RIVERWOOD HEALTHCARE CENTER

Connecting Community & Population Health Practices: Together we will be Naturally Better!

Heidi Olesen, MAEd, RN, PHN
Rachel Johnson, MBA

May 16, 2024

Overview

- Welcome & Introductions
- Riverwood Healthcare Center Overview
  - Patient Center Healthcare Home
- Patient Stories- This is why we are here!
- Riverwood Connects
- Discussion, Questions, and Wrap Up

Welcome & Introductions

Heidi Olesen, MAEd, RN, PHN
Clinic Manager

Rachel Johnson, MBA
Population Health
Program Manager

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Overview

Riverwood Healthcare Center (Riverwood) is a 25-bed Critical Access Hospital with primary care clinics and retail pharmacies in Aitkin, Garrison, and McGregor.

RHCC offers care close to home with services including:

- Specialty Care with more than 40 physicians, surgeons and clinicians;
- Surgery
- 24/7 Emergency Department with Level III Trauma Center Designation
- Neck, Back and Spine Care
- Comprehensive Cardiology, Oncology and Stroke Care Services
- Physical, Occupational and Speech Therapies
- Robust Diagnostic Imaging and Laboratory Services
- Behavioral Health

Mission, Vision and Values

OUR MISSION (Why we're here.)

To improve health by providing high quality, compassionate and personalized care.

OUR VISION (Where we're going.)

To be the region's preferred health system providing exceptional, high value care.

VALUES (How we act.)

Integrity
Compassion
Adaptability
Respect
Excellence

Population We Serve

- Population 16,102
- Aitkin County and portions of Crow Wing & Mille Lacs County
- Medically Underserved Area
- “Oldest” County in MN median age 55.5
- 34.1% of residents in Aitkin County are over 65 years
- 50%+ over 60 years of age – live in a township or unorganized area
- 13.5% Poverty Rate

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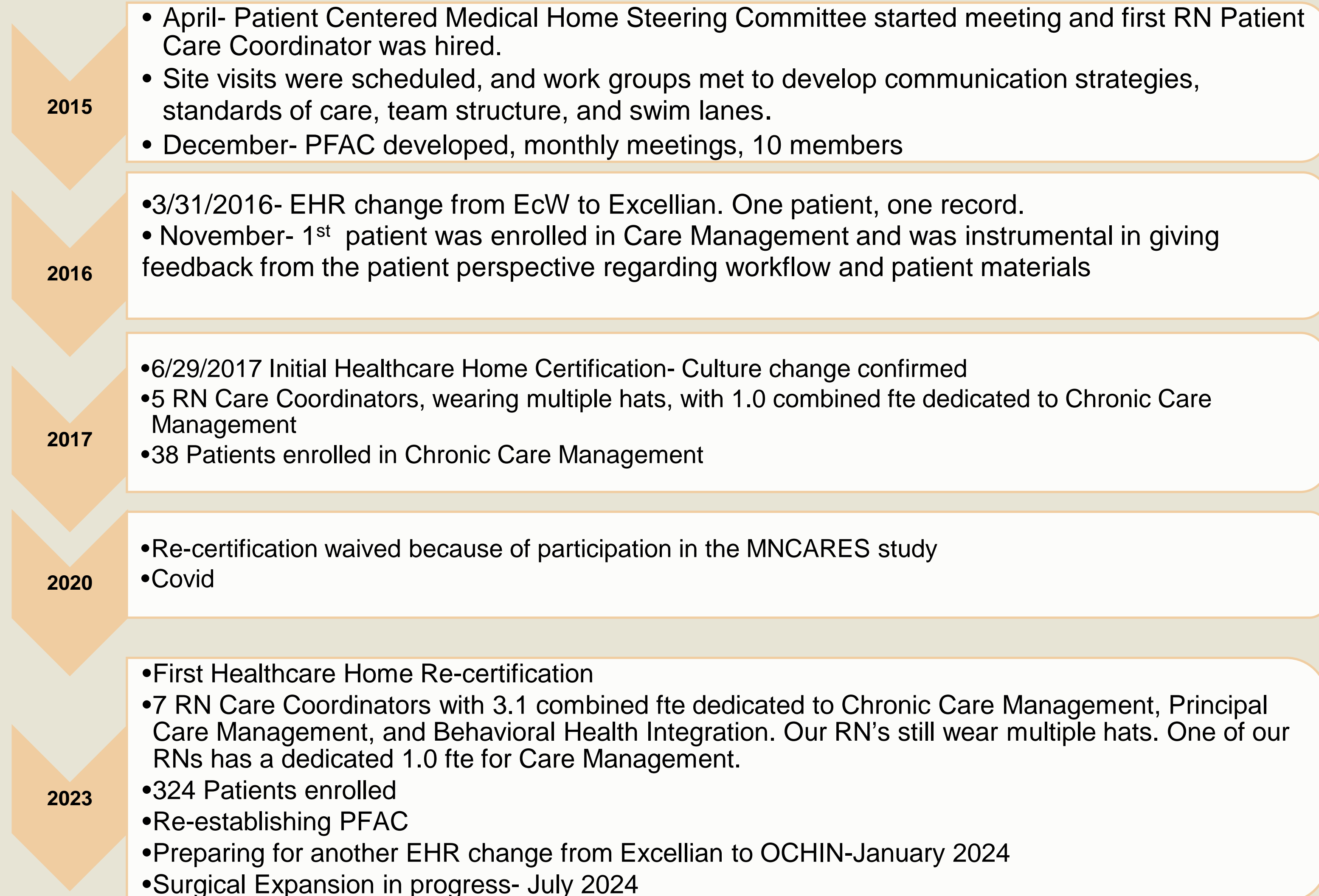
Patient Stories

Riverwood's Patient Centered Healthcare Home Journey

PCHH- Riverwood's Definition

- Patient Centered Healthcare Home (PCHH) is a coordinated team approach where everyone has a responsibility to deliver high quality patient centered health care with the goal of improving patient care and satisfaction both inside and outside of the clinic. –Defined by RHCC's PCHH Committee, 2015

We have come a long way…



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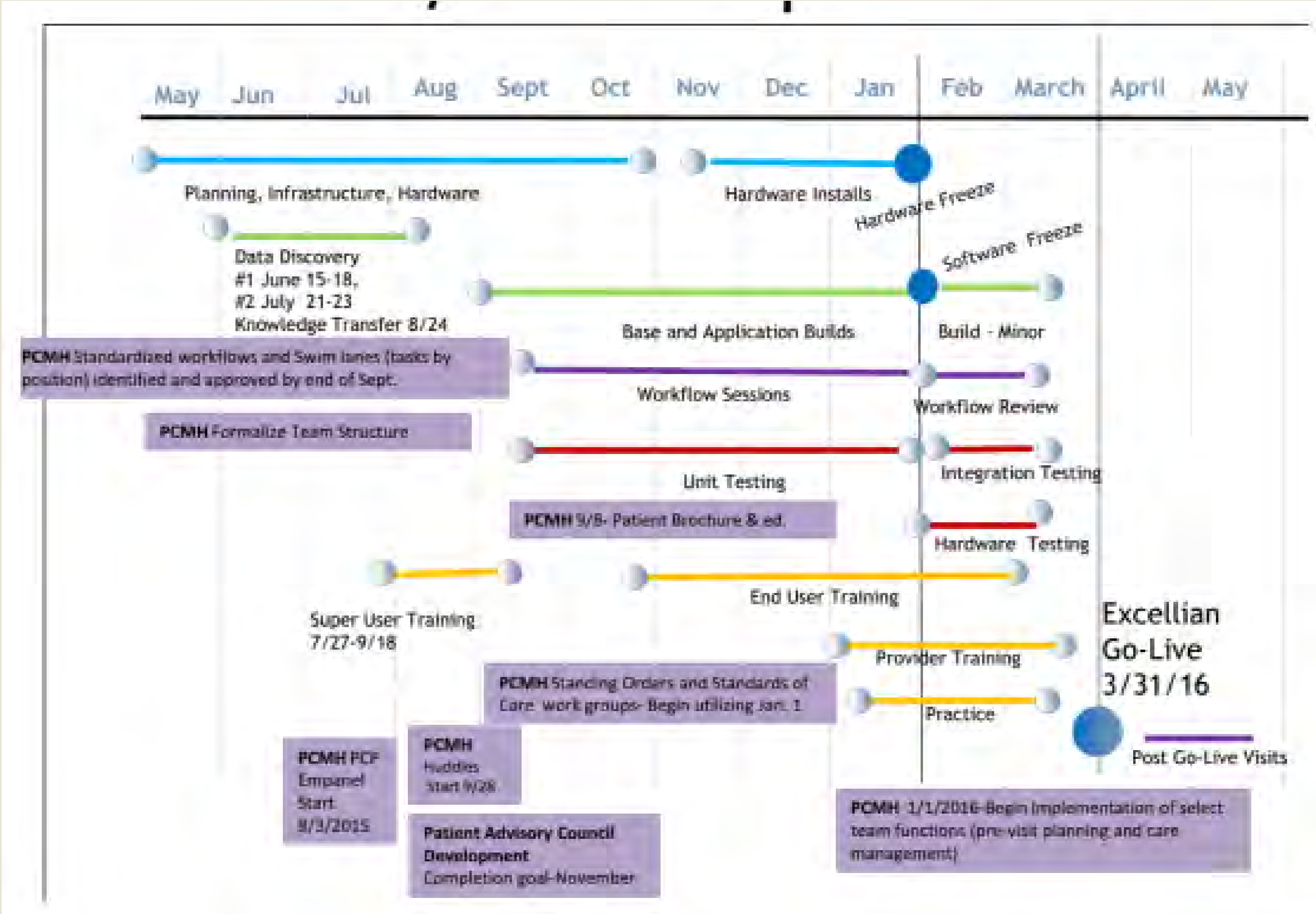
Foundational Work 2015-2016



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Access and Communication Standard

- Active outreach to patients of all ages past due for annual appointments
  - We know we can make the biggest difference for a patient when they are in the clinic where we can work to close health maintenance gaps and connect patients with resources.
  - Reports are available in our ERH and from our Medicare ACO, IHP, and 3rd party payors
- We work to provide a non-discriminatory environment
  - Provide staff support and assistive devices to help patients navigate within the building
  - Utilize interpretive and translation devices as needed to enhance communication
  - Provide care coordination and care management services to connect patient with the resources and support they need to meet their goals
- All patients have access
  - Triage telephone line and symptom checker app available. Specialized patient populations (OB, Post-op, and Care Managed) have access to staff that can view their medical record and plan of care 24 hours a day, 7 days a week.
- Patient engagement
  - Feedback from patients in the form of healthcare safety events, PFAC, and Patient Satisfaction Surveys are reviewed, and improvements are made as appropriate

Participant Registry and Tracking

- Patient Care is monitored, tracked and managed through searchable electronic registries
- Monthly dashboard reports are prepared to reflect organizational goals compared to current state
  - Emailed to staff, presented at PI Committee and provider meetings, and posted on the employee portal
- Utilization claims are available for review and action from our organizations Medicare ACO, IHP, UHC, Humana, and Cologuard.
- Previsit planning and planning forward
  - The processes of planning ahead to ensure the patient's future visits are as meaningful and productive as possible while ensuring that the patient and care team understands what is going to happen at future visits.
  - Previsit planning is driven by a Standards of Care Protocol in addition to best practice alerts in the EHR.

