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Transforming Ourselves to Achieve Triple Aim Results: The Experiences of An Integrated Health System

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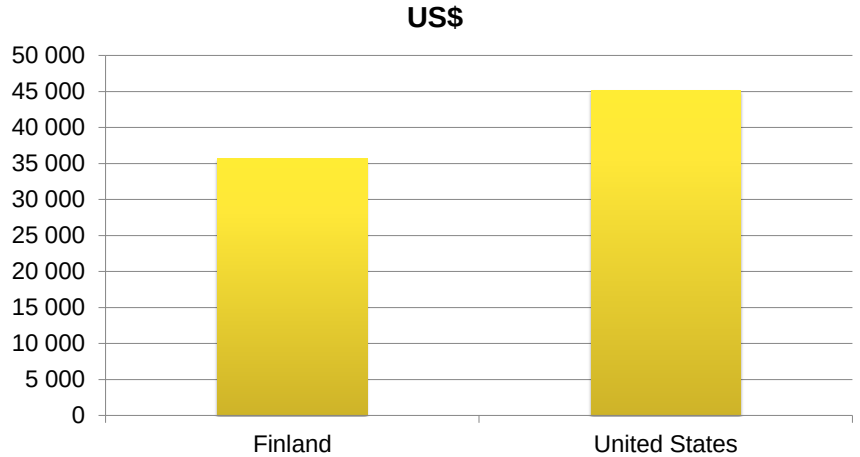
Medical Director for Evidence-Based Health
Consulting Cardiologist
Helsinki, Finland – 25 May 2012

Originally prepared for
Mary Brainerd, CEO
Beth Waterman, Chief Improvement Officer

GDP/capita 2009: Finland and United States



Source: OECD Stat Extracts

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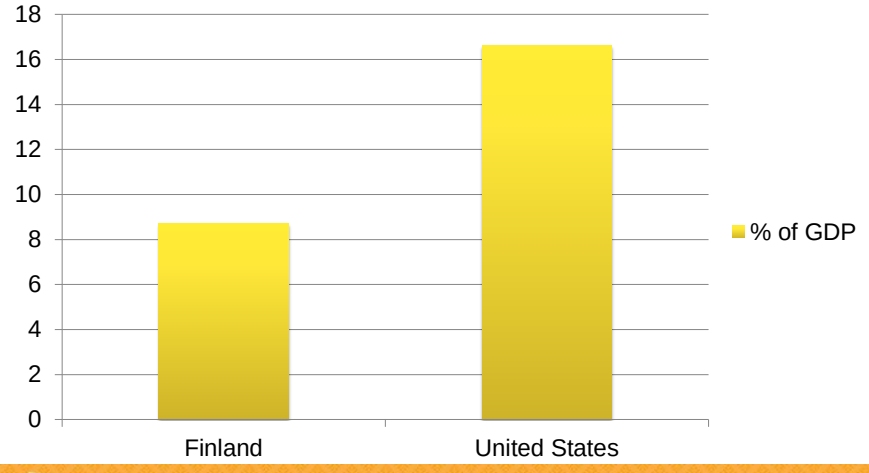
Health Care Expenditures as % of GDP: 2009



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Source: OECD Stat Extracts

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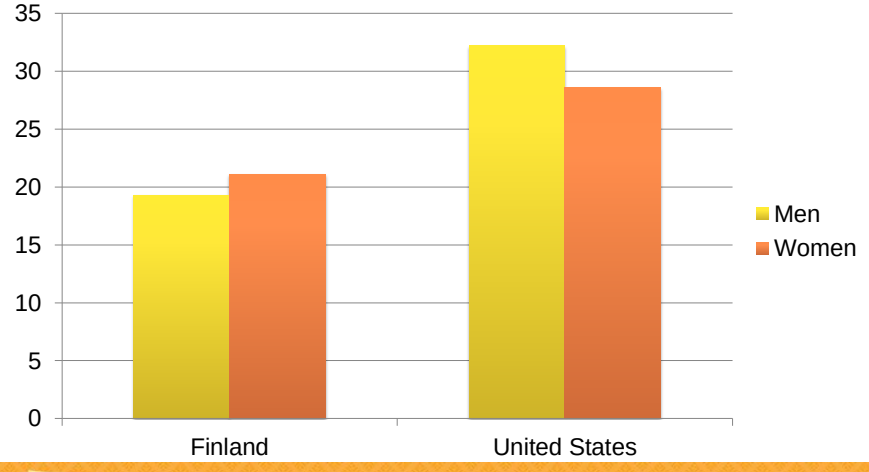
% Obese Age 15+ in 2007: Finland and United States



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Source: OECD Stat Extracts

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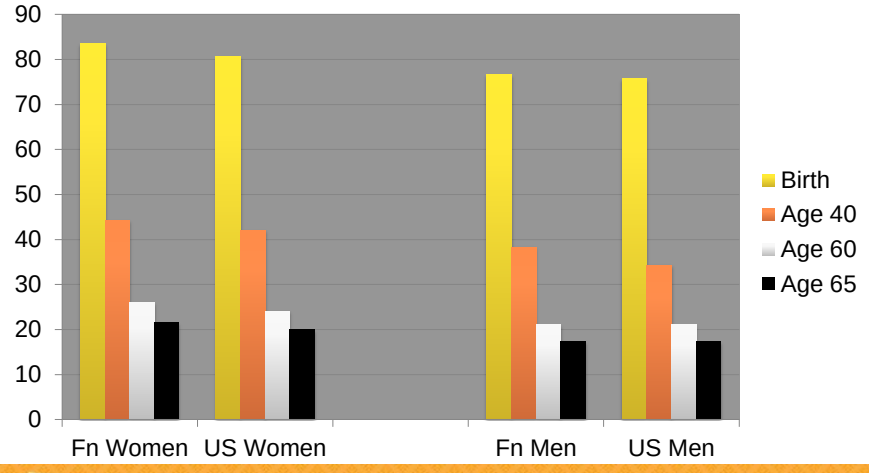
Life Expectancy in 2009: Finland and United States



Source: OECD Stat Extracts

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- Not-for-profit, consumer-governed
- Integrated care and financing system
  - 12,000 employees
  - Health plan
    - 1.36 million members in Minnesota and surrounding states
  - Medical Clinics
    - 500,000 patients
    - 800 physicians
      - HealthPartners Medical Group
      - Stillwater Medical Group
    - 35 medical and surgical specialties
    - 50 locations
    - Multi-payer
  - Dental Clinics
    - 60 dentists
    - Specialties: oral surgery, orthodontics, pediatric dentistry, periodontics, prosthodontics
    - 20 locations
  - Four hospitals
    - Regions: 454-bed level 1 trauma and tertiary center
    - Lakeview: 97-bed acute care hospital, national leader in orthopedic care
    - Hudson: 25-bed critical access hospital, award-winning healing arts program
    - Westfields: 25-bed critical access hospital, regional cancer care location

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Who We Are

Health is what we do. Partnership is how we do it.

Mission: Why we're here

Improve the health of our members, our patients and the community.

Vision: Where we're headed

Through our innovative solutions that improve health and offer a consistently exceptional experience at an affordable cost, we will transform health care. We will be the best and most trusted partner in health care, health promotion and health plan services in the country.

Values: How we act

PASSION • TEAMWORK • INTEGRITY • RESPECT

We live our values thru our Promises to Each Other & our Promises to Patients, Families & Members.

Strategies: What we do

PEOPLE • HEALTH • EXPERIENCE • STEWARDSHIP

We approach our work and create our work plans by breaking it up into four dimensions.

Results: How we will know we did it

Balanced scorecard: A quarterly report that tracks our progress in the 4 dimensions

Partners for Better Health: The long-term road map for our work in the Health, Experience and Stewardship dimensions also known as the Triple Aim.

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Achieving Value in Health Care

- The stakeholders agree on a set of mutual, measurable goals for the health system
- The extent to which the goals are being achieved is reported to the public
- Resources are available to achieve the goals
- Stakeholder incentives, imperatives, and sanctions are aligned with the agreed-on health system goals
- Leaders among all stakeholders endorse and promote the agreed-on health system goals.

