Transforming Rural Health: Case Study of New Ulm, MN

Toby Freier, MBA, FACHE
President, New Ulm Medical Center

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
New Ulm Medical Center

- City – 13,500
- Primary Service Area – 40,000
- Critical Access Hospital
- Allina Health
- 500 employees
- 40 providers
- $65 million budget
Learning Objectives

• Identify key foundational pillars to rural health performance
• Recognize key strategies and tactics to apply in rural health organizations to improve access, quality, experience and affordability
• Review programs, services and stakeholders with a community (population) health initiative
• Recognize the benefits and challenges of a community health initiative
mission
vision
success?
Rural Hospitals

**Past Attributes**
- Duplicative
- Fragmented
- Illness focused
- Provider centric
- Technology deficient
- Isolated (non-collaborative / independent)
- Generalists

**Current Environment**
- Workforce
- Technology
- Facilities
- Regulatory
- Quality
- Reimbursement
- Scale
- Population

Allina Health
New Ulm Medical Center Vision

To be a national model for rural health

STRATEGIES

Community Health

Quality of Care

Patient Experience

Clinical Growth

Financial Performance & Affordability

Healthcare Team Integration

Electronic Health Record

Community Health Engagement

Clinical Service Line and System Integration

“Foundational Pillars”
Hard work ahead

Sales are dropping like a rock.

Our plan is to invent some sort of doohickey that everyone wants to buy.

The visionary leadership work is done. How long will your part take?
Integration

- Physicians Group of New Ulm
  - Professional Services Agreement in 1996 (30 yrs)
  - 30 physicians (21 primary care)
  - Shared Governance and Management
  - Aligned strategy and operations across continuum of care
  - Aligned incentives to move the needle in new care models
  - Selection, Autonomy, Compensation
  - Shared non-compete

- Home care, Hospice, DME, Ambulance

- Working on Skilled Nursing & Long-term Care
Electronic Health Records

- Epic EHR
- 2005/06 Big Bang Implementation
- 6 Years of Physician Incentive Goals
- 2 Physician Champions
- Invested in staff training in data analytics
- Critical for Quality Improvement and Population Health
- Regionalization and Clinical Integration
Community Engagement

- Relationship business
- Reactive to Proactive
- Illness Care to Health Care
- Needs assessment
- Community Engagement Council
  - Schools, Public Health, City, Seniors, Physicians
System Clinical Service Lines

- System benefits – financial vs. clinical
- Continuum based care model
- Rural sites included and valued
- Oncology, Neurology, Mother Baby, Mental Health, etc
- Telehealth
- Training / Education
Strategy

• Our Team
• Quality of Care
• Patient Experience
• Clinical Access and Growth
• Community Health
• Financial Performance and Affordability
### Primary Care

<table>
<thead>
<tr>
<th>Goal</th>
<th>Measurement</th>
<th>2012 Actual (10-31)</th>
<th>Goal</th>
<th>YTD Actual</th>
<th>Accountable Leader</th>
<th>Committee Review</th>
<th>Tactics / Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Care to Patients with Chronic Illness</td>
<td>Diabetes: % of patients 18-75 at Optimal Care (Allina report)</td>
<td>40.9%</td>
<td>48%</td>
<td></td>
<td>Miller / Messenger</td>
<td>Primary</td>
<td>• Incentive Goal: partial payout begins at 45%</td>
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<td></td>
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<td>• Develop and implement a Care Management model for chronic care conditions</td>
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<td>• Evaluate use of Excellian WorkBench Reporting to support nursing and provider work in managing this population</td>
</tr>
<tr>
<td>Vascular: % of patients 18-75 at Optimal Care (Allina report)</td>
<td></td>
<td>49.7%</td>
<td>50%</td>
<td></td>
<td>Miller / Messenger</td>
<td>Primary</td>
<td>• Develop and implement a Care Management model for chronic care conditions</td>
</tr>
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<td>• Evaluate use of Excellian WorkBench Reporting to support nursing and provider work in managing this population</td>
</tr>
<tr>
<td>Depression: % of adult patients with a coded major depression or dysthymia encounter with a completed PHQ9 (Allina report)</td>
<td></td>
<td>61%</td>
<td>80%</td>
<td>in Qtrs 3 &amp; 4</td>
<td>Miller / Schneider</td>
<td>Primary</td>
<td>• Incentive Goal</td>
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<td></td>
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<td></td>
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<td>• Education for providers on coding for depression related diagnoses</td>
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<td>• Develop a consistent workflow for completion of the initial and subsequent PHQ9</td>
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<tr>
<td>Depression: % of pts with initial PHQ9 score of &gt;9 who achieve remission at 6 months (Allina report)</td>
<td></td>
<td>10%</td>
<td>25%</td>
<td>in Qtr 4</td>
<td>Miller / Schneider</td>
<td>Primary</td>
<td>• Incentive Goal: partial payout begins at 20%</td>
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<td>• AMG Goal = 35%</td>
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<td>• Incentive Goal</td>
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<td>• Develop an algorithm to provide guidance for providers on recommended treatment interventions</td>
</tr>
<tr>
<td>Asthma: % of patients age 5-50 with coded visit of asthma that meet all 3 care criteria: 1) most recent ATAQ score is 0; 2) no more than 1 reported ED or IP admit for asthma; 3) has a documented asthma management plan (new</td>
<td></td>
<td>23%</td>
<td>55%</td>
<td></td>
<td>Miller / Messenger</td>
<td>Primary</td>
<td>• Develop and implement a Care Management model for chronic care conditions</td>
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<td>• Evaluate the role that RT should play in supporting this work</td>
</tr>
</tbody>
</table>
Clinical Growth