Performance Improvement Metrics

Performance Improvement Metrics: June 2023

Key Performance Indicators (KPIs)		Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
QUALITY	Diabetes Optimal Control	43.0%	47.2%	46.1%	46.3%	48.7%	50.6%	50.8%	50.4%	50.3%	51.8%	49.9%	49.3%	50.1%	50.8%	
	Colon Health Optimal Control	72.0%	79.0%	79.1%	79.2%	79.0%	79.3%	79.4%	79.2%	79.6%	79.8%	80.1%	80.0%	80.3%	80.4%	
	Hypertension Optimal Control	75.0%	73.9%	74.1%	74.5%	73.8%	74.2%	73.4%	73.7%	72.9%	73.1%	73.2%	74.0%	73.9%	74.3%	
	Vascular Optimal Control	56.0%	48.3%	49.4%	50.3%	49.1%	49.5%	47.8%	49.5%	48.4%	49.2%	48.7%	49.7%	48.9%	49.6%	
	Press Ganey - Pt Satisfaction (PrimaryCare)	>85th (%)	84	86	84	86	97	97	97	95	95	94	92	96		
	Press Ganey - Pt Satisfaction (SameDayClinic)	>85th (%)	71	59	59	53	48	42	71	65	80	82	83	76		
GROWTH / STEWARDSHIP	**SAME DAY CLINIC**															
	TOTAL VISITS	>350	433	506	496	349	368	322	300	218	202	212	250	398	386	
	AITKIN PRIMARY CARE															
	TOTAL VISITS	>1440	1447	1163	1382	1461	1531	1540	1428	1558	1404	1610	1335	1559	1425	
	AVAILABLE HOURS	>750	789	624	738	809	869	907	838	935	876	972	800	860	747	
	VISITS PER HOUR	>1.8	1.8	1.9	1.9	1.8	1.8	1.7	1.7	1.7	1.6	1.7	1.7	1.8	1.9	
	FILL RATE %	>95%	96.4%	100.9%	97.1%	93.2%	90.5%	88.8%	86.2%	84.4%	83.8%	83.9%	87.5%	94.0%	98.1%	
	NO SHOW %	<8%	4.7%	7.3%	6.2%	6.5%	5.4%	5.3%	5.0%	5.5%	5.9%	5.0%	5.9%	5.1%	4.9%	
	3rd NEXT AVAILABLE APPT	<3	5.8	9.0	6.3	9.4	7.9	4.2	3.7	3.3	3.1	4.8	3.0	3.7	5.4	
	AVERAGE VISIT LENGTH	<30	30.0	30.3	29.3	29.0	29.2	29.8	28.7	28.9	29.6	29.0	29.6	29.6	29.4	
	GARRISON PRIMARY CARE															
	TOTAL VISITS	>270	256	210	265	224	201	216	167	172	176	193	188	224	241	
	AVAILABLE HOURS	>150	151	136	157	143	144	164	150	155	156	178	153	150	151	
	VISITS PER HOUR	>1.8	1.7	1.5	1.7	1.6	1.4	1.3	1.1	1.1	1.1	1.1	1.2	1.5	1.6	
	FILL RATE %	>95%	89.5%	82.4%	92.2%	85.6%	76.7%	70.0%	60.0%	61.5%	62.1%	57.8%	66.6%	81.6%	86.3%	
	NO SHOW %	<8%	3.0%	3.7%	4.0%	3.4%	4.3%	1.4%	4.6%	8.5%	6.4%	3.4%	6.5%	3.4%	4.0%	
	3rd NEXT AVAILABLE APPT	<3	5.0	6.0	8.1	2.8	3.5	2.3	0.0	1.3	4.7	2.3	1.4	2.4	1.5	
	AVERAGE VISIT LENGTH	<30	30.9	31.0	31.6	31.6	31.6	31.4	30.9	30.6	30.8	30.5	30.3	31.5	31.2	
	MCGREGOR PRIMARY CARE															
	TOTAL VISITS	>900	916	864	1005	926	964	959	846	843	728	904	712	901	880	
	AVAILABLE HOURS	>450	459	453	486	490	490	519	453	469	441	490	363	429	434	
	VISITS PER HOUR	>1.8	2.0	1.9	2.1	1.9	2.0	1.8	1.9	1.8	1.7	1.8	2.0	2.1	2.0	
	FILL RATE %	>95%	93.1%	92.4%	94.5%	90.3%	92.4%	88.9%	86.4%	84.7%	77.2%	85.3%	84.4%	96.1%	88.2%	
	NO SHOW %	<8%	6.4%	9.0%	8.0%	8.4%	7.3%	8.1%	7.8%	8.8%	10.0%	8.4%	6.9%	10.4%	9.2%	
	3rd NEXT AVAILABLE APPT	<3	2.7	4.0	3.0	2.1	2.4	2.3	3.1	3.2	4.3	9.7	3.2	5.3	4.2	
	AVERAGE VISIT LENGTH	<30	26.3	26.6	25.3	26.3	26.3	26.7	25.6	25.8	25.3	25.5	24.2	24.7	24.4	

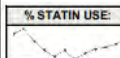
Definitions

AVAILABLE HOURS	Represents "true" Provider Available Hours within schedule template. Amount of time available to schedule appointments. Excludes blocked template time (meetings, PTO, Admin, etc.)
VISITS PER HOUR	Arrived Visits/Available Hours
Fill Rate %	% of Available Hours filled with Scheduled Appointments
No Show %	% of Scheduled Appointments with No Show Status. Excludes same day cancelations.
3rd Next Available	# of days between date of appointment request and 3rd next available appointment slot. Indicator used to monitor supply and demand.
AV VISIT LENGTH	Average Arrived Visit length (minutes)
	Above Target
	Approaching Target
	Below Target

Diabetes (MNCM)

This report returns patients that have an active diabetes diagnosis on their problem list or on a contact within the specified date range. Patients must also have had an eligible visit with an eligible provider during the date range. The report shows the percentage of patients in optimal control of diabetes.Patients are in optimal control if all of the following conditions are met: •Most recent blood pressure is less than 140/90 in the last year •Currently not a tobacco user •Most recent A1c value is less than 8 in the last year • For vascular disease patients, ASA or anticoagulant used in the past year (or contraindication) • Statin used in the past year (or contraindication). Age Guidelines: 18-75

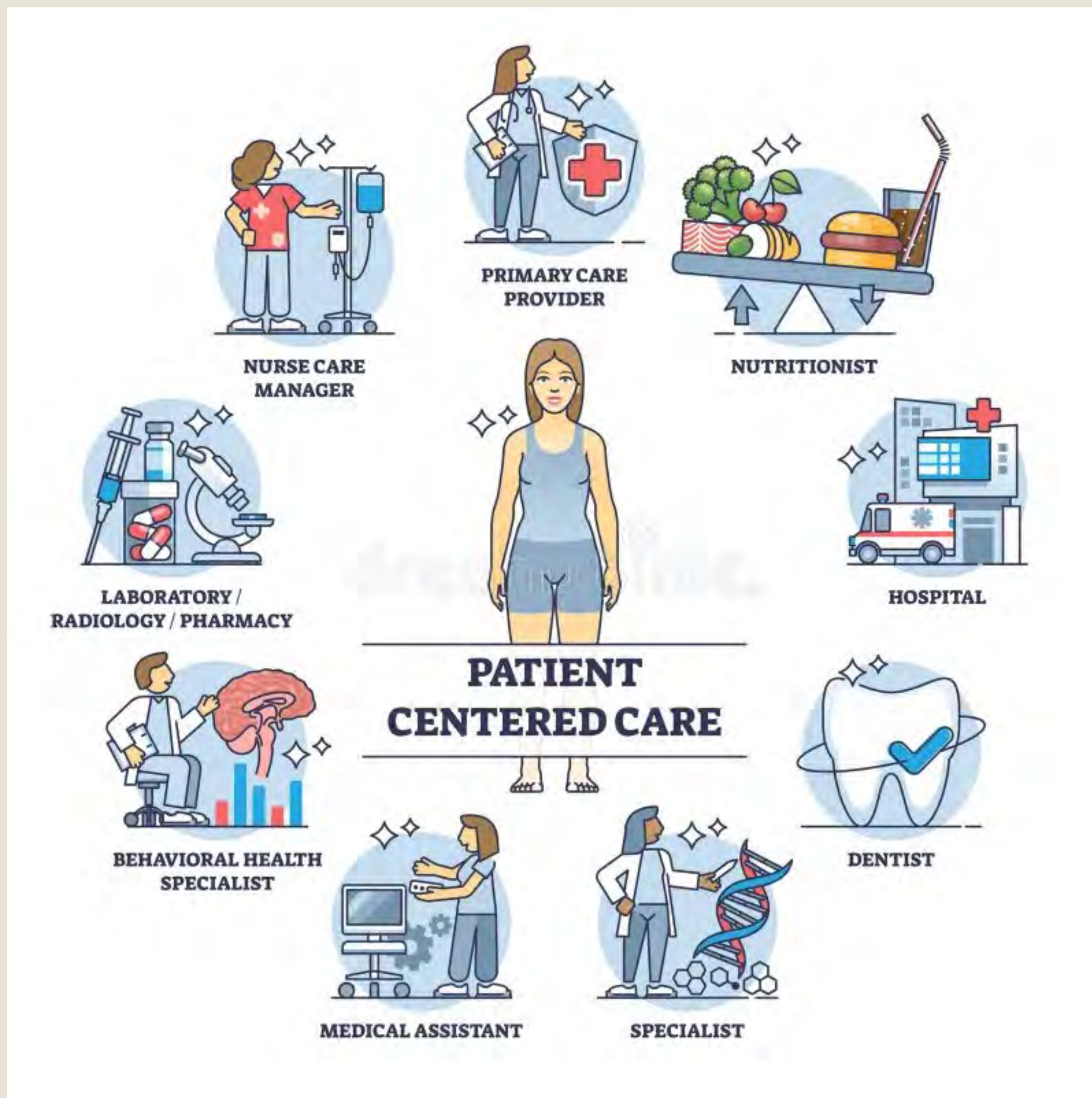
DATE RANGE: LAST FULL MONTH		6/1/2023								
Provider	Patients (Last Mth)	Patients	Statin %	% BP <140/90	% A1c <8	Tobacco Free	% ASA	% Eye Exam	% Optimal Control	% Optimal Control Trend
HUGHES, DONALD B - D26422	77	76	93.4%	84.2%	90.8%	84.2%	100.0%	56.6%	63.2%	
NYBERG, FAITH M - D41499	18	18	77.8%	94.4%	83.3%	77.8%	100.0%	38.9%	61.1%	
BOSTROM, ERIK R - D73425	37	38	100.0%	86.8%	89.5%	89.5%	100.0%	36.8%	60.5%	
ARNOLD, TIMOTHY J - D91179	62	62	96.8%	87.1%	80.6%	82.3%	100.0%	51.6%	59.7%	
TRUEBLOOD, JANELLE A - D8743	44	41	90.2%	87.8%	95.1%	75.6%	100.0%	36.6%	58.5%	
LAWSON, THOMAS J - D43155	49	48	91.7%	83.3%	75.0%	95.8%	100.0%	54.2%	56.3%	