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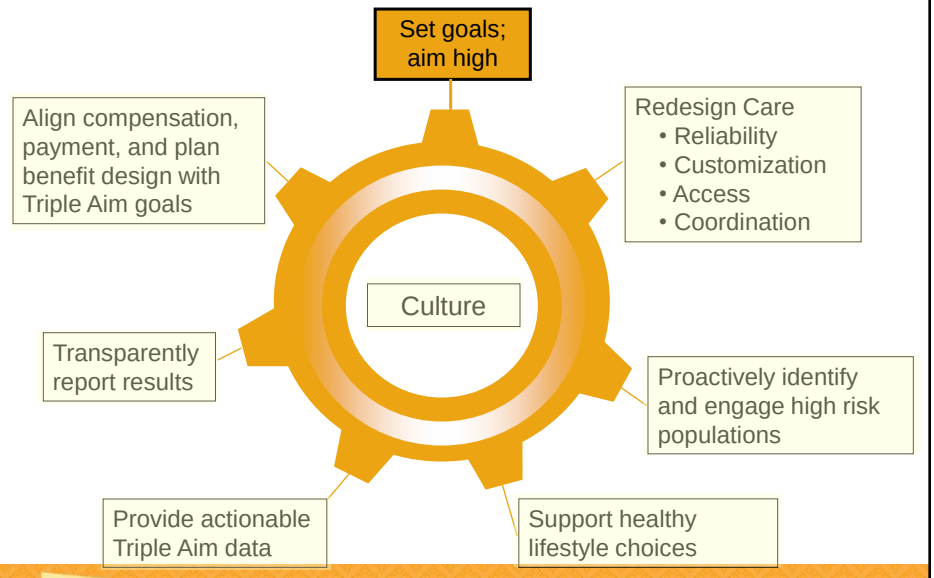
Kottke TE, Pronk NP, Isham GJ. The simple health system rules that create value. Prev Chronic Dis 2012;9:110179.8

Triple Aim: Transformation Elements



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Partners for Better Health Goals 2014

Health Success	Experience Success	Affordability Success
Improved health for our customers and community as measured by: •Better well being, more satisfied and healthy lives. •The best local and national health outcomes and the best performing health care costs in the region.	**Deliver an exceptional experience that customers want and deserve at an affordable cost as measured by:** •The best performance on customer's willingness to recommend our clinics, hospitals and health plan to family and friends. •Feeling well-supported, respected and cared for throughout life.	**Lower health care costs for our customers as measured by:** •Cost trends that are at or below general inflation (Consumer Price Index, a leading economic indicator). •The best performing overall health care costs in the region. •HealthPartners clinics and hospitals will be in the best 10 percent in the region in overall costs of health care.

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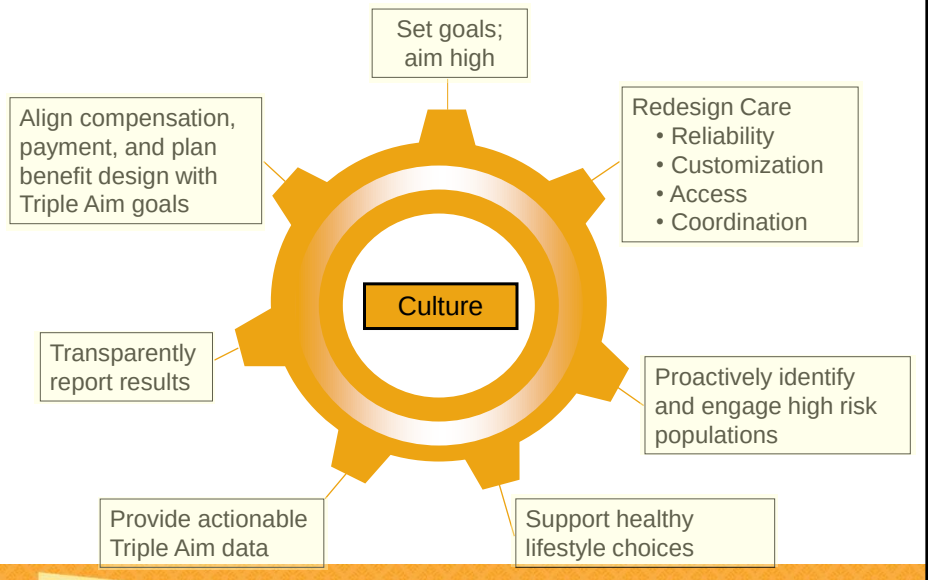
Triple Aim: Transformation Elements



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Culture

- Partners with those we serve
- Patient-centered
- Embraces the triple aim
- Supports innovation
  - Team-based
  - Safety
  - Standardization

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Physician/Dentist Culture: Grounded in Partnership

- **Started with vision for the future of health care**
  - "Escape Fire," Dr. Don Berwick's Plenary Address at IHI's 1999 National Forum.
  - *Crossing the Quality Chasm*. Institute of Medicine (2001)
  - Zen and the Art of Physician Autonomy Maintenance. Reinertsen. *Annals of Internal Medicine,* 138(12), 992-995. (2003)
- **Discussion with every doctor: Partnership Agreement**
- **Built into our ongoing processes**
  - New physician interviews/orientation
  - Annual performance reviews for doctors and leaders
  - Approaches to care redesign

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HealthPartners Physician & Dentist Partnership Agreement

ORGANIZATIONAL GIVES

Involve and engage doctors

Support a practice that works for both patients and doctors

- Be Patient Centered
- Support the 6 aims of 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

PHYSICIAN & DENTIST GIVES

Excel in clinical expertise and practice

- 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

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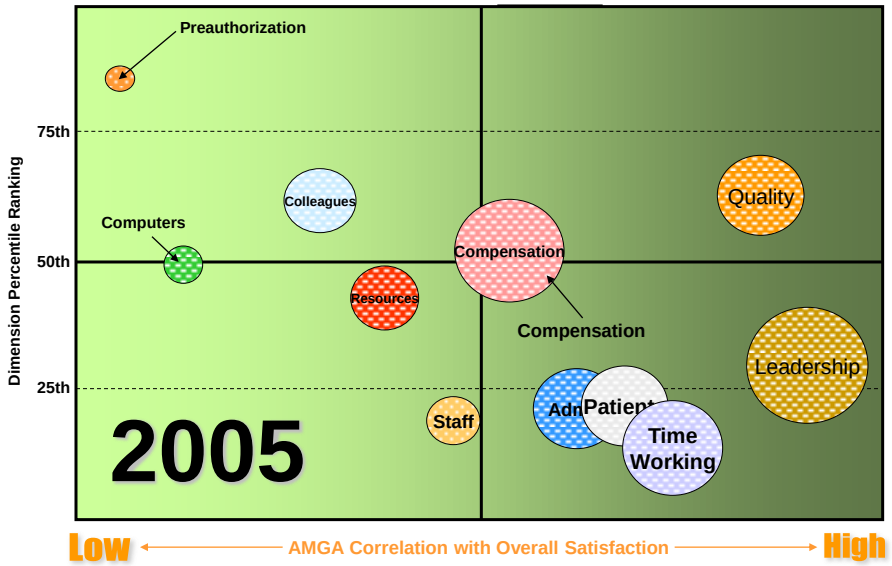
AMGA Physician Satisfaction Survey 2005