Relationships

Number of people entrusting us with their care

+ Scope of services provided to patients
Clinical Access & Growth

• Primary Care
  - Walk-in, rural health clinics/geography, senior care, occupational health, on-line care
  - Hospitalists / ER physicians
  - Team care

• Specialty care
  - 2 person teams
  - New specialists / collaboration
  - Allina Integrated Medical Network

• Pipeline strategy
Medical Staff Development Plan

Physician Timeline

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<tbody>
<tr>
<td>Candidate J - FP</td>
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<td>Candidate G - FP</td>
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<td>Candidate H - FP</td>
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<td>Candidate K - FP</td>
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<td>Candidate B - FP</td>
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<tr>
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<td>Candidate A - Ortho</td>
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<td>Candidate D - FP</td>
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<td>Candidate E - FP</td>
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<td>Candidate F - IM</td>
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</table>

| Transition to Part-time   |      |      |      |      |      |      |      |      |      |      |
| Physician B               |      |      |      |      |      |      |      |      |      |      |
| Physician C               |      |      |      |      |      |      |      |      |      |      |
| Physician D               |      |      |      |      |      |      |      |      |      |      |
| Physician F               |      |      |      |      |      |      |      |      |      |      |
| Physician G               |      |      |      |      |      |      |      |      |      |      |
| Physician H               |      |      |      |      |      |      |      |      |      |      |
| Physician I               |      |      |      |      |      |      |      |      |      |      |
| Physician J               |      |      |      |      |      |      |      |      |      |      |
| Physician K               |      |      |      |      |      |      |      |      |      |      |
| Physician L               |      |      |      |      |      |      |      |      |      |      |

| Retirement                |      |      |      |      |      |      |      |      |      |      |
| Physician A               |      |      |      |      |      |      |      |      |      |      |
| Physician E               |      |      |      |      |      |      |      |      |      |      |
| Physician B               |      |      |      |      |      |      |      |      |      |      |
| Physician C               |      |      |      |      |      |      |      |      |      |      |
| Physician D               |      |      |      |      |      |      |      |      |      |      |
| Physician F               |      |      |      |      |      |      |      |      |      |      |
| Physician G               |      |      |      |      |      |      |      |      |      |      |
| Physician H               |      |      |      |      |      |      |      |      |      |      |
| Physician I               |      |      |      |      |      |      |      |      |      |      |
| Physician J               |      |      |      |      |      |      |      |      |      |      |
| Physician K               |      |      |      |      |      |      |      |      |      |      |
| Physician L               |      |      |      |      |      |      |      |      |      |      |
**AIM: Become a preferred provider for Cancer Care in Southwestern Minnesota**

<table>
<thead>
<tr>
<th>SPACE EXPANSION</th>
<th>VPCI INTEGRATION</th>
<th>PROVIDER GROWTH</th>
<th>REGIONALIZATION</th>
</tr>
</thead>
</table>
| • Co-location of treatment and clinic  
  • Doubling the size of chemotherapy area  
  • Patient / Family Support Functions | • Clinical trials  
  • Genetic Counseling  
  • Care Navigation  
  • Development of pathways, guidelines, and protocols  
  • Complimentary and Ancillary Integration | • Increase Dr. Piroso to full-time  
  • Integrate with Minnesota Oncology | • Onboard new Oncology Leader  
  • Community Engagement across the Continuum  
  • Provider Networking across SW Minnesota |
The Heart of New Ulm Project: A Population-Based Approach To Preventing Heart Disease
Health Outcomes