Performance Improvement Metrics

- Performance Improvement Metrics
  - Fiscal Year 2022-2023
    - June 2023
    - April 2023
    - March 2023
    - February 2023
    - January 2022
    - December 2022
    - November 2022
    - October 2022
  - Fiscal Year 2021-2022

Patient Focus



Patient centered care makes me feel:

- Like it's all about me
- Like my Care Team cares. They know me and are all on the same page
- I have meaningful and timely appointments
- I am listened to and respected
- My preferences, needs, and values are important
- I have access to my team when I have a question or need
- Connected with resources
- Empowered to self manage my health
- I have added layers of support when I need them

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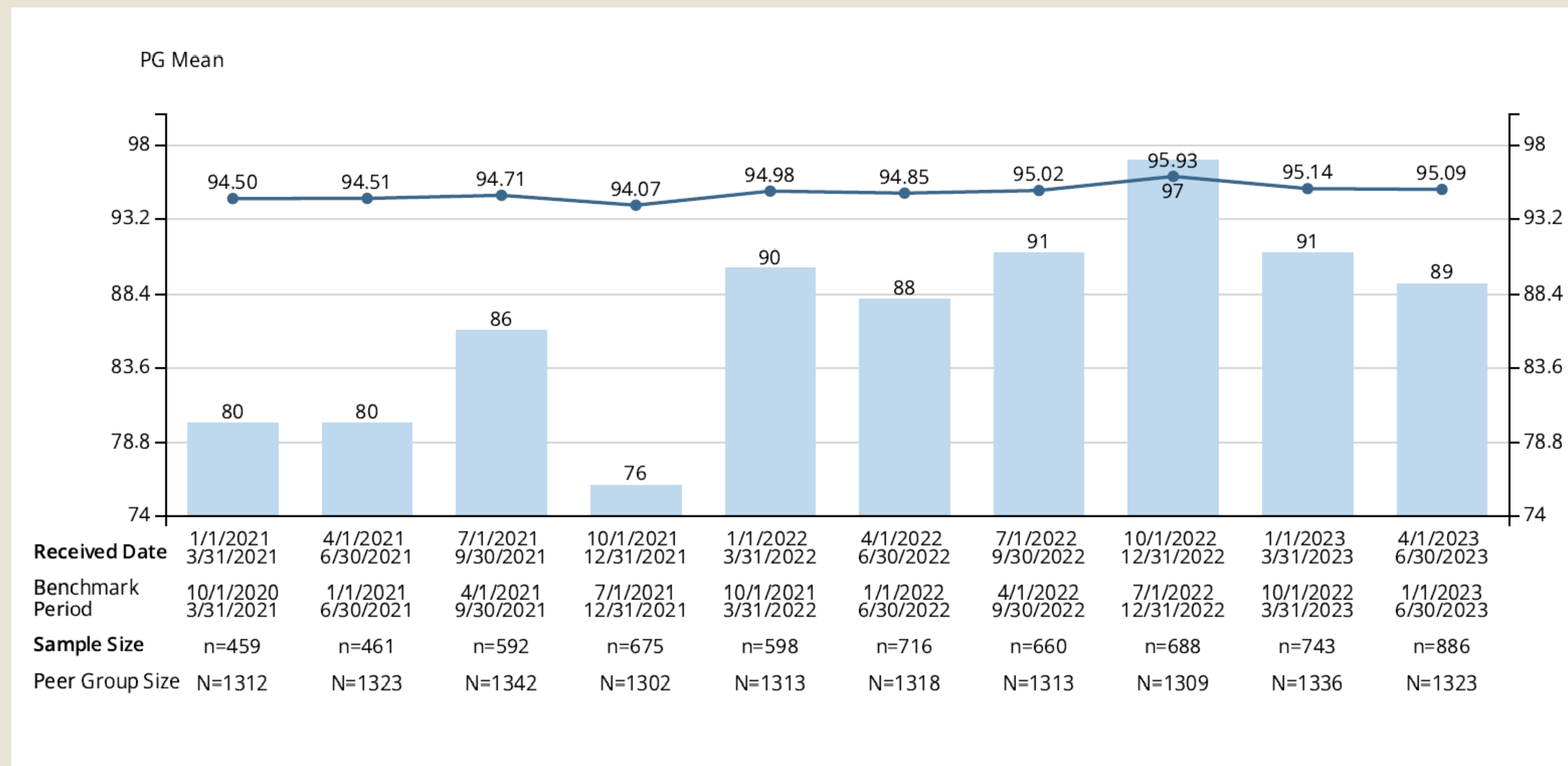
Patient Experience

- Data collected across 7 domains (Access, moving through your visit, nurse/assistant, care provider, personal issues, telemedicine technology, and overall assessment)
- Currently ranked at the 89th percentile overall compared to other facilities in Press Ganey's database



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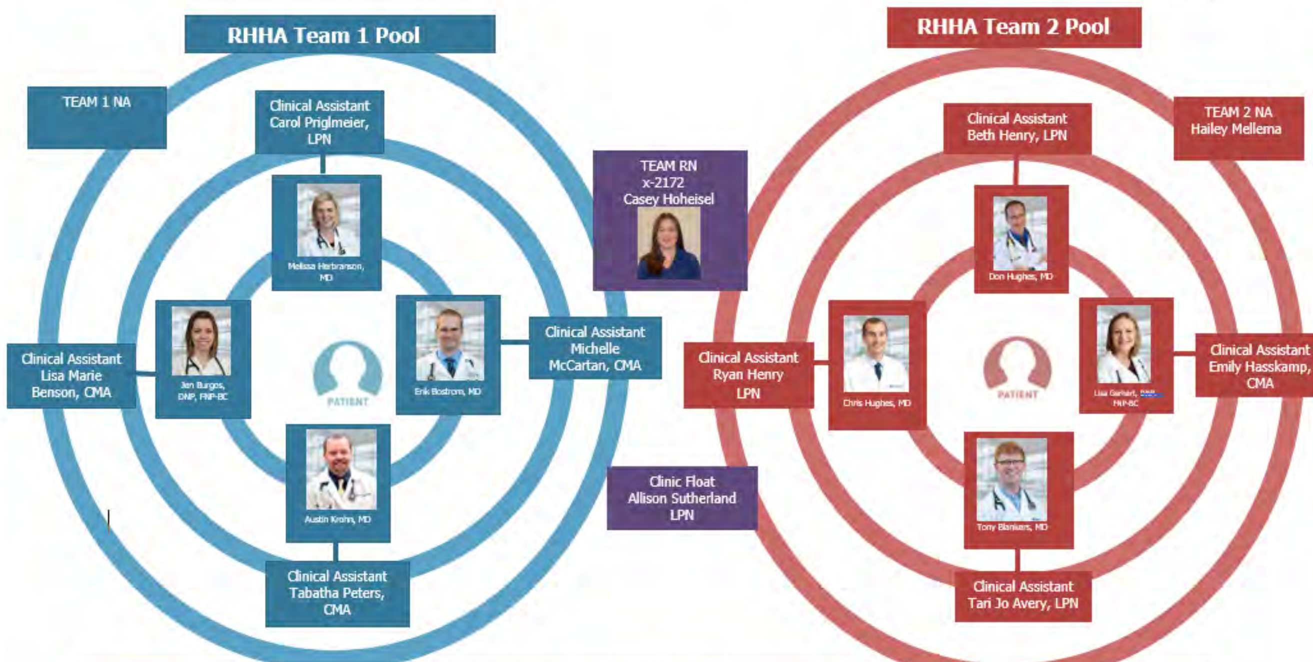
Care Coordination Standard

Aitkin Primary Care Healthcare Home Coverage Teams-6/26/23



Additional Resources

TEAM RN
Boots on the ground go to person for primary care teams. Conducts daily huddles and first line of contact for problem solving. Manages RN schedule of patients. Provides short term care coordination, ACP, notary, med refill, triage calls, and critical results notification.

CARE MANAGER/COORDINATOR
Part of the patient care team promoting patient-centered care. Assist patients and their support systems in managing medical conditions more effectively through motivational interviewing, goal setting, care planning and resource connection. Referral based on diagnosis and risk.

Care Manager

Lynn Christensen RN

Care Manager

Marcy Mateyka RN

- Collaboration within the care team through huddles and communication throughout the day. Each staff member plays their part to get the work done and meet the needs of the patients.
- Collaboration between clinic and hospital through bedside rounding, after hours care, and transitional care management
- Referrals are made to outside agencies and healthcare providers
- Community partnerships ensure collective efforts working toward similar goals
- Readmission meetings held quarterly with quality, clinic, ED, and HNS with the goal to improve care transitions that reduce readmission, adverse events, and unnecessary ED utilization
- Staff meetings held routinely to knowledge share, collaborate, and update.

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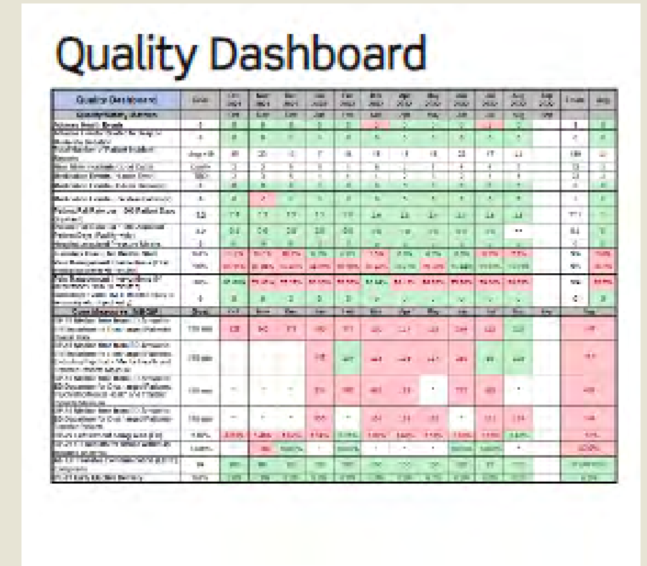
Transitions of Care

- Multidisciplinary Readmission Review meeting that meets monthly
  - Participants: Care Coordinators, Case Manager (Inpatient), Hospital Nurse Manager, Social Worker, Quality, Surgery Leadership, Pharmacy, and Therapy Services
  - Focus Areas:
    - Completed Minnesota Hospital Association Transitions of Care Roadmap- 93% Score
    - Development of Transition of Care Management (TCM) Phone Call Process – **Currently a Lean Project**
    - Decrease inpatient all-cause 30-day readmissions to less than 10%- Currently at 10.8% in Qtr 3

Performance Reporting/ QI Standard

- Performance Improvement committee meets every two months
  - Agenda: Patient story, patient experience, CPI projects, patient safety and quality, reportable quality measures, current department reports, goal review
    - Community board/patient representation
    - Minutes shared with the community governing board



- Star ratings, patient experience recognition, joint commission accreditation and other awards are displayed on website, social media, and waiting rooms