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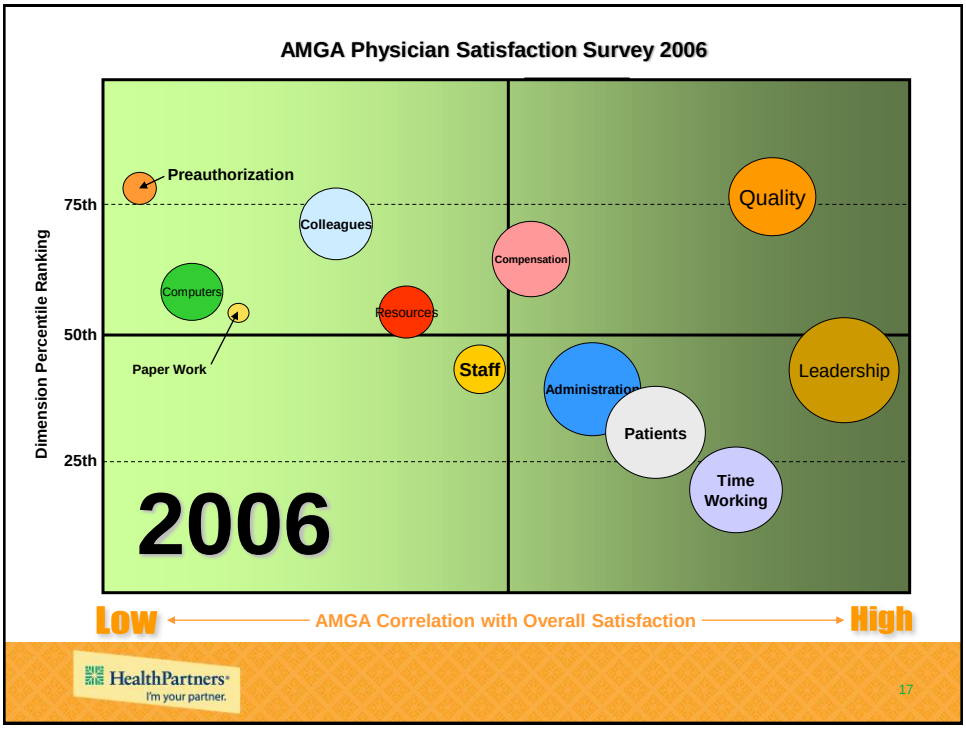
AMGA Physician Satisfaction Survey 2006
Dimension Percentile Ranking
75th
50th
25th
Preauthorization
Colleagues
Computers
Resources
Compensation
Quality
Paper Work
Staff
Administration
Leadership
Patients
Time Working
2006
Low
AMGA Correlation with Overall Satisfaction
High
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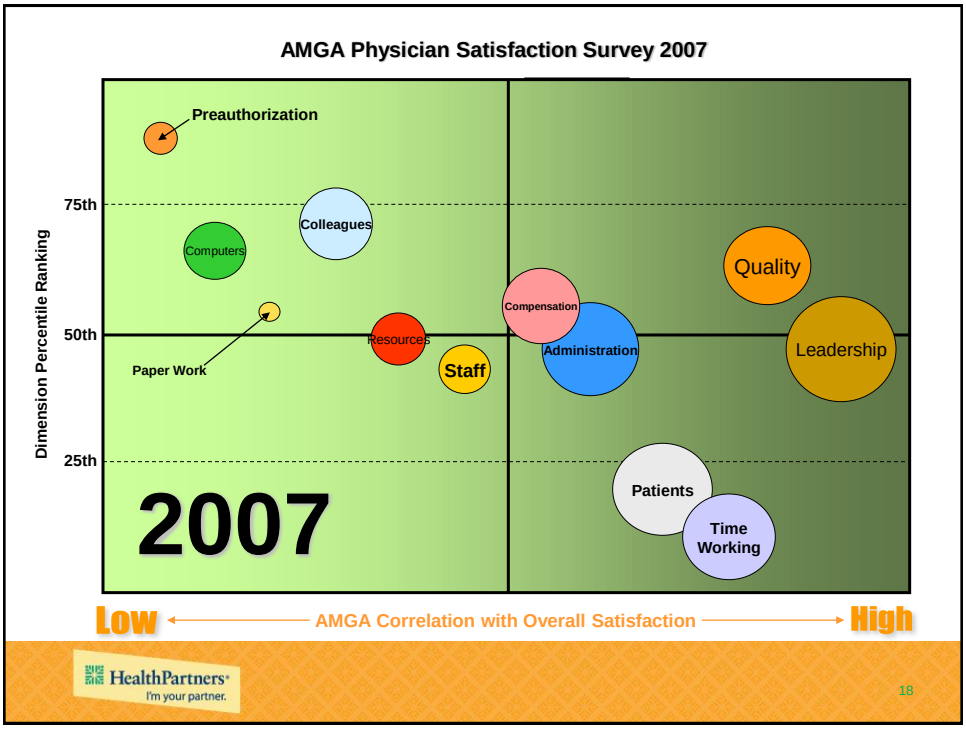
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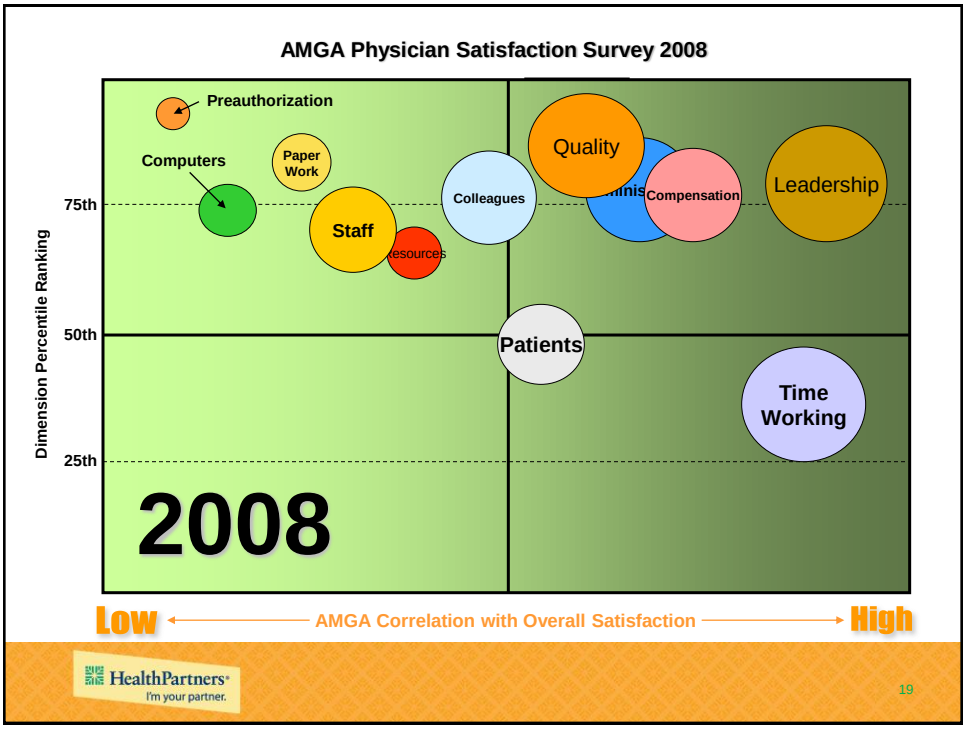
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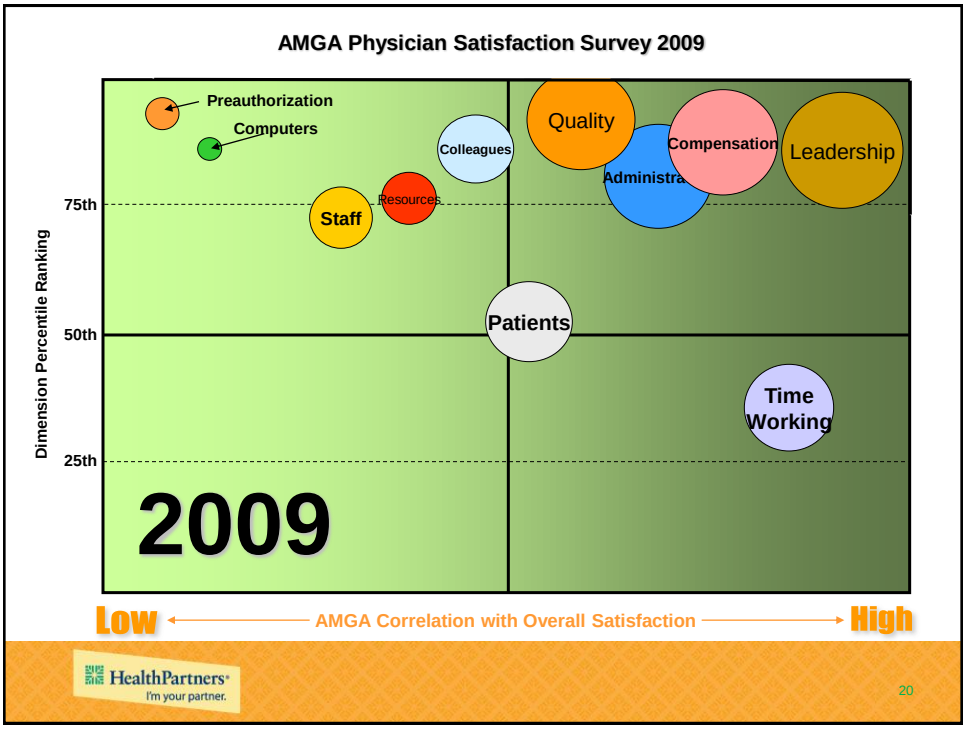
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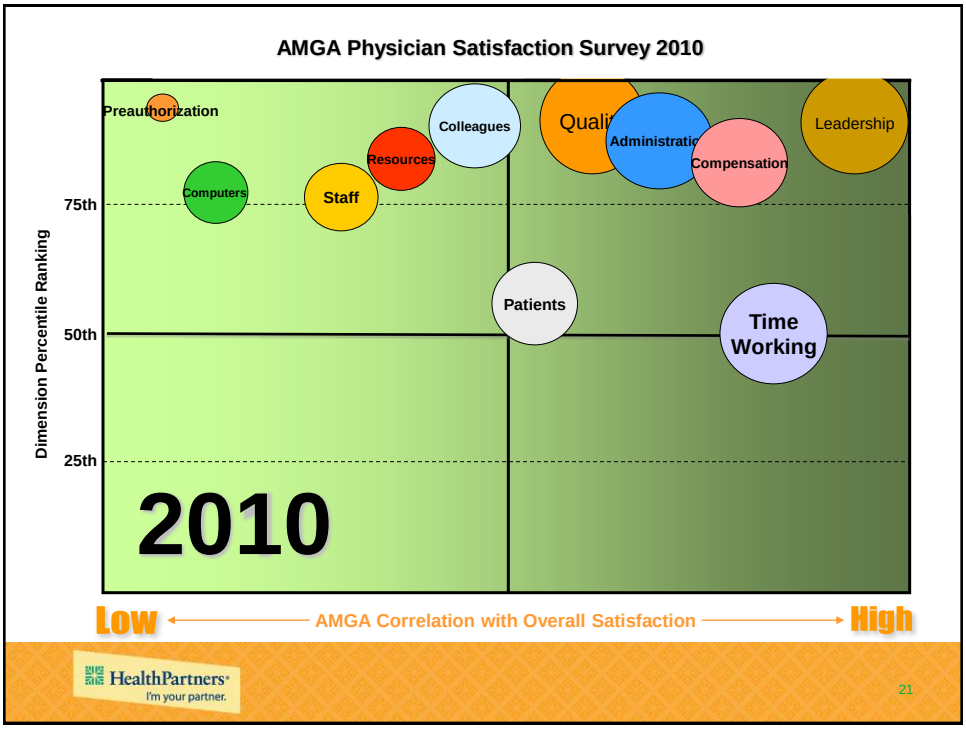
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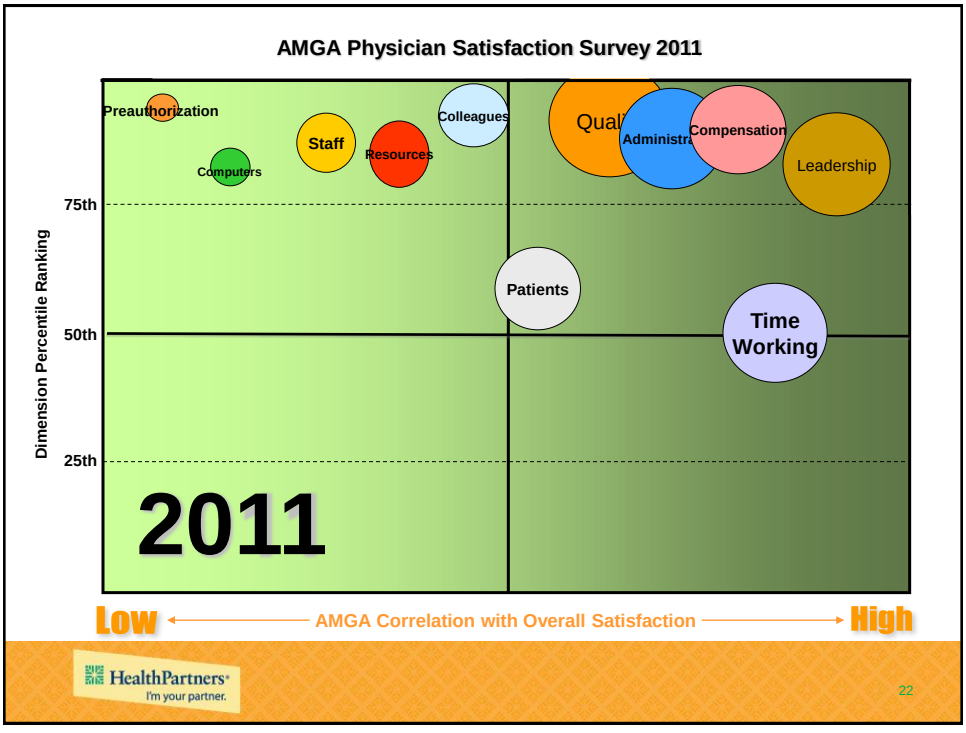
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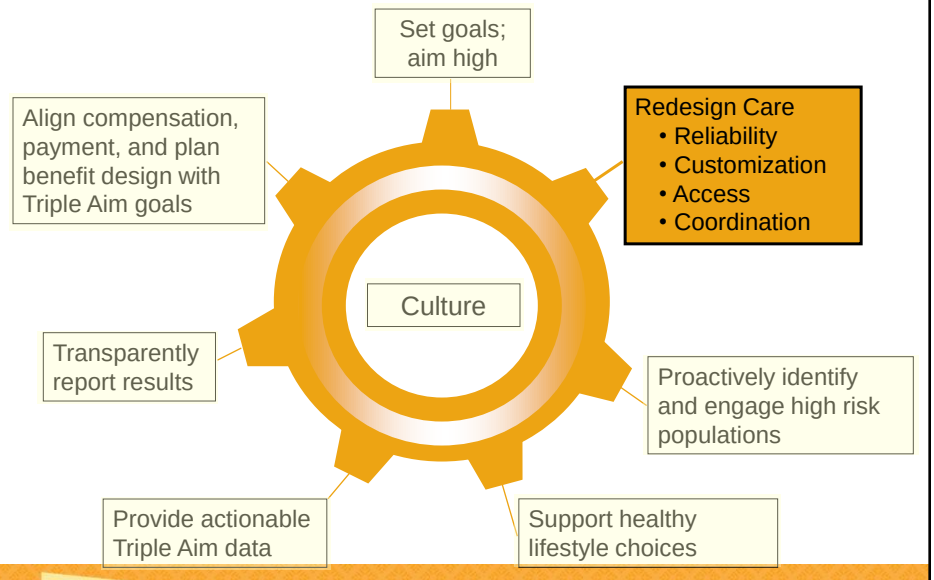
Triple Aim: Transformation Elements



