



[Robina Foundation](#)

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# ROBINA FOUNDATION

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**TO:** Robina Board of Directors  
**FROM:** Penny Hunt  
**DATE:** April 21, 2015  
**RE:** Listening Tour Meetings with Allina and University of Minnesota Law School

From the looks of the material – hot off the press! – in this notebook, we are in for several days of interesting meetings!

As with the Yale and CFR meetings, Allina and the U will be talking about programs they feel are transformative for the Board to consider in the context of the Grantmaking Principles of the Robina Foundation.

## A bit of logistical information:

### April 28, 2015:

Allina Meetings: 8:00 a.m. – 1:00 p.m. (Breakfast available at 7:45 a.m.)

Attendees: Gordy, Susan, Kathleen, Peter (by phone), Steve L., Marianne, Steve S, Penny, Nancy

Location: The Commons at Midtown Exchange, 2925 Chicago Avenue, Minneapolis

Directions and Parking: See first page (front and back) of Allina material

Transportation for Susan and Steve: Pick up at 7:30 a.m. by Paul Forsline of Transportation Outfitters

Meeting with Yale President Peter Salovey: 2:00 p.m. – 3:00 p.m.

Attendees: Peter Salovey, Patty Pedersen, Gordy, Susan, Steve L., Steve S., Penny

Location: Minneapolis Club: Mississippi Room

Parking: Minneapolis Club Ramp

### April 29, 2015:

University of Minnesota Law School Meetings: 8:30 a.m. – 1:00 p.m. (Breakfast available at 8:30 a.m.)

Attendees: Gordy, Susan, Kathleen, Peter (by phone), Steve L., Marianne, Steve S, Penny, Nancy

Location: University of Minnesota Law School, 229 19<sup>th</sup> Avenue South, Minneapolis

Directions and Parking: See first page of the U of M material

Transportation for Susan and Steve: Nancy to pick you up at 8:10 a.m.

Please feel free to contact Nancy or me if you have questions in advance of the meetings. Nancy's cell: 612-501-0554; my cell: 612-381-7790.

# **ROBINA FOUNDATION**

## **November 2014**

### **Guiding Principles for Robina Grantmaking**

principle: a fundamental truth or proposition that serves as the foundation for a system of belief or behavior or for a chain of reasoning.

The Robina Foundation will:

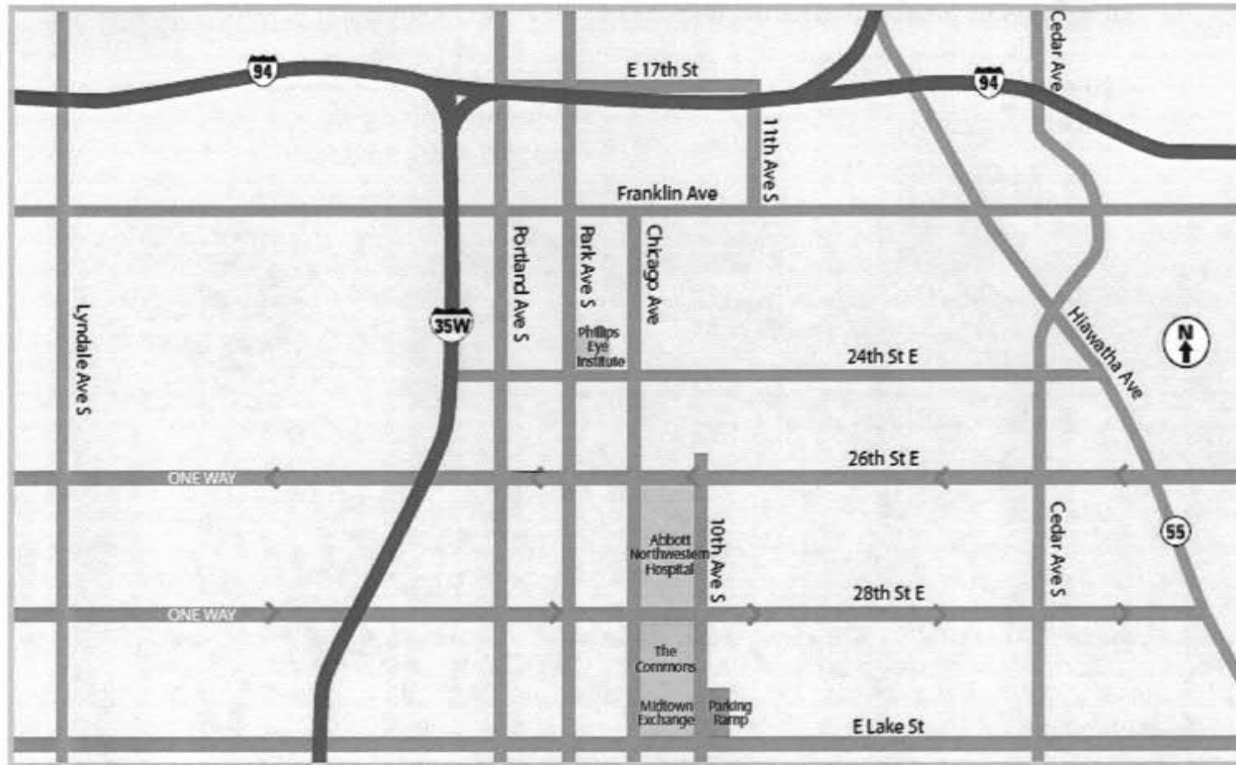
- 1) work closely with Robina Grantees to hear their ideas and ensure a full partnership with them
- 2) fund programs that fill an important niche with the possibility of substantial achievement, with particular emphasis on impacting people's lives rather than producing abstract ideas
- 3) be willing to go through trial and error processes to get things right and be ready to persist despite criticism
- 4) seek to influence the larger environment in which programs operate and increase the chances of impact and sustainability through partnerships with other funders and substantial matching funds raised by Robina Grantees
- 5) invest in leadership of institutions and individuals
- 6) strive to establish a Robina legacy of impact in areas of need

Programs involving several Robina Grantees are desirable, but will not be required.

In addition to programs that address the Foundation's guiding principles, the Robina Board is interested in programs, whether joint or individual, that:

Advance human rights, justice, fairness and equality  
Make U.S. diversity an asset, not a liability  
Ease human suffering  
Prepare the next generation of leaders  
Foster artistic / cultural creativity

# Getting to The Commons



## The Commons at Midtown Exchange

2925 Chicago Ave.

Minneapolis, MN 55407

Ph: 612-262-5000

### From the North

#### *Recommended from 35W:*

- Take the I-94 W exit 17B – go 0.5 mi
- Take the I-94 W ramp – go 0.1 mi
- Keep right onto the 11th Ave S ramp – go 0.2 mi
- Continue on E 17th St – go 0.5 mi
- Turn left at Portland Ave S – go 1.2 mi
- Turn left at E Lake St – go 0.3 mi
- Turn left at Elliott Ave S  
– Reserved Parking Stalls on the right
- Enter the building and walk towards your left, past US Bank office, to the Allina Commons lobby – you will enter the lobby through glass doors.
- Check-in with the security guards.

### From the East

#### *Recommended from I-94:*

- Take Cedar Ave S exit 234C – go 0.2 mi
- Turn left at Cedar Ave S – go 0.1 mi
- Turn left at Minnehaha Ave – go 0.2 mi
- Turn right at Cedar Ave S – go 1.1 mi
- Turn right at E Lake St – go 0.7 mi
- Turn right at Elliott Ave S  
– Reserved Parking Stalls on the right
- Enter the building and walk towards your left, past US Bank office, to the Allina Commons lobby – you will enter the lobby through glass doors.
- Check-in with the security guards.

### From the South

#### *Recommended from 35W:*

- Take the 31st St exit 15 to Lake St – go 0.2 mi
- Continue on 2nd Ave S – go 0.1 mi
- Cross Lake St to 28th St (one way) – turn right at 28th St – go 0.6 mi
- Turn right at Elliott Ave S  
– Reserved Parking Stalls on the right
- Enter the building and walk towards your left, past US Bank office, to the Allina Commons lobby – you will enter the lobby through glass doors.
- Check-in with the security guards.