Health Behavior
- Tobacco, alcohol, drug use
  - Diet and exercise
  - Unsafe sex

Physical Environment
- Workplace safety
- Infectious diseases
- Air/Water quality
- Community safety

Socioeconomic
- Health insurance coverage
- Education
- Employment/Income
- Family & social supports
- Affordable housing

Health Care – 25%
- Access to care
- Quality of care
- Coordination of care
- Affordability of care
OBESITY TRENDS AMONG U.S. ADULTS

1991

2008-2010 Combined Data

Legend:
- No Data
- <10%
- ≥10% and <15%
- ≥15% and <20%
- ≥20% and <25%
- ≥25% and <30%
- ≥30%
What is the HONU Project and Why Try?

Most published CVD research is focused on innovative technological therapies for patients with existing disease.

There are gaps in innovative dissemination/utilization of established therapies to the masses, most of whom do not have disease.

HONU is a demonstration project designed to apply evidence-informed health improvement practices, based on the COMMUNITY’s level of risk and preferences (not ours).

It is primarily a systems-level intervention that enhances and synchronizes CVD heart health improvement efforts/resources across key areas within New Ulm, MN.
• Agricultural area of south-central Minnesota
• “The (statistically) most German town in America”
• 17,199 residents (13,594 within New Ulm city limits)
• Near perfect gender split
• Average age is 40 and adults account for 75% of the population
• 97% identify as White
• 20% report obtaining a Bachelors degree or higher education
• 60% of adults are married
• Very stable year-over-year population
Primary Objectives

Long-term is to **reduce (age/sex-adjusted) attack rate of acute myocardial infarctions over 10 years,** among 56073 zip code residents age 30-79 years.

Moderate-term is to **improve the proportion** of 56073 zip code residents (age 30-79 years; active Allina health record) with controlled modifiable heart disease risk factors over 5 years. *

1. Elevated blood lipids (i.e., total/LDL/HDL cholesterol, triglycerides)
2. High blood pressure
3. Uncontrolled glucose (i.e., type 2 diabetes, pre-diabetes)
4. Obesity
5. Tobacco use
6. Physical inactivity
7. Low fruit/vegetable consumption
8. Uncontrolled stress
9. Medication (i.e., antithrombotics, antidyslipidemia, antihypertension) underutilization/non-adherence

Funding/Logistics/Innovation

• Allina Health invested several million dollars over 5 years for seed support.
• Project implemented by Minneapolis Heart Institute Foundation with support by New Ulm Medical Center / Allina Health
• Ongoing efforts are made to match base fund through grants, reimbursement, donations.
• Relatively long-term planned timeframe at 10+ years
• More concern with reach/penetration vs. effectiveness of programs
• Primary population-level surveillance tool is the electronic health record
The 2009 “Community Diagnosis”

Obesity is very problematic in New Ulm, along with associated medical risks such as metabolic syndrome.

This is supported by observations of low fruit/vegetable consumption and significant underutilization of preventive medical therapies (e.g., aspirin, statin, blood pressure medications) among those at high risk.

Intervention efforts should focus on improving the food environment (as it relates to obesity) and medical management of those at high cardiometabolic risk.
Project Sections

The project includes community education, medical interventions and environmental changes, concurrent in the following spheres of influence:

Healthcare  Community  Worksite
<table>
<thead>
<tr>
<th>Sphere of Influence</th>
<th>Environment/Policies</th>
<th>Key Leaders</th>
<th>Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
<td><strong>Electronic Health Record</strong></td>
<td><strong>Providers</strong></td>
<td><strong>Patients</strong></td>
</tr>
<tr>
<td></td>
<td>- Enhanced flow sheet and clinical decision making aid (i.e., cardiometabolic risk assessment/treatment (dashboard))</td>
<td>- Quarterly provider continuing medical education seminars</td>
<td>- Heart risk screenings plus coronary artery calcium scoring follow-up program</td>
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<td></td>
<td>- Population dashboard to monitor population health</td>
<td>- Cardiometabolic risk management feedback reports</td>
<td>- Educational materials/resources</td>
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<td></td>
<td>- Ability to use an identification tool for program eligibility</td>
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<tr>
<td></td>
<td>- Project programs/data closely integrated with primary care to improve communication/collaboration</td>
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<td></td>
</tr>
<tr>
<td>Worksite</td>
<td><strong>Environment/policy assessment</strong></td>
<td><strong>Employers</strong></td>
<td><strong>Employees</strong></td>
</tr>
<tr>
<td></td>
<td>- Follow-up consulting (i.e., tobacco control policies; physical activity infrastructure; healthier cafeteria and vending options)</td>
<td>- Wellness committee planning</td>
<td>- Heart health screenings</td>
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<td></td>
<td>- Campaigns (e.g., stairwell prompts)</td>
<td>- Employer newsletter</td>
<td>- Lunch-n-Learn presentations</td>
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<td>- Incentive benefits design consulting options</td>
<td>- Ongoing employer group meetings and annual employer summit</td>
<td>- Health behavior change programs (individual and group)</td>
</tr>
<tr>
<td>Community</td>
<td><strong>Restaurants/Grocery &amp; Convenience Stores</strong></td>
<td><strong>Neighborhood/Organization Leaders</strong></td>
<td><strong>Residents</strong></td>
</tr>
<tr>
<td>Restaurants/Grocery &amp; Convenience Stores</td>
<td>- HONU membership program</td>
<td>- Peer mentoring and sustainability efforts</td>
<td>- Heart health screenings</td>
</tr>
<tr>
<td>Restaurants/Grocery &amp; Convenience Stores</td>
<td>- Advocacy for strengthened outdoor tobacco control policies (in partnership with SHIP Board)</td>
<td>- GIS-based feedback on health risks</td>
<td>- Social marketing campaigns promoting health behaviors</td>
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<tr>
<td>Community</td>
<td>- <strong>City Ordinances</strong></td>
<td>- Neighborhood level planned interventions</td>
<td>- Programs (e.g., cooking classes, walking clubs, physical activity programs/events)</td>
</tr>
<tr>
<td>Restaurants/Grocery &amp; Convenience Stores</td>
<td>- HONU membership program</td>
<td></td>
<td>- Tobacco cessation programs</td>
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<tr>
<td>Community</td>
<td>- <strong>City Ordinances</strong></td>
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<td>- Educational materials</td>
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<tr>
<td>Community</td>
<td>- Advocacy for strengthened outdoor tobacco control policies (in partnership with SHIP Board)</td>
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<td>- Annual community summit</td>
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Healthcare

HeartBeat Connections Program
High risk patients identified *proactively* from the medical record

Includes welcome packet, educational materials, and 1:1 telephonic coaching with a health professional which includes medication therapy management

Focuses on optimizing major risk factors such as high cholesterol, blood pressure, nutrition, exercise, and stress
Comparison of behavioral measures
for people with 2 appointments completed by May 2011

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
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<th>Most Recent</th>
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<th>p-value</th>
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<tr>
<td></td>
<td>n</td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
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<tr>
<td>Aspirin Use*</td>
<td>174</td>
<td></td>
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<tr>
<td>Daily</td>
<td></td>
<td>67</td>
<td>38.5</td>
<td>122</td>
<td>70.1</td>
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<tr>
<td>Less than daily</td>
<td></td>
<td>107</td>
<td>61.5</td>
<td>52</td>
<td>29.9</td>
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<tr>
<td>Cholesterol Medication Use**</td>
<td>150</td>
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<tr>
<td>Prescribed 100% adherent</td>
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<td>37</td>
<td>24.7</td>
<td>62</td>
<td>41.3</td>
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<tr>
<td>Prescribed &lt; 100% adherent</td>
<td></td>
<td>12</td>
<td>8.0</td>
<td>8</td>
<td>5.3</td>
</tr>
<tr>
<td>Not Prescribed</td>
<td></td>
<td>101</td>
<td>67.3</td>
<td>80</td>
<td>53.3</td>
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<td>High Blood Pressure Medication***</td>
<td>64</td>
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<tr>
<td>Prescribed 100% adherent</td>
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<td>30</td>
<td>46.9</td>
<td>41</td>
<td>64.1</td>
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<tr>
<td>Prescribed &lt; 100% adherent</td>
<td></td>
<td>3</td>
<td>4.7</td>
<td>5</td>
<td>7.8</td>
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<tr>
<td>Not Prescribed</td>
<td></td>
<td>31</td>
<td>48.4</td>
<td>18</td>
<td>28.1</td>
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</tbody>
</table>