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Care Design Principles

We use the following design principles to ensure our care achieves Triple Aim results.

Four Care Design Principles

Reliability	Customization	Access	Coordination
Reliable processes to systematically deliver the best care	*Care is customized to individual needs and values*	*Easy, convenient and affordable access to care and information*	*Coordinated care across sites, specialties, conditions and time*

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Four Care Design Principles

Reliability | Customization | Access | Coordination

- Throughout our system we develop consistent approaches to deliver reliable, standardized care focused on the patient :
  - Evidence-based
  - Decision support in electronic medical record
  - Processes are standardized; waste and rework eliminated through process redesign techniques
  - Every member of the care team contributes to their maximum potential; Defined roles and responsibilities
- Physicians, and other care team members lead improvement initiatives

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Primary Care Model Process

Scheduling	Pre Visit	Check-in	Visit	Post Visit	Between Visit

Clinical topics

- Depression
- Diabetes
- Preventive services
- Tobacco cessation
- Pediatric immunizations
- Child and teen check-up
- Pediatric asthma

Team Members

- Physician Led
- Registered Nurse
- Rooming Staff
- Clerical Staff
- Ad hoc: dieticians, pharmacists, diabetes educators

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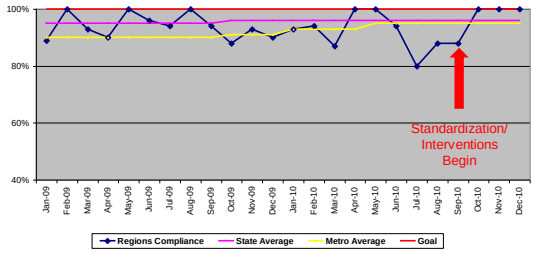
A Foundation of standardized care: Ventilator Associated Pneumonia Prevention Bundle Compliance



- Standardization / Interventions
  - Unit relocated October 2009
  - Mandatory re-education about Bundle
  - Pharmacist rounding with physicians
  - Manager rounding to verify Bundle is implemented

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Measuring reliable care for the seriously mentally ill

- Minnesota 10x10: A commitment to lengthen lifespan of people with serious mental illnesses by 10 years within 10 years
- Composite measure for Seriously Mentally Ill:
  - Body Mass Index less than 30
  - Non tobacco use
  - Cholesterol measure at target
  - Blood sugar measures at target
  - Primary care visit in past 12 months

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Measuring reliable care for the seriously mentally ill

- Measure Results:
  - January 2010 – 3.8%
  - March 2011 – 8.4% overall
  - March 2011 – 12.1% (for patients with visit to HealthPartners Medical Group primary care)
- Care Model Pilot with 4 psychiatrists has improved their rates by 3-4% in 5 months

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Four Care Design Principles

Reliability | **Customization** | Access | Coordination

- Care is customized to individual preferences and values
- One focus is reducing disparities

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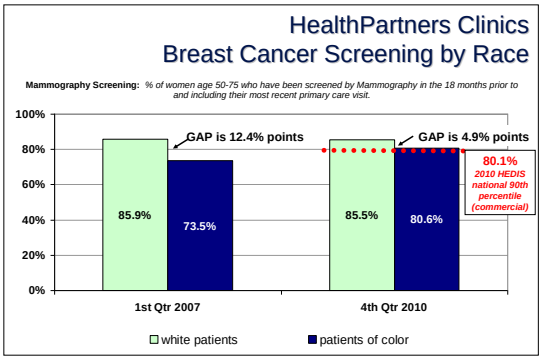
Reducing the Gap: Breast Cancer Screening

- Offer same day mammograms
- Reaches women who need extra encouragement
- Average 500/month
- Outreach calls by radiology



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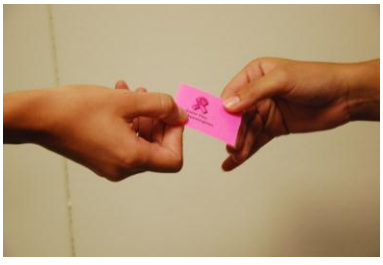
Breast Cancer Screening: *Interventions that have worked*

- Pilot: Offer walk-in mammography at time of visit
- Outreach calls then made to patients still due



The 'Pink Ticket' Program at Brooklyn Center

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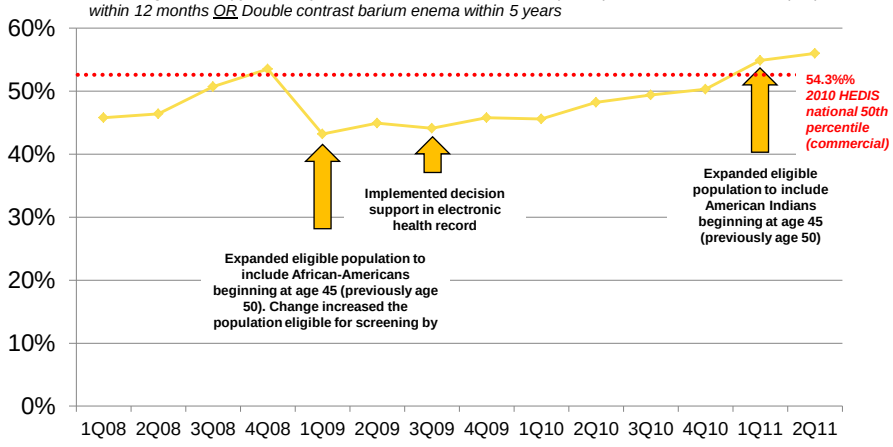
Colorectal Cancer Screening