### From the West

#### *Recommended from I-94/394:*

- Turn right onto the I-94 E entry ramp – go East 3.0 mi
- Take MN-55 exit 234A – go 0.3 mi
- Continue on Hiawatha Ave – go 0.2 mi
- Take Cedar Ave ramp – go 0.2 mi
- Turn right at Cedar Ave S – go 0.8 mi
- Turn right at E Lake St – go 0.7 mi
- Turn right at Elliott Ave S  
– Reserved Parking Stalls on the right
- Enter the building and walk towards your left, past US Bank office, to the Allina Commons lobby – you will enter the lobby through glass doors.
- Check-in with the security guards.

## Allina Commons Board/Guest Reserved Parking



Reserved Parking Stalls  
for Board/Guests

West Entrance  
Midtown Building

*Click map to access online directions*

- Please park in one of the stalls in the reserved parking area (highlighted in yellow above).
- Enter the building and walk towards your left, past US Bank office, to the Allina Commons lobby – you will enter the lobby through glass doors.
- Check-in with the security guards.

Robina Foundation Listening Session  
Allina Health  
Agenda  
April 28<sup>th</sup>, 2015

| Timing      | Topic                        | Lead           | Team                               |
|-------------|------------------------------|----------------|------------------------------------|
| 8:00-8:15   | Welcome ( <i>Breakfast</i> ) | Penny Wheeler  | All                                |
| 8:15-8:45   | Strategic Overview           | Penny Wheeler  | Ben Bache-Wiig<br>Tim Sielaff      |
| 8:45-9:45   | LifeCourse Overview          | Eric Anderson  | Heather Britt<br>Sandy Schellinger |
| 9:45-10:00  | Break                        |                |                                    |
| 10:00-11:00 | LifeCourse Integration       | Ben Bache-Wiig | Scott Flaata<br>Tim Sielaff        |
| 11:00-12:00 | LifeCourse Impact            | Heather Britt  | Paige Bingham<br>Kim Radel         |
| 12:00-1:00  | Discussion ( <i>Lunch</i> )  | Penny Wheeler  | All                                |

## Robina LifeCourse – Allina Health Delivering 'What Matters Most' in Late Life

*"The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in shadows of life, the sick, the needy, and the handicapped." – Hubert H. Humphrey*

To build on the spirit of Senator Humphrey's powerful call-to-action, Allina Health is asking the Robina Foundation to consider a 5-year philanthropic investment of \$25 million to implement a deeper, more comprehensive and expansive activation of LifeCourse. In doing so, the Robina Foundation will:

- Demonstrably change the arc of living for individuals with serious illness by attending to quality of life, and by restoring dignity and control in the final years of life.
- Provide compassionate and informed support to families and friends of those patients.
- Transform a part of the health care delivery system that is currently failing this critical patient cohort in both cost and care, via an evidence-based model anchored in clinical study and rigorous financial analysis.
- Lead an urgently needed national conversation around the health care of aging.
- Influence the policy decisions necessary for a higher performing healthcare delivery system.
- Create long-term impact on the healthcare system and profound short-term impact on countless individual lives.

### Background

The Robina LifeCourse program, founded in 2012, set out to address the limitations in existing end-of-life arrangements and the upstream challenges people face when reaching the final stages of serious progressive illness. LifeCourse focuses on the institutional and societal changes needed to effectively care for 'what matters most' to people in the end. By building collaborative relationships, we are changing the conversation and developing the means to systematically improve late life care.

### Why Now

Late life has become a focus of national attention with Atul Gawande's bestselling book *Being Mortal*, IHI's Conversation Project, and Ken Burns' series on cancer, *The Emperor of All Maladies*. Two of our LifeCourse national advisors are engaged in dialog at the federal level as contributors to the Institute of Medicine's most recent publication, *Dying in America*. The time is ripe to exploit this rise in national consciousness and come forward with a pragmatic, comprehensive, evidence-based model – LifeCourse. LifeCourse can uniquely contribute to the local and national need for supports and solutions that address the time in individual's lives after chronic disease has set in and before end of life, so as to positively affect quality of life and experiences and elicit patient-centered care and utilization.

