staffed by
- University of Minnesota Heart cardiologists
- Nurse practitioners
- Physicians assistants
- Currently have 800 C.O.R.E. patients

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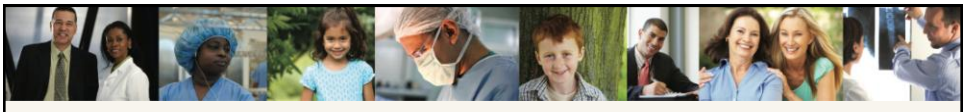

Why it Works

Little details matter for people with heart failure

- Follow-up visit within 3 days of hospital discharge
- Nurse practitioners and physicians tailor care around patient's lifestyle
- Focus on patient engagement: diet, exercise patterns and medications
- High-risk patients:
  - Transition to an appropriate 24-hour care setting *or*
  - Participate in tele-management program
- Enrollment: Physician, cardiologist or self-referral

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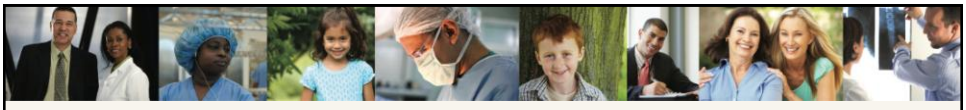

What Are The Results?

At one hospital, we were able to…

Based on 2011 data, C.O.R.E. Clinic patients experienced:

- 67% lower rate of readmissions for a primary diagnosis of heart failure compared to patients not in the clinic
- 85% lower rate of readmissions for all causes compared to patients not in the clinic

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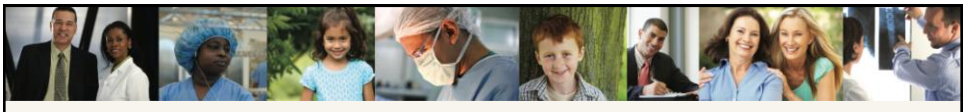

The impact on patients

Veronica's story

After landing back in the hospital in January 2013,

Veronica's physician referred her to the C.O.R.E. Clinic

- Enrolled into the tele-management program.
- Treated her hypertension and sleep apnea.
- Veronica has been seen monthly and has stayed out of the hospital.

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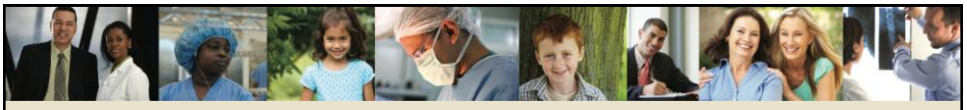

QUESTIONS?

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