Measure: The % of all Black or African-American (and Native American, starting 1Q11) patients ages 45-80 having an eligible primary care or OB-GYN office visit during the most recent quarter who are up-to-date with colorectal cancer screening, which includes the following: colonoscopy within 10 years OR flexible sigmoidoscopy within 5 years OR Fecal Occult Blood Test (FOBT) or Fecal Colorectal Test (FIT) within 12 months OR Double contrast barium enema within 5 years



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An Equitable Health Collaborative

The EBAN Experience™

Reduce Health Disparities

- Each team completes QI project
- Present data and results to collaborative at year-end
- Sponsors leverage recommended changes into large scale improvements
- Participants gain an increased awareness and understanding of the communities they serve
- Community advisors will affirm that their voices were heard and acted upon
- Improve health disparities, patient care and community health

Teams	Target Population
Increase Pediatric Immunizations	East African patients
Improve Diabetes Outcomes	Ethiopian patients
Increase Breast Cancer Screening Rates	Hmong and Somali patients
Reduce Readmission Rates	Patients of color and public program enrollees
Improve time to Pain Medication in the ED	Patients of color
Improve Colon Cancer Screening Rates	Patients of color and public program enrollees
Increase Number of Completed Advance Directives	African American patients
Increase Pediatric Preventative Dental Care	Public program enrollees

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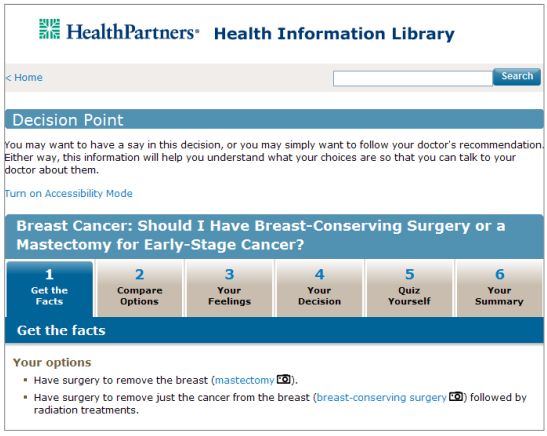
Customization: Shared Decision Making

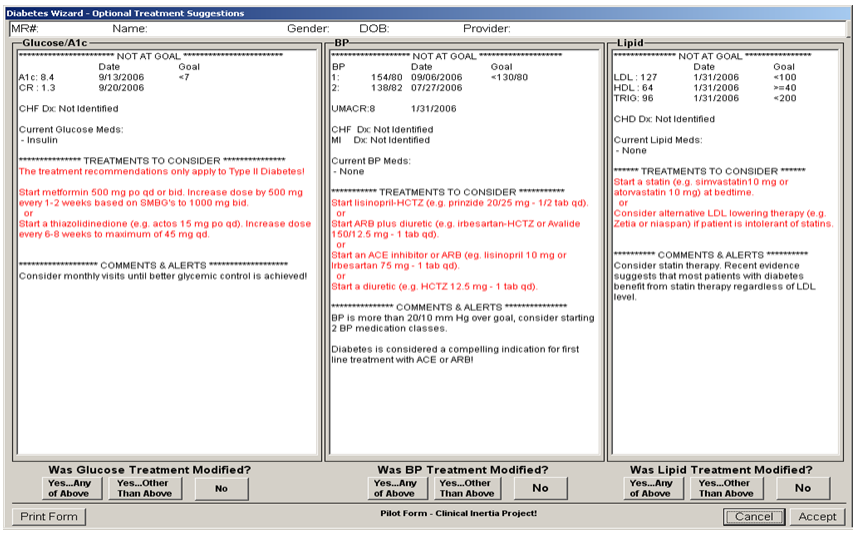


- Approaches used in our clinics, hospital, and in health and care management
  - Back pain
  - Early stage breast cancer
  - Prostate cancer treatment options
  - Vaginal birth after caesarean
  - Palliative care/end of life

The Diabetes Wizard standardizes and customizes care

- A tool in the electronic medical record that gives prompts and reminders to the care team
- Version 1 developed for diabetes to personalize goals and prioritize treatment options based on the evidence and patient preference
- Version 2 will address risk factors for cardiovascular disease: blood pressure, cholesterol, smoking, obesity, aspirin use and glucose
- Version 2 will prioritize the treatment options based on the degree of benefit to the patient

HealthPartners Wizard Provider Interface



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The Diabetes Wizard standardizes and customizes care

The Wizard was helpful because it pushed me to intensify medication regimens and I could show it to the patient to help support an increase in medications. Anita MacDonald, MD

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Four Care Design Principles

Reliability | Customization | **Access** | Coordination

- We design ways to make care and information
  - More convenient
  - Easy to access; and
  - Affordable

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Convenient Services and Patient Choice
Call, Click or Come In

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Appointments

- Primary Care
  - 30% same day availability
- Specialty Care
  - Goal is routine access in 2 weeks
  - Efficient systems in place to ensure urgent access
- Emergency Room access
  - Wait time decreased 36% at same time visits grew 14%
  - Patients who left without being seen is 1.5%
- Urgent Care and ER wait times posted online

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Online Services

- 34% of Patients enrolled
- Lab results automatically shared online with patients; most within 4 hours
  - Over 15 million results-to-date
  - Test results linked to patient friendly explanations
- Access medication list and immunization records
- Refill prescriptions and mail order pharmacy
- Online appointment scheduling (9% of all appointments)
- Online bill pay increased four fold in one year
- Secure email with doctor, nurse

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Virtuwell

Cough. *(We treat over 30 common conditions.)*

Click. *(Easy online interview. Diagnosis by a nurse practitioner in 30 minutes.)*

Cured. *(Get treatment and prescription if needed.)*

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virtuwell: at a glance

- Available around the clock – 24/7/365
- Custom Treatment Plan with prevention advice
- A simple $40 price, insurance accepted
- Money-back guarantee
- Free & easy triage
- Free 24/7/365 follow-up care
- Evidence-informed & physician-endorsed, backed by five decades of care delivery innovation
- Ability to connect with a nurse practitioner anytime

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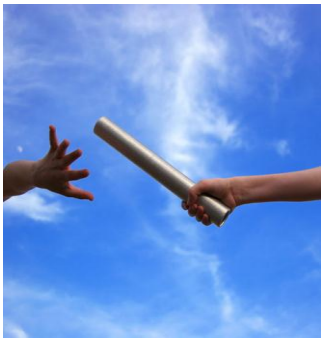
Four Care Design Principles

Reliability | Customization | Access | **Coordination**

- We coordinate care across sites, specialties, conditions and time



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Coordination Across Specialties: Lung Cancer Pathway

- Consistent, coordinated approach to providing evidence-based care
- Partnership between primary care, oncology, pulmonary and thoracic surgery
- Pathway is built into electronic record
  - One order for all lung nodules and cancers
  - Standardized treatment algorithms based on best evidence
  - Ability to measure outcomes
- Impact for patients
  - Builds trust when messages are consistent
  - Builds confidence when patient has one evidence-based care plan across all specialties
  - Increases satisfaction when care is coordinated by the same nurse

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Cancer Pathway-Patient Roadmap

	Where	What	When
Diagnostic Workup	Lab/Imaging at Specialty Center	•Blood tests •Diagnostic scan •Meet your specialist & discuss options (surgeon, pulmonologist)	Month 1
Treatment	Cancer Care Center	Planning and education visit with Oncologist & Nurse •Plan your treatment •Emotional Needs Assessment •Advanced Directives •Pain Assessment & Education •Shared Decision Making •Chemotherapy Intent Discussed	Months 2 – 6
	Regions Interventional Radiology Clinic	•Portacath placement (for chemotherapy)	
	Cancer Care Center	•Chemotherapy Education •Meet with Oncologist & Nurse – start chemotherapy	
Follow-up	Cancer Care Center	•Follow-up visit with Oncologist	6-9 months after last chemo
	Survivorship Clinic	•Get a comprehensive post-treatment plan that addresses medical, psychological, social and educational needs for cancer survivors	

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Care Coordination to reduce readmissions

- Reduce readmissions through collaboration of our hospital, clinics, care management and pharmacy services:
  - Identify high risk patients
  - Create care plans that reach across ambulatory, ED, ICU and inpatient
  - Schedule orders for follow up clinic appointment
  - Refer to home care and other resources
  - Simplify patient discharge instructions
  - Engage patients in “teach back” methods
  - Call patients post discharge

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Jane's Story

- 35 year old Female with a history of Diabetes type 1, borderline personality, narcotic abuse, severe anxiety
- 6 weeks prior to Care Plan
  - 14 Emergency Department visits/6 hospitalizations
- 6 weeks after Care Plan
  - 1 Emergency Department visit, 2 hospitalizations

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What Changed?
Plan of care developed with Jane