### LifeCourse Today

The LifeCourse approach is to listen and care for people 'where they are at' and honor their story across systems. LifeCourse is delivered in-person and in-home, connecting patients, their caregivers, and their care system teams. Outcomes thus far are consistently positive and approaching statistical significance, demonstrating a slower rate of decline in quality of life (and in some areas, improvement) among patients as compared to controls; improved patient and caregiver experience as compared to controls; and a 17% reduction in total cost of care, coupled with increases in utilization of hospice and inpatient palliative care. To date, one publication and presentations at 4 Minnesota conferences and 8 national conferences are confirmed for this year, with another 13 publication submissions and 6 conference submissions in the queue. National conversations with Mayo (V. Montori), Dartmouth (G. Elwyn), and Yale (M. Tinetti) reinforce the innovative value of the LifeCourse approach.

The LifeCourse team, with Twin Cities Public Television, has aired 6 documentaries with 3 more to air this year (available, along with our public engagement activities, at [www.LifeCourseMN.org](http://www.LifeCourseMN.org)). In addition, KMOJ, in partnership with LifeCourse, hosted a community conversation on April 23 for the African American community, with continuing broadcasts by AMPERS across diverse public radio stations. On June 3 and November 19, the team will host additional stakeholder conversations for leaders in community, faith-based, health, and public sectors with broadcasts on public television following the events.

### Accelerating Impact

LifeCourse holds enormous promise as a bold, ambitious and evidence-based change agent. The model is demonstrating positive clinical outcomes, improved patient wellbeing, and the potential for cost savings. The imperative, however, is to scale the model, by finding productive business models and driving awareness, acceptance, and behavior change. Meaningful impact will require broad and deep adoption at many levels – by payers, providers, and policymakers – in order to establish structures and systems for implementation, and to drive engagement by patients and key friends and family members.

The expanded Robina investment will enable development of the pathways reasonable and practical payer models and the community engagement necessary to drive behavior change among providers, patients, and their key friends and family. LifeCourse plans for 2016 – 2020 revolve around implementing the program across Allina Health, accompanied by a payer integration strategy for sustainable reimbursement, and engagement of the local and national community aiming for lasting impact through broad dissemination, adaptation and ongoing evaluation.

Integration of LifeCourse across Allina Health will require an implementation process that allows for any eligible patient to receive support through any individual mechanism they rely upon to connect with the organization (e.g., primary care relationship, specialty provider support, hospital discharge). As LifeCourse is expanded to scale, payment streams for improved cost-effective results will lag the real-time loss in hospital revenue. Robina Foundation funds will be vital during the payment transition, as reimbursement shifts more toward pay-for-performance and value-based purchasing. Allina Health will take advantage of its position as a Pioneer Accountable Care Organization with the Centers for Medicare and Medicaid Services to champion further risk-sharing contracts, as well as explore numerous additional payment options, the assembly of which will yield sufficient coverage for transition away from philanthropic support internally and yield replicable payment models for other early adopters.

Broad engagement locally should yield opportunities for dissemination and deployment of LifeCourse in other organizations, including other provider groups, assisted living, public housing, faith-based and community-based organizations. Micro grants will support early adopters especially around bridging socio-economic and racial barriers. Further seed opportunities, such as enlisting caregivers who could be trained as care guides, will also be explored.

The impact of LifeCourse will be enhanced through community engagement as well as broad dissemination across the Twin Cities and nationally. Increasing awareness of LifeCourse and late life options through media engagement and outreach will be a key activity, including carrying forward the message of a better approach to late life. Expanding the message about LifeCourse beyond the Twin Cities and tying our media approach to the national dialogue will help spur discussion and adoption of LifeCourse and generate greater conversation nationally around how late life care is delivered. A strategic communications plan will allow for the connection of seminal publications and national presentations to key healthcare publications and mainstream media outlets, maximizing the ripple effect of LifeCourse. Such a strategic plan, with proper pacing and sequencing of messaging, allows us to influence the five key levers in healthcare decision-making – patients, payers, providers, policymakers, and key friends and family members, all toward a profound impact on those in the twilight of life.