*excludes missing and people with a contraindication
**excludes missing, people with a contraindication and those not dyslipidemic
***excludes people who are not hypertensive and missing
## Comparison of behavioral measures
for people with 2 appointments completed by May 2011

<table>
<thead>
<tr>
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<th>Baseline</th>
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<th>Most Recent</th>
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<th>p-value</th>
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<tr>
<td></td>
<td>n</td>
<td>Frequency %</td>
<td>n</td>
<td>Frequency %</td>
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<tr>
<td>Daily fruit and vegetable</td>
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<tr>
<td>5+</td>
<td>49</td>
<td>24.3</td>
<td>119</td>
<td>59.2</td>
<td>0.000</td>
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<tr>
<td>&lt; 5</td>
<td>153</td>
<td>75.7</td>
<td>82</td>
<td>40.8</td>
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<tr>
<td>Missing</td>
<td>3</td>
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<td>At least 150 mins moderate exercise /wk</td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>49</td>
<td>24.3</td>
<td>71</td>
<td>35</td>
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Comparison of biometric risk factors for people with 2 appointments completed by May 2011 and 2 lab values available for comparison

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<td>%</td>
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<td>%</td>
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<td><strong>LDL</strong></td>
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<td>74</td>
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<td>66.4</td>
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<td>48</td>
<td>36.3</td>
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Other healthcare initiatives

Grand Rounds

• Provider education seminars every 3-4 months to inform physicians about state-of-the-art prevention therapies
• Heart & Vascular Clinic with Minneapolis Heart Institute Partnership
• Weight Management Program
Community Programs, cont.

Community Health Challenge Program

New Ulm divided into 23 districts
Health initiatives led by a volunteer “district leader”

FoodWorks
Project Registered Dietician works with local restaurants, grocery and convenience stores to develop more healthy, affordable items

GEORGE’s HEART OF NEW ULM MENU!!

— YOUR MEALS WILL START WITH A SALAD SERVED WITH Newman’s Own Local Ranch OR French. THEN, ENTREES SERVED WITH FRESH STEAMED VEGETABLES AND STEAMED WILD RICE!! ENJOY!!

CHOOSE FROM THE FOLLOWING.

ANGIE’S SAUTEED SALMON — 6 OUNCES OF DELICIOUSNESS. DONE TO YOUR DESIRED “SEAR”: INCLUDES GARLIC MUSHROOMS $12

Kalories: 500 / Protien: 35g / Fat: 22g / Sodiu: 750 / Mois: 14g / Caliores: 560 / Protien: 38g / Fat: 12g / Sodium: 480 / Cholesterol: 115mg / Sodiu: 825mg / Fibre: 5g

WICKED WRAPS — CHICKEN AND SAUTEED VEGGIES OR PORTOBELLA AND SAME. W/PROVOLONE & FRESH SALSA $12

Kalories: 460 / Cholesterol: 26g / Protien: 26g / Fat: 10.26g / Sodium: 455mg / Fibre: 5g

Snack SWAP
Simply SWAP a Top Snack off our list for one of your usual snacks to save calories and improve your heart health. Make a SWAP today!

Making healthful eating easy one SWAP at a time!

- Blue Diamond® almonds (1.5-ounce package)
- Planters’ peanuts (1.75-ounce package)
- Lean Cuisine® meal
- Honey Kist Cheerios® (1.2-ounce cereal crisp) with skim milk (8 ounces)
- Yogurt® Original low-fat or light yogurt (8-ounce container)
- Green Club Coll® cheese or fat free yogurt (8-ounce container)
- Banana apple or orange
- Baked Lays® Original Potato Chips (1 ounce)
- Cut-up vegetables and dip
- Nature Valley® Crunch ‘N’ Honey granola bar
- Fiber One® bar
- Kellogg® GOMIN® bar
- String cheese (1 stick)
- Chocolate milk (8 ounces)
WorkSite

• Environment/Culture audits, e-newsletter
• Quarterly employee challenge programs
• Annual Employer Summit & Hot Topics Breakfast Speakers Bureau
• Employee Health Screenings
EHR as a Primary Data Source

Transition from traditional community data sources....