- Active community collaboration through Aitkin County SHIP, Healthy Northland Region 5, Mental Health Coalition, CAPS-Committee for Awareness and Prevention of Suicide, Community Planning and Care Coordination Project, and Riverwood Community Health Committee

- Facility Quality Dashboard posted on home page of the employee portal

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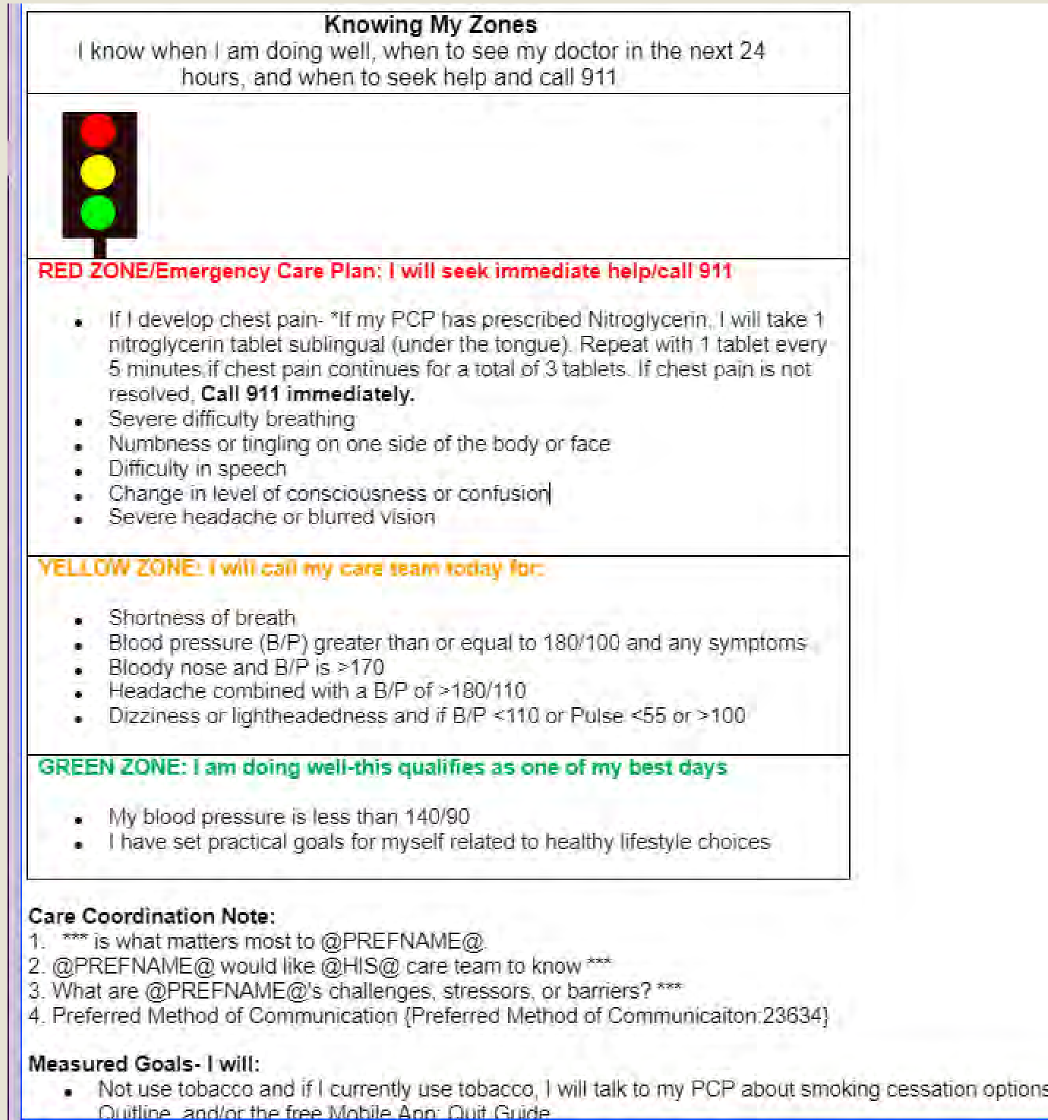
Care Plan Standard



Knowing My Zones

I know when I am doing well, when to see my doctor in the next 24 hours, and when to seek help and call 911

RED ZONE/Emergency Care Plan: I will seek immediate help/call 911

- If I develop chest pain- *If my PCP has prescribed Nitroglycerin, I will take 1 nitroglycerin tablet sublingual (under the tongue). Repeat with 1 tablet every 5 minutes if chest pain continues for a total of 3 tablets. If chest pain is not resolved, **Call 911 immediately.**
- Severe difficulty breathing
- Numbness or tingling on one side of the body or face
- Difficulty in speech
- Change in level of consciousness or confusion
- Severe headache or blurred vision

YELLOW ZONE: I will call my care team today for:

- Shortness of breath
- Blood pressure (B/P) greater than or equal to 180/100 and any symptoms
- Bloody nose and B/P is >170
- Headache combined with a B/P of >180/110
- Dizziness or lightheadedness and if B/P <110 or Pulse <55 or >100

GREEN ZONE: I am doing well-this qualifies as one of my best days

- My blood pressure is less than 140/90
- I have set practical goals for myself related to healthy lifestyle choices

Care Coordination Note:

1. *** is what matters most to @PREFNAME@.
2. @PREFNAME@ would like @HIS@ care team to know ***
3. What are @PREFNAME@'s challenges, stressors, or barriers? ***
4. Preferred Method of Communication {Preferred Method of Communicaiton:23634}

Measured Goals- I will:

- Not use tobacco and if I currently use tobacco, I will talk to my PCP about smoking cessation options Quitline and/or the free Mobile App: Quit Guide

- We have a **standardized workflows** outlining the referral process, enrollment, assessment, and documentation of care for our patients referred to CCM, BHI, or PCM.

- Our EHR provides a Compass Rose Platform and **Patient Outreach Encounter type** which promotes consistency.

- Care Coordinators utilize **Care Guides** specific to different disease processes
  - These are individualized to meet the patient's uniqueness
  - Smart Goal work sheets and smart phrases are utilized to facilitate goal setting and change

- **External Care Team members** and contact information are added to the Care Team section of the chart. Collaboration with care coordination efforts is promoted to meet the needs and circumstances of the patient.

Riverwood Connects

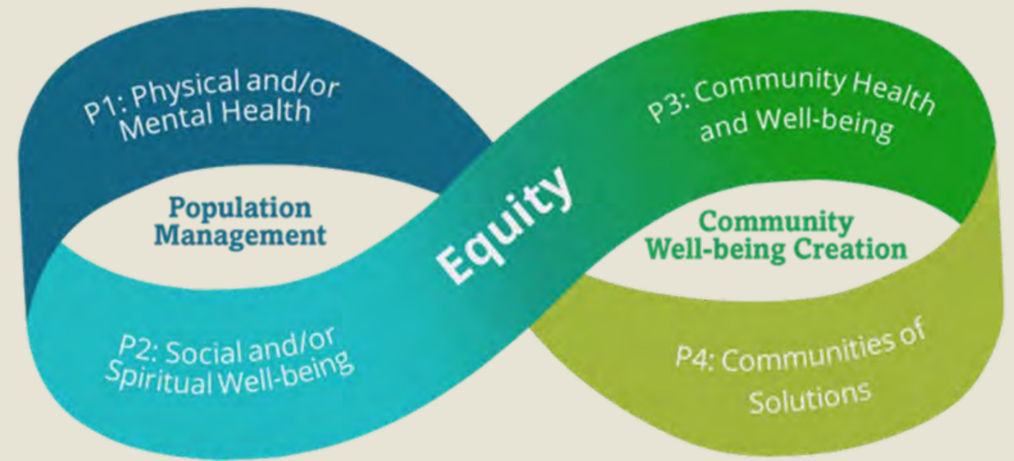
Population and Community Wellbeing

Population Health Management

The process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.

Community Wellbeing

The health and well-being of surrounding communities.



Within these are four portfolios of improvement work. Maintaining an ***equity*** lens across all four portfolios is crucial to true population health improvement.

Institute for Healthcare Improvement (IHI) | American Hospital Association (AHA)
ihi.org Pathways to Population Health | aha.org/center/population-health-management

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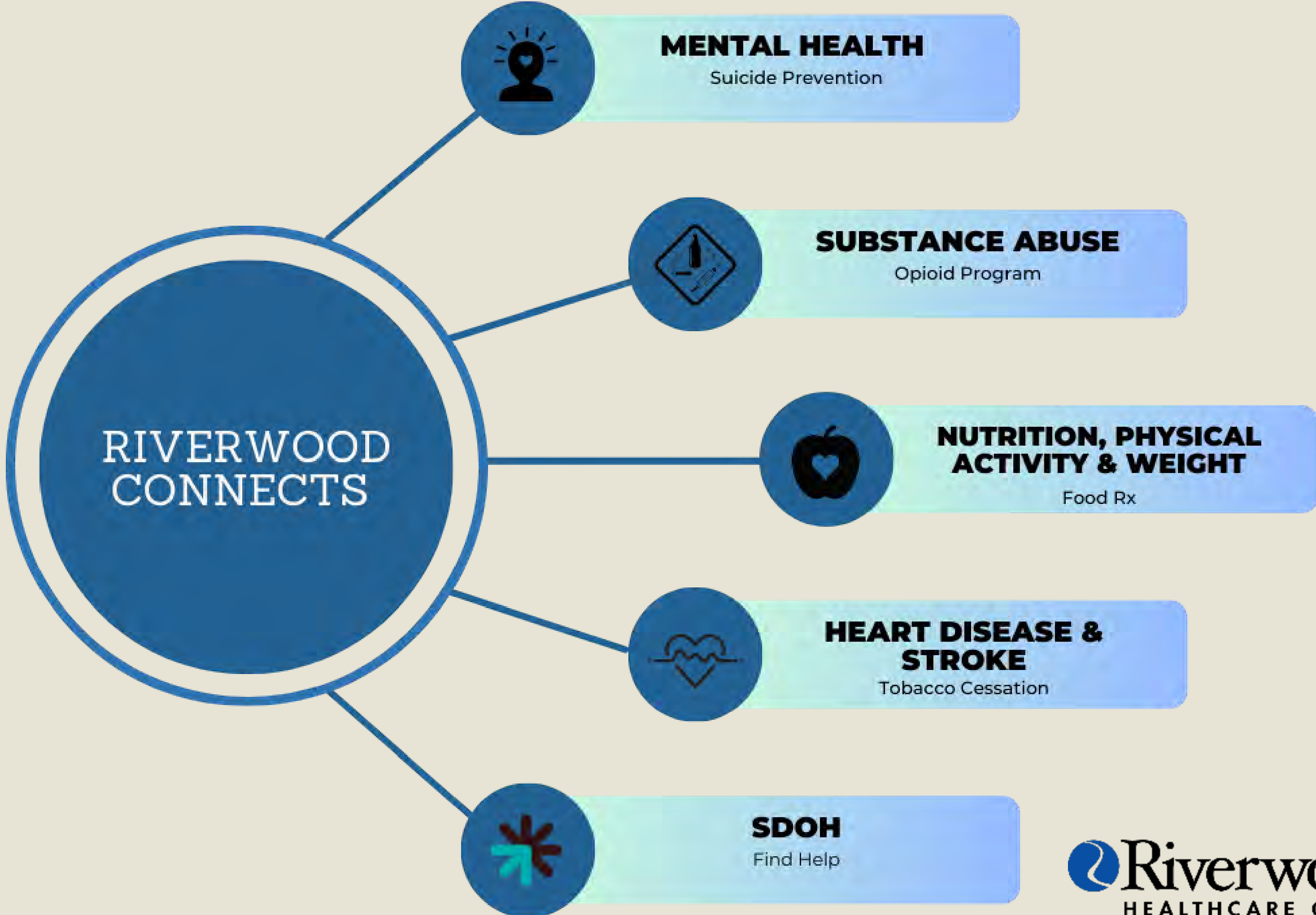
Riverwood Connects