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**Penny Wheeler, MD**

Penny Wheeler is president and chief executive officer of Allina Health. Prior to this role, she served as the organization's Chief Clinical Officer. As Chief Clinical Officer, she led the organization's quality and value agenda through alignment of the clinical and operational leadership to optimally benefit those served by Allina Health. A board-certified obstetrician/gynecologist, Dr. Wheeler served patients at Women's Health Consultants in Minneapolis, and has served as president of Abbott Northwestern Hospital's medical staff, chaired the Allina Quality Committee, and served on the Allina Board of Directors.

In addition to her current role, Dr. Wheeler chairs the Minnesota Community Measurement board, a regional health quality collaborative, and is on the board of Portico Healthnet, an organization dedicated to helping uninsured Minnesotans receive affordable health coverage and care. She has presented nationally on Allina Health's approach and success in quality advancement and outcomes-based quality payment models. Dr. Wheeler was named the Minnesota 2012 Outstanding Health Care Executive, largely based on her ability to form internal and external care collaboratives and their impact on community health.

Allina Health is one of the nation's leading health systems. The organization is made up of 14 hospitals, 90+ clinics, 26,000+ employees and several related health care services including home health, hospice, transportation, medical equipment, and retail pharmacy.

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**Timothy Sielaff, MD, PhD, FACS**

Tim Sielaff is the chief medical officer and senior vice president of specialty care and research for Allina Health. He also serves as the Eugene W. and Elizabeth B. Leonard Trusts Chair in Oncology and President of the Virginia Piper Cancer Institute at Abbott Northwestern Hospital in Minneapolis.

Dr. Sielaff is a practicing liver and pancreas surgeon with specific interests in minimally invasive surgery, clinical trials and multidisciplinary cancer care models. He has been the Principal Investigator for multiple local pancreatic and liver cancer clinical protocols, and is on the Executive Committee of the Pancreatic Cancer Research Team. Dr. Sielaff is a member of several national and international surgical societies and has presented both regionally and nationally on a variety of topics related to liver, pancreas and biliary disorders. He has authored numerous original articles, abstracts, and book chapters based on his broad knowledge of liver and pancreas cancer.

Tim graduated with a BS in psychology from the University of Wisconsin-Madison, received his MD and AOA from the Medical College of Virginia, PhD from the University of Minnesota Department of Surgery, and completed a Hepato-pancreato-biliary and Liver Transplantation Fellowship at the University of Toronto. He has been involved in a variety of leadership positions locally and nationally including serving on the American College of Surgeons Board of Governors, the Midwest Board of the American Cancer Society and the Pancreatic Cancer Research Team Executive Committee. He also completed the Health Care MBA at the University of St. Thomas and the Advanced Training Program at Intermountain Health.

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**Ben Bache-Wiig, MD**

Ben Bache-Wiig is the president of Abbott Northwestern hospital. Since he began his tenure as president, he has worked to establish Abbott Northwestern as a world-class hospital, as measured by five pillars of success: access, patient and staff safety, clinical quality, compassion and growth—all built on a foundation of operational excellence:

In addition to leading these efforts, Dr. Bache-Wiig is a contributing member of Allina Health's Executive Leadership Team and led the system-wide pain management team. Prior to being Abbott Northwestern's president, he served as vice president of Medical Affairs at Abbott, beginning in July 2009. Dr. Bache-Wiig was part of the North Clinic for 20 years as medical director, physician president, and partner. He served as the chief of the Medicine Department at North Memorial Healthcare and on the board of directors for North Memorial and Medica.

Dr. Bache-Wiig has been recognized several times by *Minneapolis/StPaul* magazine as one of the area's top physicians. He completed his undergraduate studies at Michigan State University, went to medical school at the University of Wisconsin – Madison and completed a residency in internal medicine at the University of Minnesota – Minneapolis.