*National Health and Nutrition Examination Survey*
*Behavioral Risk Factor Surveillance System*
*County Health Tables*

....to the EHR as a the center of surveillance
*MESA (Marshfield Epidemiologic Study Area)*
*HealthPartners/Group Health*
*Heart of New Ulm*
Changes Among Residents Participating In Both 2009 and 2011 Screenings (n = 1766)

Prevalence of Behavioral Factors

- Current Smoker: 6.3% in 2009 vs 5.3% in 2011
- High Stress Level: 11.2% in 2009 vs 7.6% in 2011
- 5+ Fruit & Veg/day: 18.5% in 2009 vs 31.5% in 2011
- Exercise > 150 min/wk: 68.4% in 2009 vs 77.0% in 2011

* P<.05 2009 vs 2011
Changes Among Residents Participating In Both 2009 and 2011 Screenings (n = 1766)

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<tr>
<th>Condition</th>
<th>2009</th>
<th>2011</th>
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<tr>
<td>Obese (BMI &gt; 30 kg/m²)</td>
<td>36.0</td>
<td>35.6</td>
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<tr>
<td>Hypertension (&gt; 140/90 mmHg)*</td>
<td>24.0</td>
<td>18.8</td>
</tr>
<tr>
<td>High Cholesterol (&gt; 200 mg/dL)*</td>
<td>49.4</td>
<td>42.8</td>
</tr>
<tr>
<td>High LDL (&gt; 130 mg/dL)*</td>
<td>37.7</td>
<td>32.9</td>
</tr>
<tr>
<td>hs-CRP (&gt; 3 mg/dL)*</td>
<td>29.8</td>
<td>26.4</td>
</tr>
<tr>
<td>High Glucose (&gt; 100 mg/dL)*</td>
<td>26.6</td>
<td>23.2</td>
</tr>
</tbody>
</table>
Changing Reimbursement Models

Slow shift from fee-for-service to total-cost-of-care does not (yet) favor a focus on population health

Interim strategies are necessary

- External supplemental funding for infrastructure
- Need time to establish a business model

Eventual transition to a mix of …

- Total-cost-of-care
- Risk sharing for population performance
- Accountable Care Organizations
- Direct fees for population health services
- Patient designated funds focused on population health options
Heart of New Ulm Project: A Community's Quest to Eliminate Heart Attacks


How the town of New Ulm joined together to lose weight, lower cholesterol levels and eat healthier.
NEW ULM, MINNESOTA

it takes a village

This is the story of how the people in one small city are banding together to make health a priority. They are on a 10-year mission to move more, eat better, and reduce heart attacks—and it's working!

Home of beer, brats, and butter, New Ulm, Minnesota, is a quaint small city a couple hours south of Minneapolis populated by about 14,000 people, many of German ancestry. “Our German heritage put beer, brats, and butter on the menu too often, widened our waistline, and escalated our heart disease risk factors,” says Rebecca Fleszar, RD, a community dietitian.

But in 2008, the town leaders decided to do something that would impact New Ulm and its residents for years to come. They designated their community’s health as a top priority and began taking action by installing sidewalks and parks. At the same time, Kevin Graham, M.D., former cardiologist and president at the Minneapolis Heart Institute Foundation, and Dick Pettingill, former CEO of Allina Health System, who both knew coronary artery disease is the leading cause of death in the United States and worldwide, were planning a long-term community project to reduce risk factors for heart disease and, ultimately, reduce incidences of heart attacks.

To implement the project, they were looking for a community that was ready and willing to change. The heart of New Ulm

Even though New Ulm had heart disease and diabetes risk factors a bit higher than national averages, choosing this town had more to do with vision and infrastructure than diet and disease risk. New Ulm already had support and facilities in place, and Graham, who traveled there for years as a cardiologist,

50%

Nearly half of the town population was at risk of or living with prediabetes or diabetes when the project began.
Successes

- 5,198 of 10,000 adults screened
- Successful use of EHR in community based screenings
- Successful creation of specifications for a population health dashboard
- 94% of residents aware and feel good about the project
- Development of a community-wide steering committee to create community buy-in.
- Engagement of our Legislators/Public policy stakeholders
- Implementation of programs in clinic, worksites, community
- Decline in community rate of heart attacks
- Behavioral and health outcomes are also improving
Challenges Ahead

- Funding and project governance
- Payer collaboration
- Maintaining project momentum and interest within the community
- EHR – integration of HONU programs and clinical decision support tools
- Further engagement of primary care teams
- Integration of new technology
- Engagement of at risk populations
HONU Video

Thank you!
Toby Freier
toby.freier@allina.com