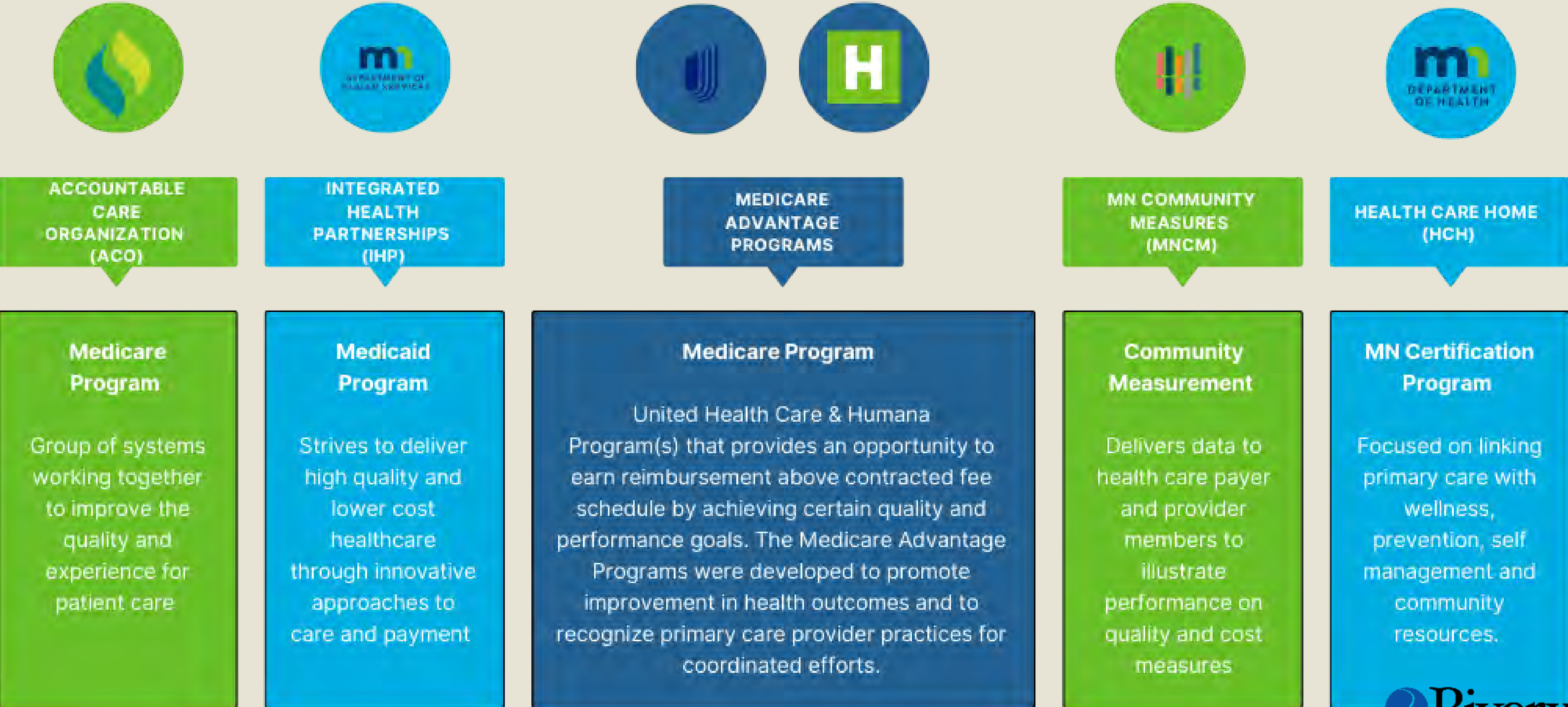
Community Health Needs Assessment

Employee Wellness

Grants / Advocacy



Riverwood’s Value-Based Contracts



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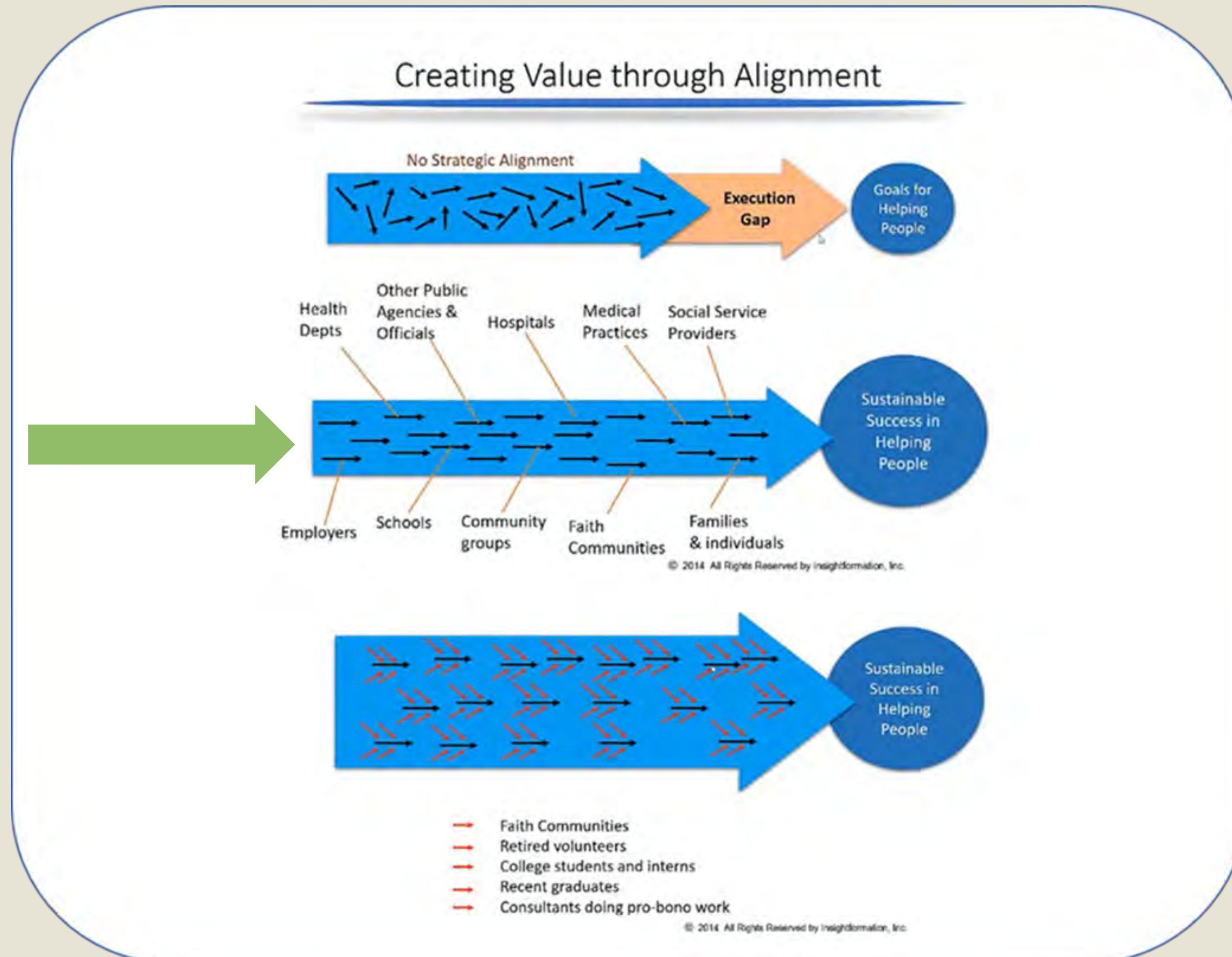
Collective Impact and moving the Arrows!

We can gauge collective impact in the work we are doing! We are aligning community leaders and organizations through committees and coalitions throughout the Riverwood Service Area.



Collective impact is a network of community members, organizations, and institutions who **advance equity** by learning together, aligning and integrating their actions to achieve **population, social, and system level change**.

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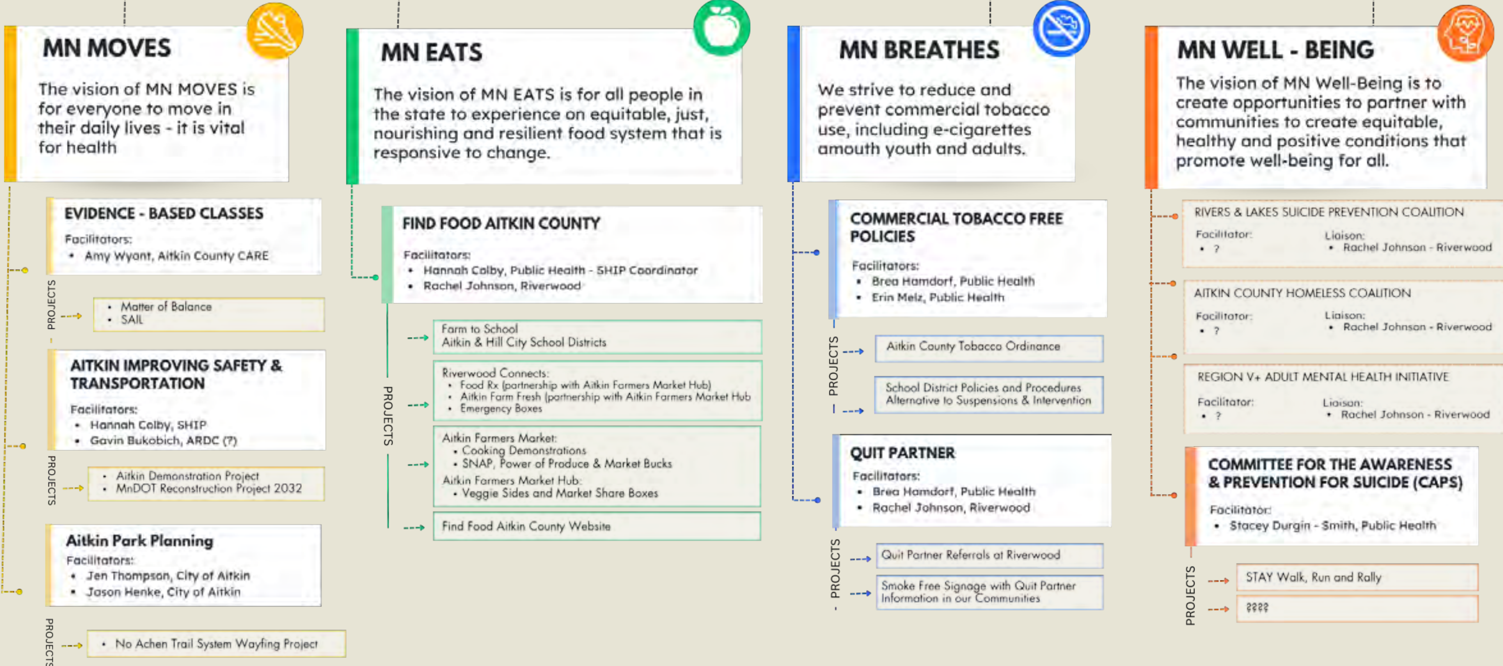
DRAFT