- No IV narcotics in Emergency Department, inpatient or outpatient, unless it is emergently necessary
- Will not refuse blood glucose monitoring or labs
- Will not refuse insulin or medications to optimally manage her diabetes

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What Changed?
Plan of care developed with Jane

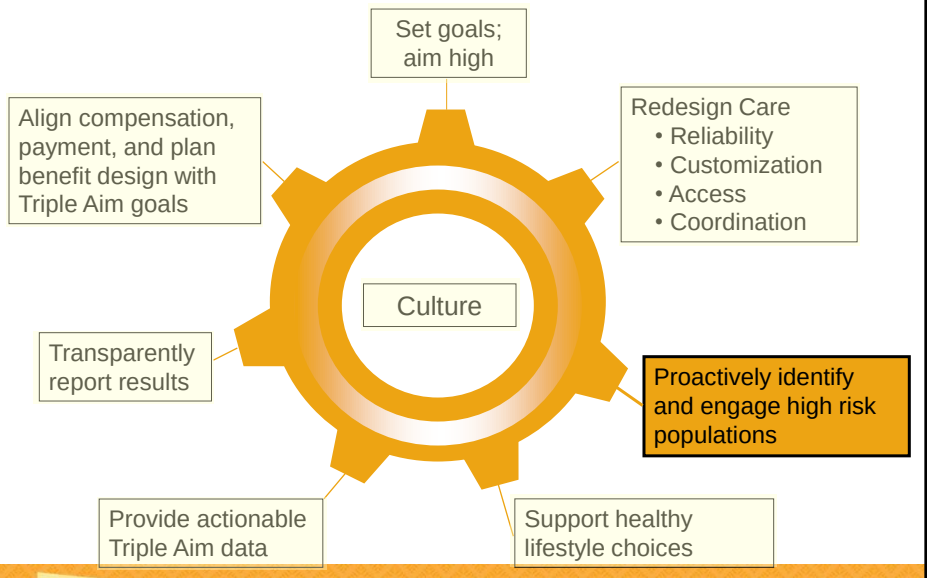
- Will not miss appointments with outpatient providers or education
- Outpatient appointments will be scheduled with primary care and Endocrinology
- The Emergency Room is not to be used for diabetes management or pain medication request
- Will use Careline before going to the Emergency Department

Jane's Story

Care Management note from ED last week:

She kept saying "I did it myself. I can't believe I did it myself. I am not taking my pain medications like I used to, isn't that great?" Last time I saw patient, hair was dirty, skin pale and she was depressed. Today patient is clean, hair also clean and shiny.

Triple Aim: Transformation Elements



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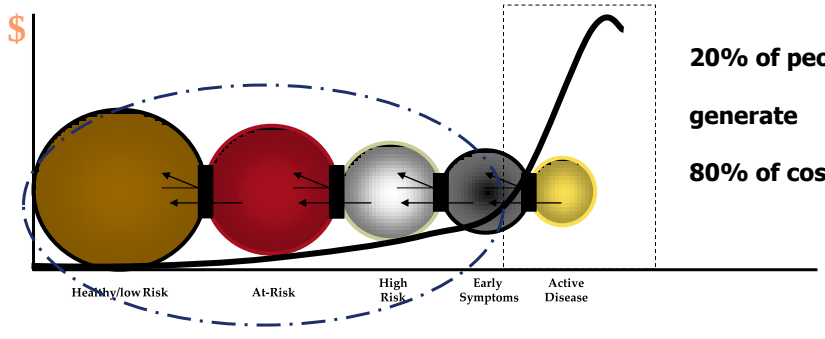
Proactively Identify and Engage High-Risk Populations



20% of people

generate

80% of costs

Claims Cost Distribution

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Case and Disease Management

- Using health plan and care delivery capabilities
- Identify patients at high risk
  - Leverage clinical and administrative data
  - Health risk assessment
  - Referrals from care team
- Engage patients to optimize health and prevent predictable complications
  - Both Case & Disease Management and care teams have a role
- Partnering with Allina, Essentia, Park Nicollet, etc. to coordinate with medical home/ACO development

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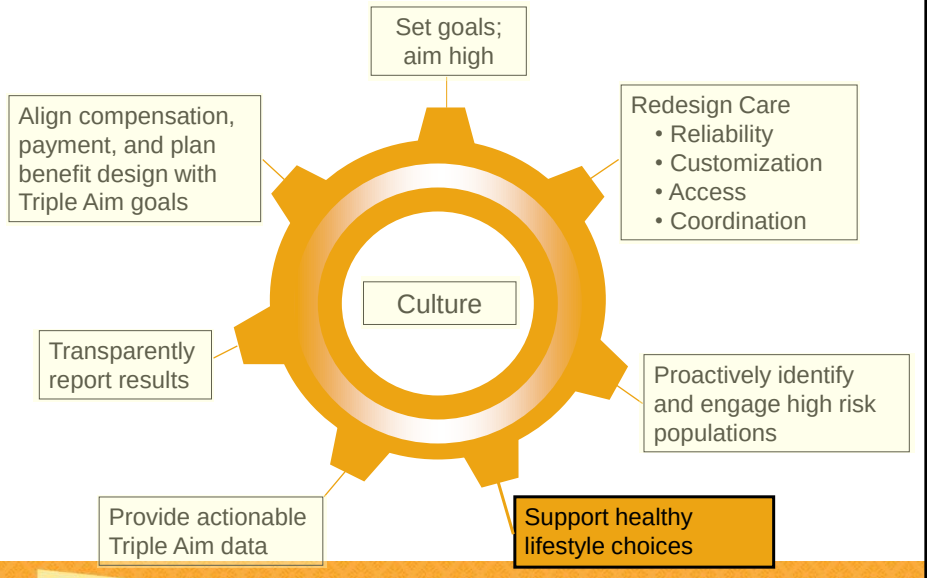
Triple Aim: Transformation Elements



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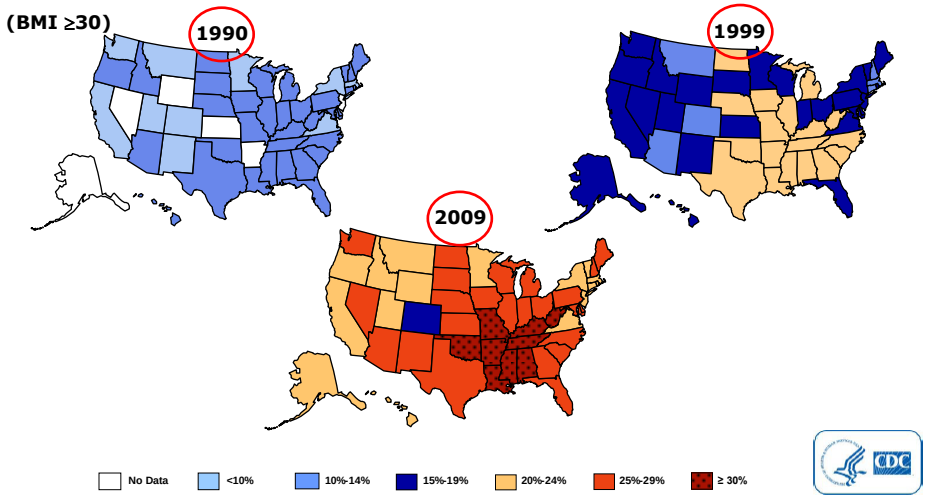
Focus on Health - Importance of Healthy Lifestyle: Obesity Trends Among U.S. Adults



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Source: Behavioral Risk Factor Surveillance System, CDC.

57

Healthy Behaviors that affect 25% of health care costs (and 14 more years of life!)

- **Being physically active**

- **Not smoking**

fruits & veggies more matters

- **Eating 5 fruits and vegetables each day**

- **Drinking alcohol in moderation**

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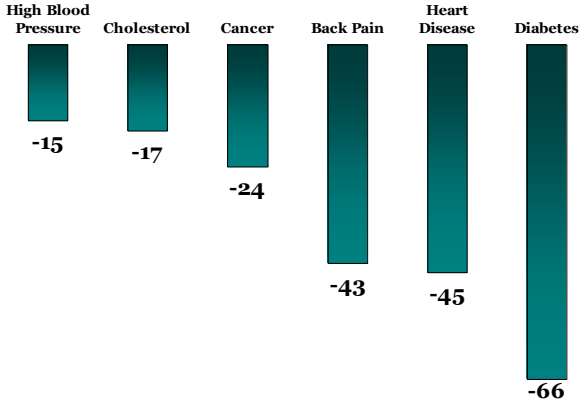
Healthy Lifestyle: Lower Incidence of Chronic Disease

Difference in 2-year incidence of new disease between people who adhere to 0 or 1 and 3 or 4 healthy behaviors (%)



Source: HealthPartners Health Assessment database, 2007

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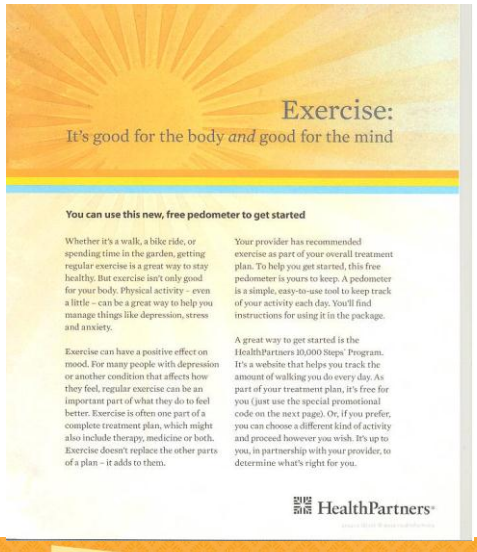
Pedometers for Patients with Depression



Exercise:
It's good for the body *and* good for the mind

You can use this new, free pedometer to get started

Whether it's a walk, a bike ride, or spending time in the garden, getting regular exercise is a great way to stay healthy. But exercise isn't only good for your body. Physical activity – even a little – can be a great way to help you manage things like depression, stress and anxiety.