Vitalize Aitkin County

VITALIZE *Aitkin County Team* 2024



Community Health Needs Assessment

Workforce

Veterans / Currently Serving Military

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Vitalize Aitkin County Steering Team

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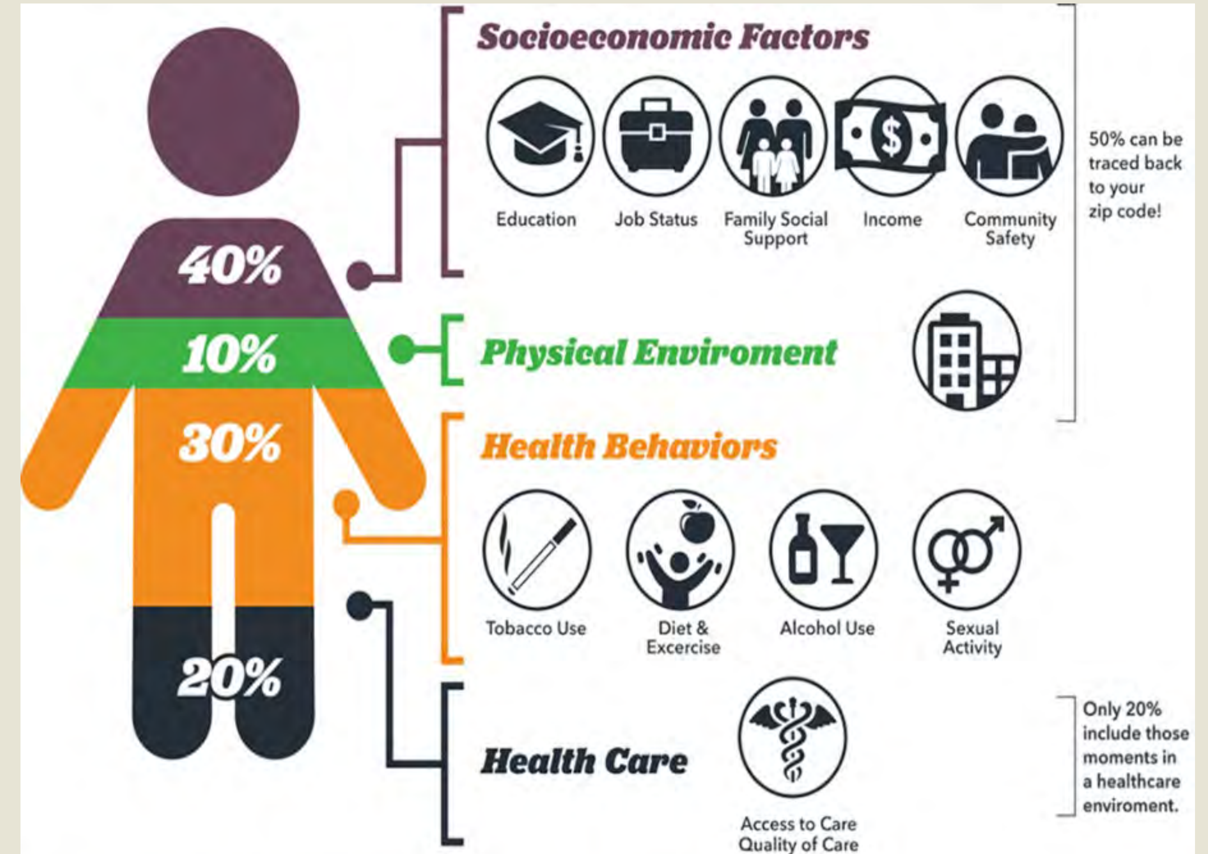
Social Determinants of Health (SDoH)

What are the social determinants of health?

SDoH are the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

SDoH have a major impact on people's health and well-being.

Health.gov/healthypeople



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Screening SDoH

Riverwood started screening SDoH in June 2023.

1986 Total Unique Survey’s Completed
5% Feeling Lonely or Isolated
4% At-Risk Housing Insecurity
4% At-Risk Food Insecurity

Isolation: None
No PCP
Primary Cvg: None
Allergies: Not on File
No patient types
Ext Rec: Show All PACS Images
No vital signs recorded for this patient.
SINCE YOUR LAST VISIT
No visits
No results
PROBLEM LIST
Gastroesophageal reflux disease
BPH with obstruction/lower urinary tract symptoms

Social Determinants of Health
Add screening
Financial Resource Strain: At Risk 3 mo ago
Housing: At Risk 3 mo ago
Food: At Risk 3 mo ago
Transportation: Not at Risk 3 mo ago
Utilities: At Risk 3 mo ago
Safety: Not at Risk 3 mo ago
Physical Activity: At Risk 3 mo ago
Social Connections and Isolation: Not at Risk 3 mo ago
Stress: Not at Risk 3 mo ago
Employment: Not at Risk 3 mo ago
Recent Data
Synopsis (All Data)
Community Resources (FindHelp)

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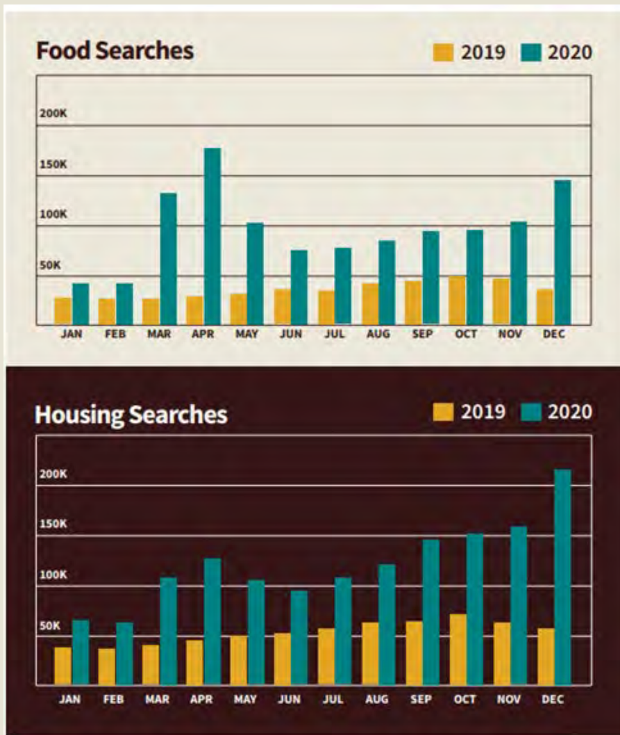
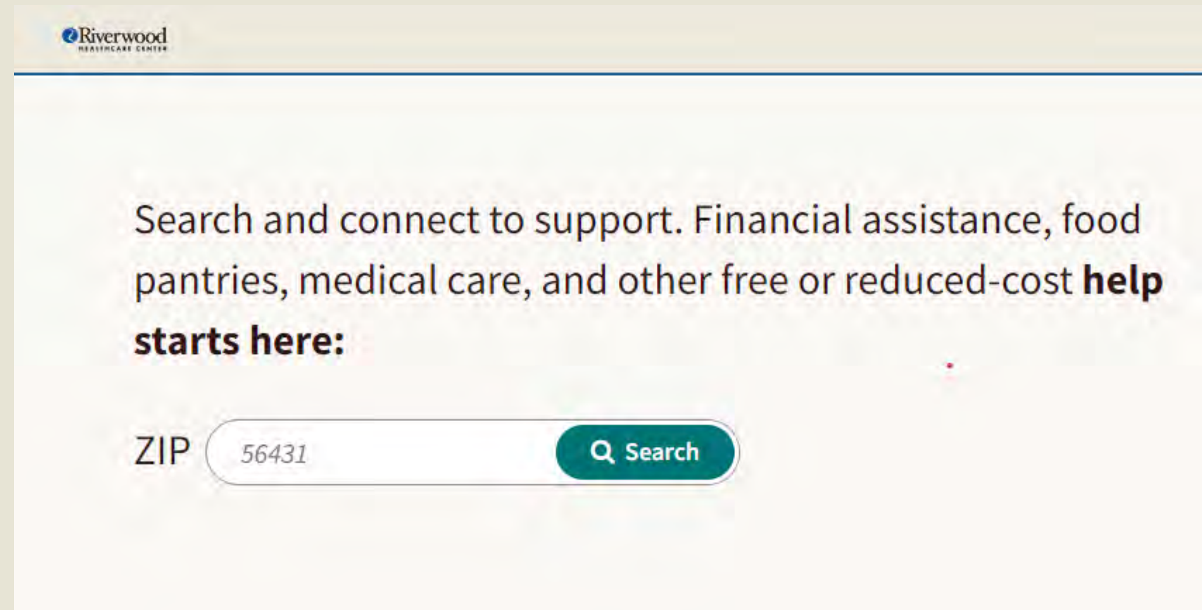
Find Help

Find Help was built in 2010 to offer an easier way to find social services and to connect to them directly and electronically. Find Help has since built the largest network of free and reduced-cost programs in every ZIP CODE across the US – this includes federal, state, county, municipal, and local resources.





findhelp.org

CARE
COORDINATING AREA RESOURCES EFFECTIVELY

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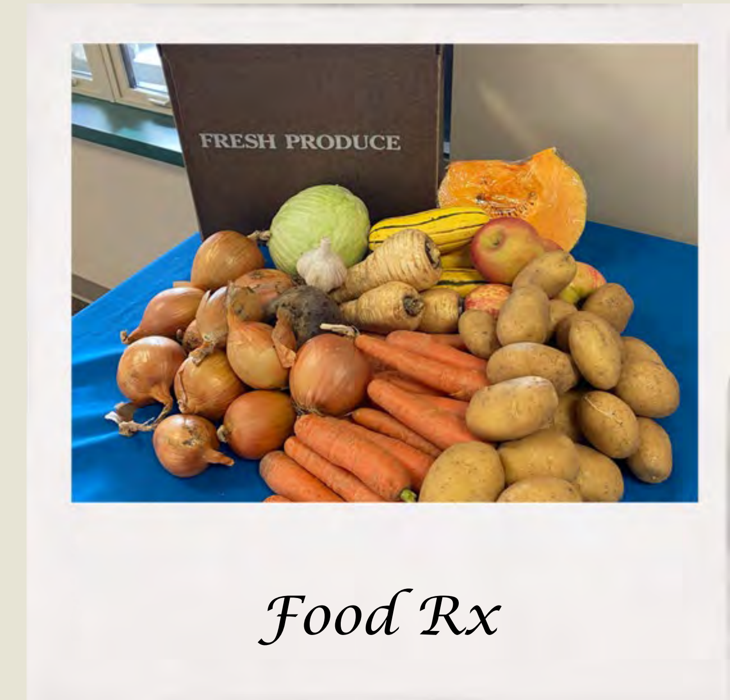
Food Rx Strategy

Program	Program Details	Program Reach
Food Rx GusNIP Grant	• Community Supported Agriculture (CSA) Share vegetable boxes distributed monthly aggregated from Hub and offset with produce from local grocer • Offers home delivery or pick - up at clinic locations • Aitkin Farmers Market Hub - works with 9 farmers throughout the county, Aitkin County SHIP	131 Referred 91 Participants Enrolled 11 Dropped Out 1 on Hold
	• Patients and community members can now go to the website and self screen for the Food Rx program • All referrals go to Natalie Braden, Outpatient Services Coordinator	50 Self-Screened 25 No Show 3 Scheduled for May Appointments with RD
Riverwood Connects Bucks	• Food Rx participants receive $50 during the summer growing season to spend at the Aitkin Farmers Market or they can redeem to be used for another CSA Share	54 Participants Received $2,650 Provided $1,037 Used @ Market $225 Used for Extra Box



Food Rx

Riverwood HEALTHCARE CENTER
Together we will.

Food Rx Strategy

Program	Program Details	Program Reach
Aitkin Farm Fresh Program LFPA Grant	• Aitkin Farmers Market Hub food boxes to be distributed to seniors within Aitkin County • Program will run JAN - MAY 2024 / JAN - MAY 2025 • Aitkin County CARE and Angels of McGregor will each receive 30 boxes to distribute to seniors they serve. • There are no guidelines associated with this program other than food has to be purchased from the local food system.	January 16, 2024 February 5, 2024 March 19, 2024 April 16, 2024

Program	Program Details	Program Reach
Emergency Pantry Packs	• Pilot has started with emergency pantry packs • Pantry Packs are located: ○ Aitkin, Garrison, McGregor Clinics ○ Behavioral Health ○ Social Services ○ Nutrition Office ○ Emergency Department ○ Aitkin County Health & Human Services	February (9) 5 McGregor Clinic 2 Aitkin Clinic 2 Hospital March (3) 2 McGregor Clinic 1 Hospital April (6) 4 McGregor Clinic 1 Infusion Therapy 1 Population Health

Aitkin Farm Fresh

RIVERWOOD CONNECTS
FVRX PROGRAM

Riverwood
HEALTHCARE CENTER
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What is inside a Food Rx Box?

FOOD RX
RECIPES

CARROTS

Did you know that carrots first were used as a medicine for a variety of ailments, not for eating? Carrots come in more colors than just orange. You can find purple, red, white and yellow varieties of this vegetable.

Growing

Nantes varieties are generally recommended for home gardeners. Before sowing seeds, prepare the soil. Deep, loose, well - drained soils will produce the straightest, smoothest carrots. Compost may be added

Preparation

Carrots can be cooked in the oven, microwave, on the stove top or in a slow cooker. For example, cover carrots with foil for cooking in the oven; bake at 420 F for 30 minutes. Cut larger carrots into

Harvesting

Storing

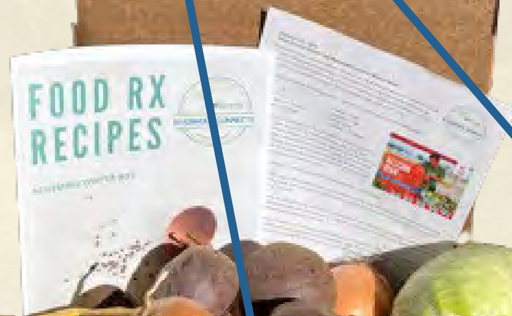
PARMESAN ROSEMARY
CARROT FRIES

Ingredients:

- 3 to 4 large carrots, peeled
- 3 tablespoons olive oil
- 1/4 cup grated Parmesan cheese
- 1 tablespoon garlic powder
- Leaves from 4 sprigs of fresh rosemary, chopped
- 1/4 teaspoon salt
- 1/4 teaspoon pepper

Instructions:

1. Preheat oven to 400 F. Peel and cut the carrots lengthwise to resemble the shape of french fries.
2. Mix olive oil, Parmesan, garlic powder, rosemary, salt and pepper in medium bowl.
3. Add carrots and toss to coat.
4. Place carrots on baking sheet lined with parchment paper and bake for 15 to 20 minutes or until carrots become slightly crispy.
5. Turn carrots over halfway through baking.



2 lbs. Rutabaga

5 lbs. Cabbage

0.75 lb. Garlic

5 lbs. Onions

7 lbs. Potatoes

6 lbs. Squash

4 lbs. Carrots

July 26, 2023
WEEK 2, Aitkin Farmers Market Hub Riverwood Connects Market Boxes

This week, Riverwood Connects brings you:

Romaine – Buck Hills Farm
Green beans – Buck Hills Farm
Slicer tomatoes – D & L Family Farm
Cucumbers – D & L Family Farm
Heirloom tomatoes – Clear Lake Gardens
Basil – Clear Lake Gardens
Garlic – Clear Lake Gardens
Kohlrabi – Dowel Farm & Gardens

RIVERWOOD CONNECTS

ALLISON RIAN
HUB MANAGER

Dietitian's Market Pick of the Week

Carrots

Megan Perpich, RD
Riverwood Healthcare Center

Melissa Te slaa, RD
Riverwood Healthcare Center

Hannah Colby, RD
Aitkin County Public Health

Riverwood HEALTHCARE CENTER

Public Health Aitkin County

$1

Expiration: October 31, 2023

RIVERWOOD CONNECTS BUCKS

SPEND AT THE AITKIN FARMERS MARKET

Riverwood Bucks can be used to buy **fresh fruits and vegetables only** at the Aitkin Farmers' Market

Tractor Supply Parking Lot in Aitkin
Saturday | 9 AM - 1:00 PM

Riverwood HEALTHCARE CENTER
Together we will.

ship

Could you benefit from:

CDS dental clinics

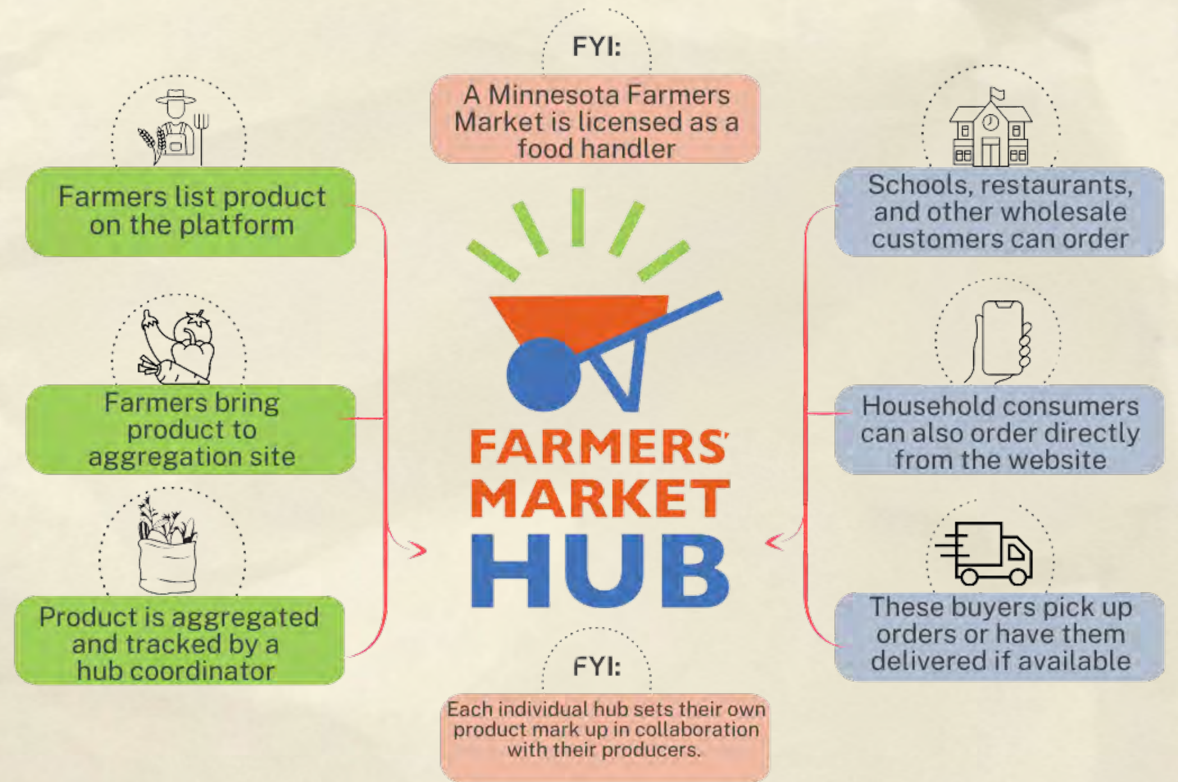
BRIDGE TO BENEFITS

Riverwood Connects Food Rx Program
It's here!

YOU MATTER.

FREE 24/7 HELP

www.farmersmarkethub.org



Farmers Market Hub Locations

- grand rapids
- Aitkin
- Wabasha
- red wing
- virginia
- Moorhead
- willmar
- the village community garden in
- rochester
- mankato
- killimo farm hub

What does the aggregation process look like ?

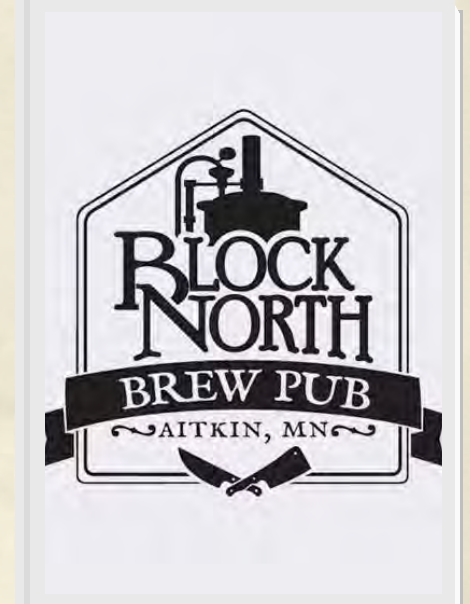
Through the Years Totals

WoW!