Exercise can have a positive effect on mood. For many people with depression or another condition that affects how they feel, regular exercise can be an important part of what they do to feel better. Exercise is often one part of a complete treatment plan, which might also include therapy, medicine or both. Exercise doesn't replace the other parts of a plan – it adds to them.

Your provider has recommended exercise as part of your overall treatment plan. To help you get started, this free pedometer is yours to keep. A pedometer is a simple, easy-to-use tool to keep track of your activity each day. You'll find instructions for using it in the package.

A great way to get started is the HealthPartners 10,000 Steps® Program. It's a website that helps you track the amount of walking you do every day. As part of your treatment plan, it's free for you (just use the special promotional code on the next page). Or, if you prefer, you can choose a different kind of activity and proceed however you wish. It's up to you, in partnership with your provider, to determine what's right for you.

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- The After Visit Summary includes a "prescription" for a pedometer – filled at the pharmacy
- Brochure highlights the benefits of exercise, provides instructions for accessing the 10,000 steps program if desired and provides tools to track progress

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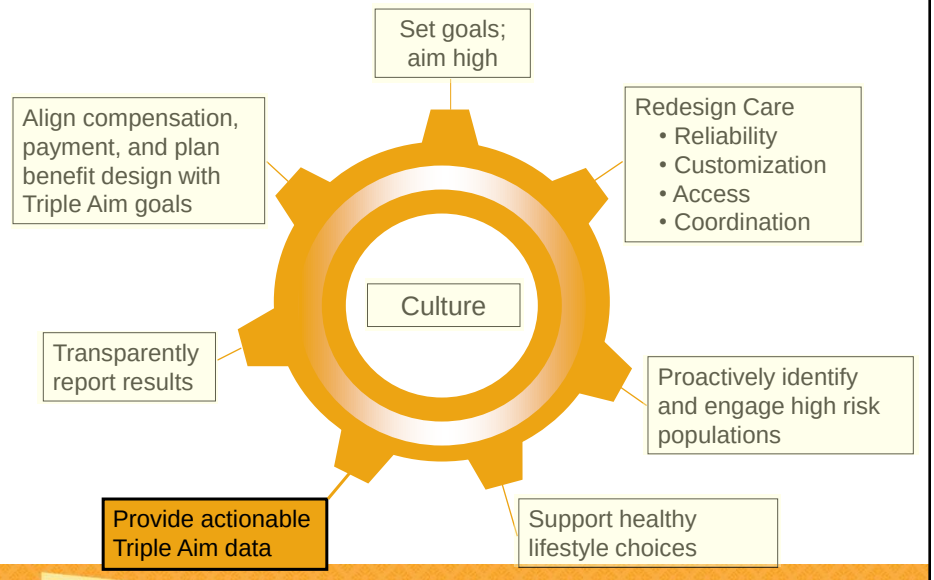
Triple Aim: Transformation Elements



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All health care systems in network use total cost, price and resource use data to drive care design changes

HealthPartners Clinics

Contracted Provider Partners

- Primary care redesign
- Care process redesign in specialties
- Use of cost effective hospitals and specialty providers
- Improved generic prescribing rates
- Standardized lab intervals
- Appropriate use of diagnostic imaging
- Shared decision making
- Evidence based back pain care
- Reducing readmissions
- Appropriate use of ER and in-patient care

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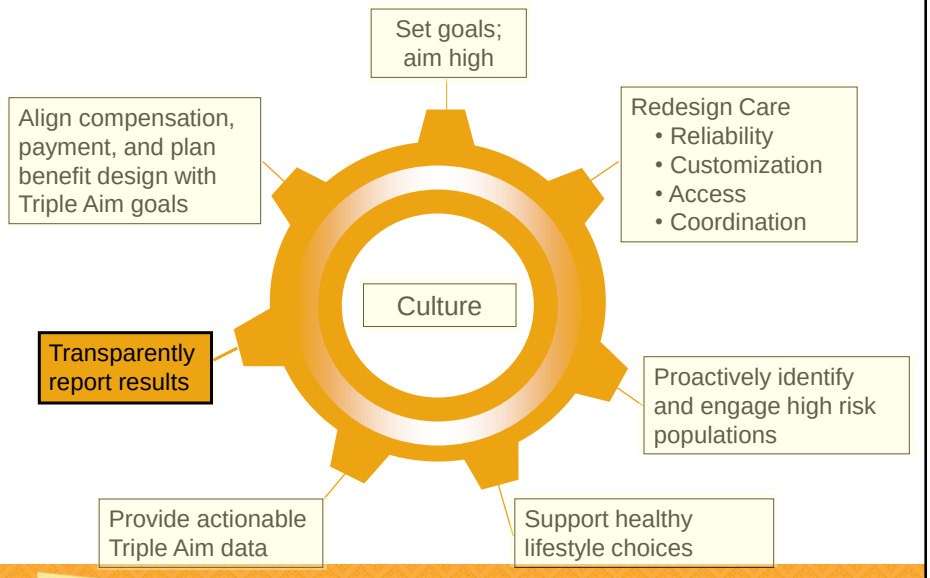
Triple Aim: Transformation Elements



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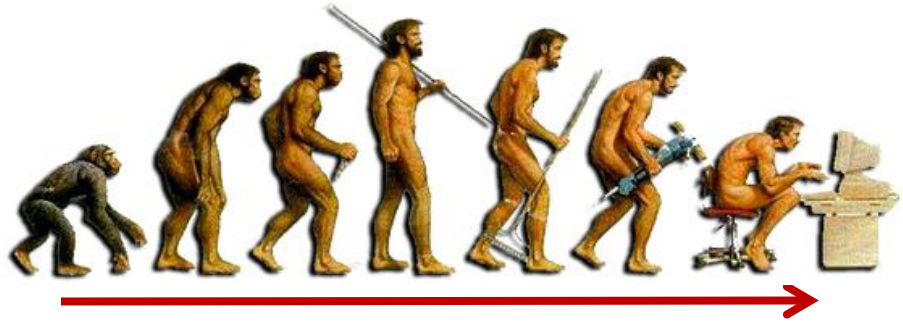
Our Transparency Journey



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Single Source Public Reporting

Table 22A: High Performing Medical Groups in 2010 - Primary Care

Medical Group	Asthma	Upper Respiratory Infection	Pharyngitis	Bronchitis	Optimal Diabetes	Optimal Vascular	Controlling High BP	Colorectal Cancer Screening	Breast Cancer Screening	Cervical Cancer Screening	Cancer Screening Combined	Chlamydia Screening	Childhood Immunization Status	COPD
HealthPartners Clinics 12 out of 14		●	●		●	●	●	●	●	●	●	●		
Park Nicollet Health Services 9 out of 14		●	●		●	●	●		●	●		●	●	●
Quello Clinic 9 out of 14					●	●	●	●	●	●	●	●	⊘	●
CentraCare Health System 8 out of 14	●	●			●	●		●	●	●	●			
HealthEast 8 out of 14		●	●		●	●	●	●			●		●	
Fairview Health Services 8 out of 14		●	●	●	●	●				●	●	●		

● = Medical group rate and CI fully above average
⊘ = Data size too small
Blank = Measure reported but rate was average or below average.

Source: MN Community Measurement – 2010 Health Care Quality Report

We sponsor and actively participate in statewide public reporting through MN Community Measurement

- Single source results used by plans and other stakeholders
- Robust processes to support multiple stakeholders using collaborative approaches to measurement innovation and design

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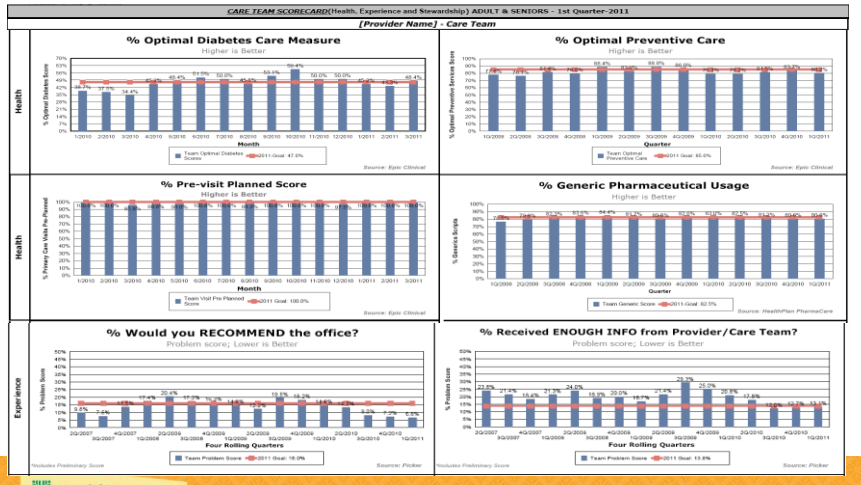
Care Team Results

Intentional Design of Internal Care Team Level Performance Reporting to Drive Improvement

HealthPartners Medical Group & Clinics



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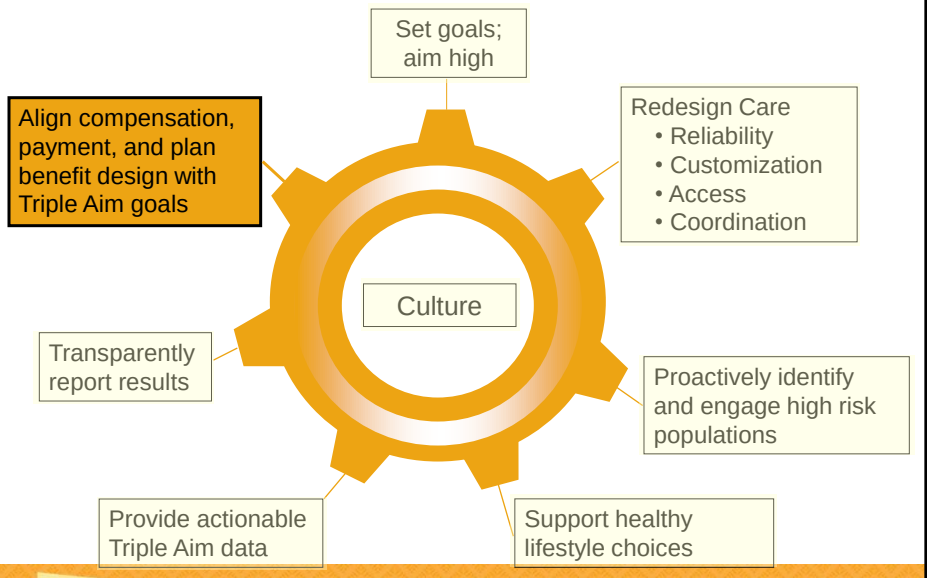
Triple Aim: Transformation Elements



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Paying for Value

1997
- **Partners in Excellence**
  - Financial incentives for better health, better care and lower costs.

2001
- **Partners in Progress**
  - Blends payment for better health, better care and lower costs into market-based reimbursement rates.

2009
- **Total cost of care payment approach introduced**
  - Focuses care systems on managing the overall cost of care while improving health and care

2011
- **2/3 of members receive care from a provider with a total cost of care agreement**

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Results

- In top 20 national in NCQA's Health Insurance Plan rankings for 2010/11
- Medical Home recognition for all clinics
  - NCQA Primary Care Medical Home highest level designation
  - State of MN Health Care Home certification in Primary Care and Infectious Disease
- Hospital: Leapfrog Group's Highest Value Hospital Award 2009/10
- Employee engagement 8% above high performer norm
- Physician satisfaction (AMGA survey)
  25th percentile → 82nd percentile
- Achieved margin target in each of last 9 years
- Plan administrative costs at 5.4%; clinic unit costs moderated (1.07% compound annual growth rate 2004-10)
- Growth
  - 20% increase in medical plan membership over three years; 15% in dental plan
  - Regions Hospital achieved top market share position in 2010
  - Clinic's active patients increased

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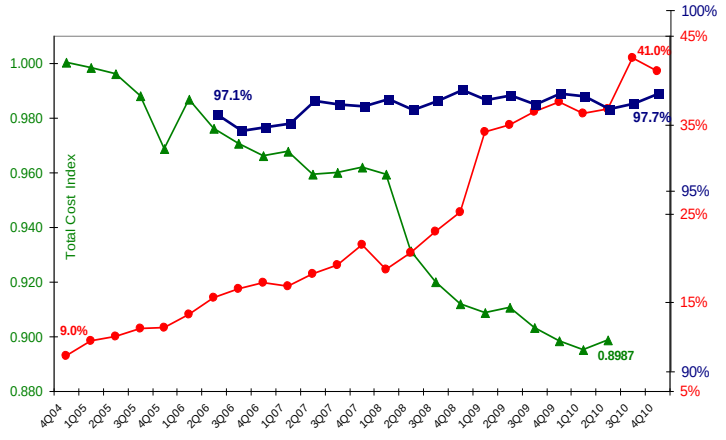
TRIPLE AIM: Health-Experience-Affordability HealthPartners Clinics



▲ **Total Cost Index**
(compared to statewide average)
< 1 is better than network average

● **% patients with Optimal Diabetes Control***
- *controlled blood sugar, BP and cholesterol (per ICSI guideline A1c changed from < 7 to < 8 in 1Q09 and BP control changed from <130/80 to <140/90 in 3Q10), AND daily aspirin use, AND non-tobacco user*

■ **% patients "Would Recommend" HealthPartners Clinics**

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HealthPartners Delivers Value

- Ingenix Consulting Findings
  - *"HealthPartners is delivering care to its members more efficiently than the health plans included in the benchmark database"*
  - HealthPartners risk adjusted TCOC
    - 17% lower than regional and MN costs
    - 8% lower than national costs

Don Berwick's ACO

- Will put patient and the family at the center
- Engage people in shared decisions
- Teamwork will be paramount
- Handoffs will matter
- Deliver on the Triple Aim
- Proactivity, innovation, investment, health information

Assets

- Integration of financing and care delivery
- Ahead on affordability focused culture/consumer centric value proposition
- Brand and differentiation – growth
- East region care delivery system strength
- Health outcomes, quality results
- Innovation
- Improving results on patient experience/top-notch performance in member services
- Informatics
- Pioneering initiative in northwest quadrant
- Workforce (employee engagement 8% better than high performer companies)
- Advanced work in care process redesign and care teams
- Solid financial performance over time

Vulnerabilities

- Revenue sources from government
- Minnesota loses as high performer
- Health plans in the bulls eye; single payor focus in Minnesota
- Not metro wide/west metro strategy
- Inner city geographic footprint
- Complacency while others are catching up
- Many stakeholders
- Many uses for capital/not such a big bank account or margins
- Margin at risk

Investigation of Health Care Cost Trends and Cost Drivers
Pursuant to G.L. c. 118G, § 6½(b)

Preliminary Report
January 29, 2010

Office of Attorney General Martha Coakley
One Ashburton Place • Boston, MA 02108

*www.mass.gov/Cago/docs/**healthcare/Investigation**_HCCT&CD.pdf*

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Attributes of Successful Common Pool Resources (CPRs)

1. Both the boundaries of the CPR and the people or organizations who have rights to withdraw from the CPR are clearly defined.
2. Appropriation rules (taking resources from the CPR) and provision rules (contributing to the maintenance of the CPR) are congruent with local conditions.
3. Most people affected by the operating rules of the CPR can participate in modifying the operating rules.
4. Monitors, who actively audit CPR conditions and behavior, are accountable to the appropriators (people who withdraw resources from the CPR) or are the appropriators.
5. Appropriators who violate operating rules are likely to be sanctioned.
6. Appropriators and their officials have rapid access to low-cost local arenas to resolve conflicts.
7. The rights of appropriators to devise their own institutions are not challenged by external governmental authorities.

Ostrom E. Governing the Commons: The Evolution of Institutions for Collective Action. New York: Cambridge University Press; 1990.

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Achieving Value in Health Care

- The stakeholders agree on a set of mutual, measurable goals for the health system
- The extent to which the goals are being achieved is reported to the public
- Resources are available to achieve the goals
- Stakeholder incentives, imperatives, and sanctions are aligned with the agreed-on health system goals
- Leaders among all stakeholders endorse and promote the agreed-on health system goals.

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Kottke TE, Pronk NP, Isham GJ. The simple health system rules that create value. Prev Chronic Dis 2012;9:110179

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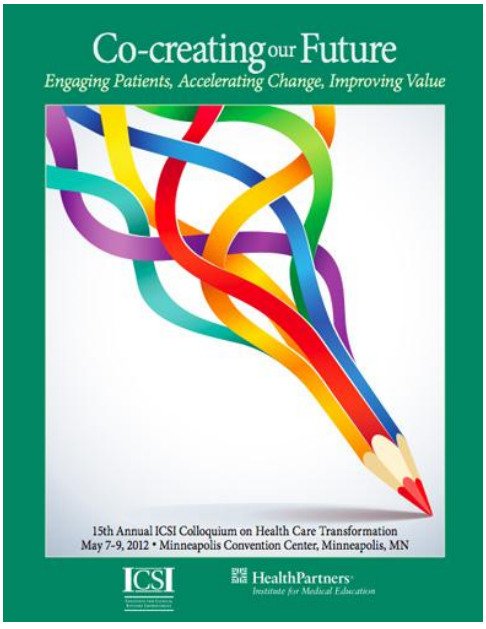

ICSI.org

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HealthPartners headquarters
Minneapolis, Minnesota

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Thank you

Thomas.e.kottke@healthpartners.com