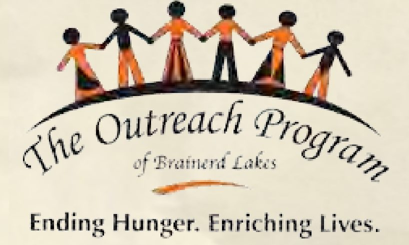
2021 gross sales: $4,849.62

2022 gross sales: $15,687.69

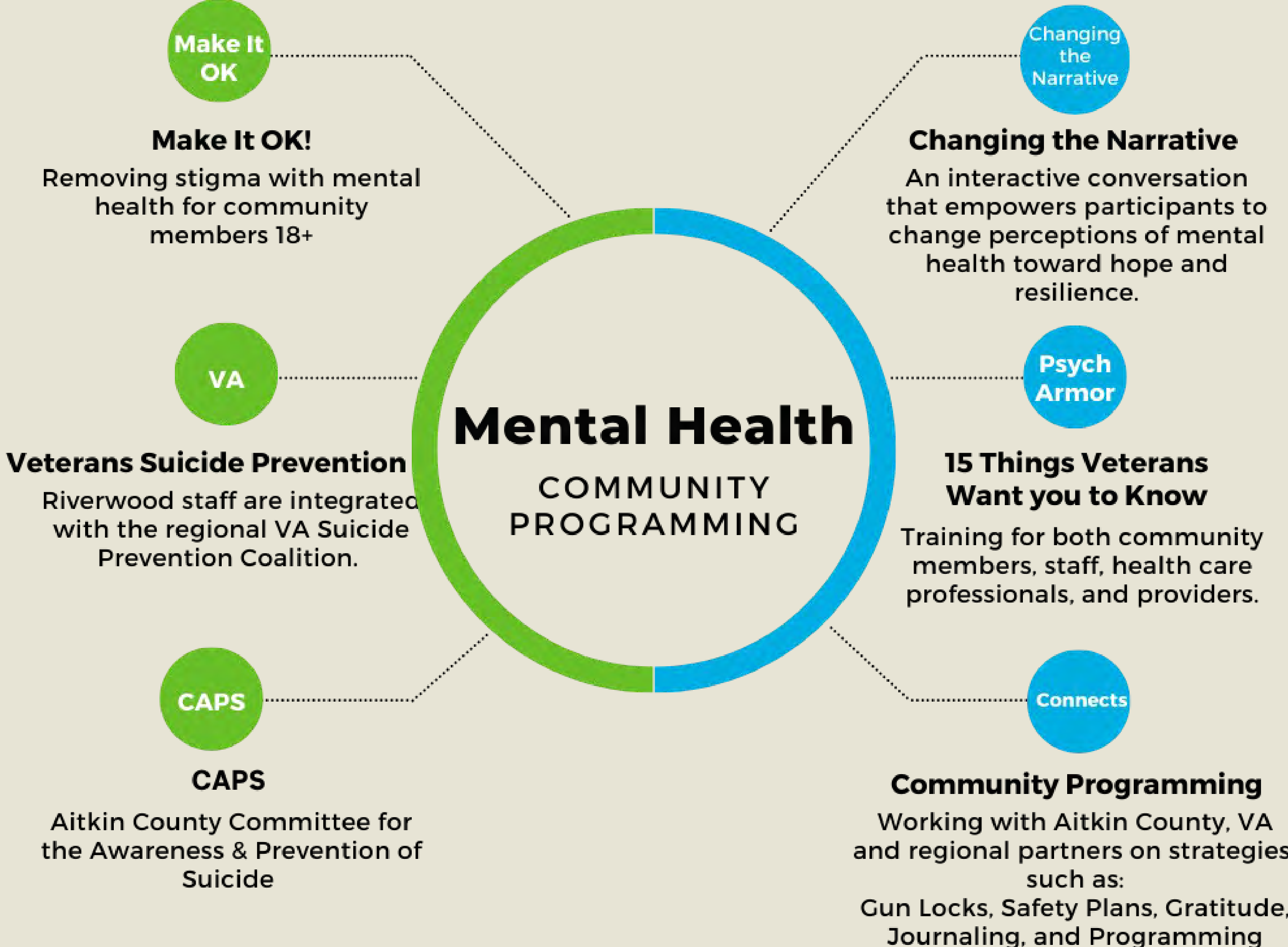
2023 gross sales: $57,415.10



PARTNERSHIPS



Mental Health Trainings



Riverwood
HEALTHCARE CENTER
Together we will.

Tobacco Cessation

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Free help to quit your way

Meet Quit Partner™
We're Minnesota's new way to quit smoking, vaping and chewing for free. Get medications, quit coaching and more.

Say, "hi."
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QuitPartnerMN.com

2X DOUBLE YOUR CHANCES OF QUITTING

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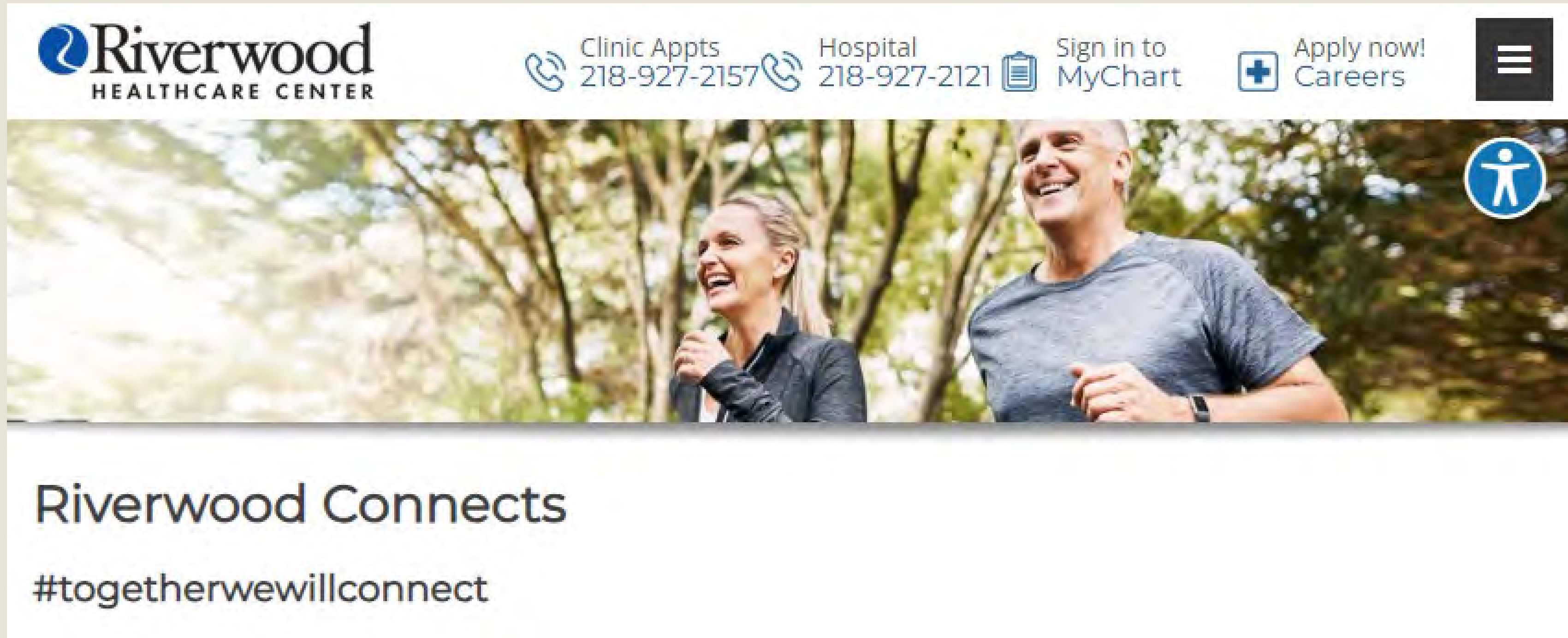
Free help to quit your way

Free 24/7 support for your quit
Whether you're quitting for the first time or have tried before, we can help you find your way to quit for good. Get free help like:

- Coaching over the phone or online
- Patches, gum or lozenges*
- Text messaging**
- Email support**
- Welcome package

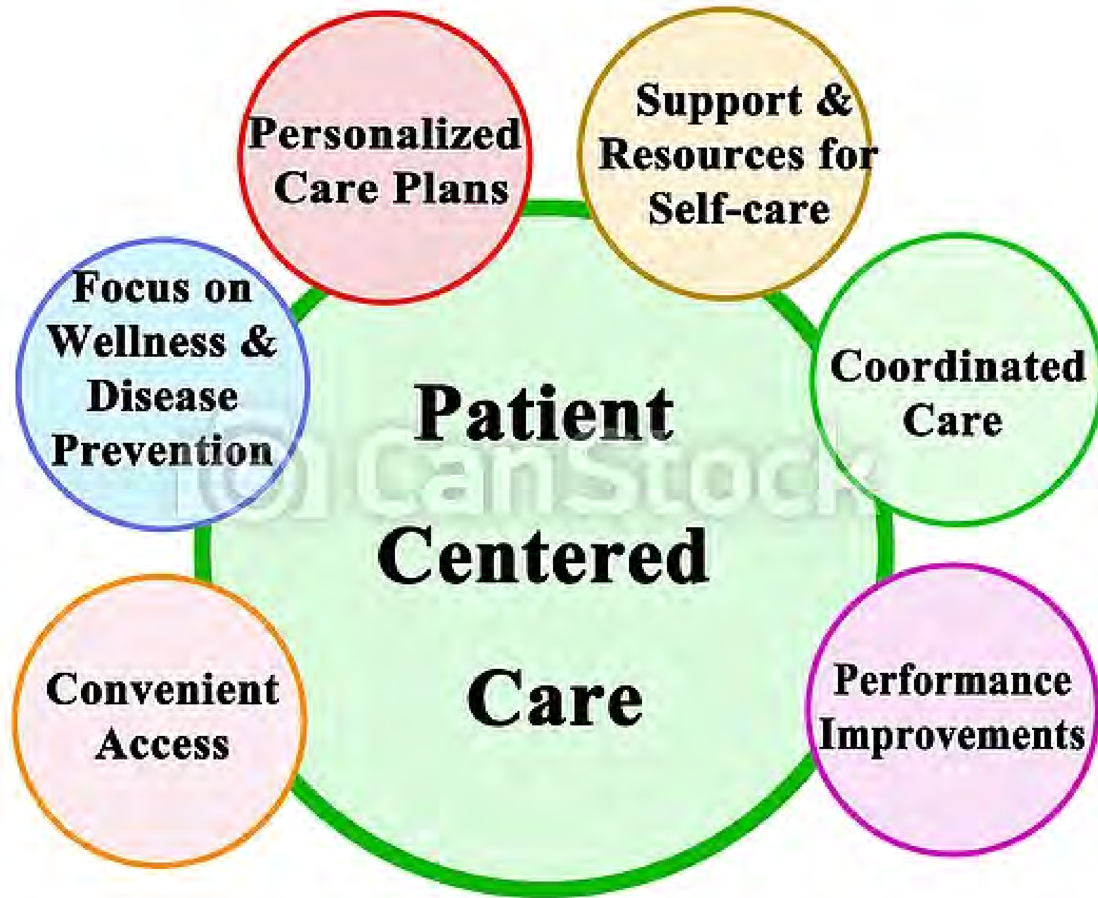
Get free medications, quit coaching and more.
1-800-QUIT-NOW
QuitPartnerMN.com

Riverwood Connects Webpage



Riverwood Connects at Riverwood Healthcare Center

Conclusion



- Patient Centered Healthcare is not a sprint or a one and done…it is a journey with ongoing commitment to improving patient care and satisfaction
- Highly engaged patients are better able to maintain a healthy lifestyle and generally have less re-hospitalizations, better medication compliance, and more satisfaction
- Every employee has a commitment to put patients and families at the center of their care and to ensure that every touch point is a positive one

Remember, there is "nothing about me without me."

Discussion/Questions/Wrap-up

Thank you!

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Population Health Program Manager
rjohnson@rwhealth.org

Riverwood Healthcare Center
Aitkin + Garrison + McGregor

Riverwoodhealthcare.org

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