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**Scott Flaata, MD**

Scott Flaata is a physician for the Allina Health Group and practices at the Allina Medical Clinic in Edina. He is also a staff physician at Abbott Northwestern Hospital. As a physician leader, he has been integral to the design and implementation of both the shared panel model and the personal primary care team strategies that are being deployed across the Allina Health clinics in a focused effort to bring higher quality care and improved patient experience.

In addition to being a lead physician at the Edina Allina Health Clinic, Scott was elected by his clinical peers to advise executive management on development and implementation of clinical programs, care delivery integration and redesign, as a member of the Allina Health Medical Advisory Council. He is also a member of the Allina Health Clinical Practice Council, Abbott Northwestern Hospital Clinical Council, and the Allina Health Pharmacy and Therapeutics Committee, as well as the Minneapolis Heart Institute Advisory Board.

Dr. Flaata comes to health care from a background in information technology program management in the health care sector. He received his DO from Des Moines University and completed his residency in Internal Medicine at Gunderson Clinic in LaCrosse, Wisconsin. He recently completed the University of St. Thomas Physician Leadership College program, developing advanced leadership skills with a focus on critical elements for transforming healthcare. Scott enjoys the outdoors, music, woodworking, architecture, skiing and golf.

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**Eric Anderson, MD**

Eric Anderson is principal investigator for the Robina LifeCourse program within the Division of Applied Research. He is interested in extending the benefits of whole person care earlier into the course of illness, prior to traditional palliative care and hospice. He is an author of several papers currently in preparation, describing the early experience with the supportive care model.

Eric has worked in hospice and palliative medicine for over thirty years, providing direct patient care and developing the practice of hospice and palliative medicine within Allina Health. He continues to see patients at United Hospital. He earned his undergraduate degree in Molecular Biophysics and Biochemistry from Yale University, and went to medical school at the University of California, San Diego. He completed Internal Medicine training at the University of Minnesota. Eric enjoys spending time with his wife and two grown sons, jogging slowly, and building things that fly in his workshop.

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**Sandy Schellinger, MSN, NP-C**

Sandy Schellinger is the Clinical Co-Investigator for the Robina LifeCourse Program within the Division of Applied Research at Allina Health. For most of her career, Sandy has been interested in improving the quality of life experience for patients and their families who are living with serious illness. Sandy's professional and personal experience with serious illness has shaped her 30 year career with Allina Health which includes direct nursing care, leadership in palliative care and advance care planning and applied research. She also serves as national faculty for the Respecting Choices program. She has recently authored three papers, two centered on the effects of advance care planning for patients with complex medical conditions and one centered on care teams serving individuals and families with serious illness in late life.

Sandy's educational background includes a bachelor's and master's degree in nursing science from the University of Minnesota and Metropolitan State University. She is certified as an Adult Nurse Practitioner from the American Academy of Nurse Practitioners and a Respecting Choices National Faculty for First and Next Steps ACP facilitation and training.

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**Heather Britt, MPH, PhD**

Heather Britt is a behavioral epidemiologist and catalyst for research and innovation at Allina. She is the director for the Division of Applied Research and has done so since its inception in late 2008. Recently, Dr. Britt has been assigned the accountability for the institution's Research Administration team. In her current role, Dr. Britt facilitates research agendas and collaborative conversations, participates actively in research teams, and seeks to grow and position research and innovation appropriately within the organization. She works across all clinical communities, but has a special interest in late life.

Before Allina, Dr. Britt was a Prevention Research Scientist with the Minnesota Department of Education's Safe and Healthy Learners team, following time as a Researcher at the Urban Coalition, a community-based organization focused on research and advocacy with low-income communities and communities of color. Dr. Britt holds a BS in biology from Cornell University, an MPH in health

behavior from the University of North Carolina, and a PhD in epidemiology from the University of Minnesota. She lives in St. Paul, MN and is a huge fan of her two children—Maddy (age 11) and Henry (9).

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**Kim Radel, MHA**

Kim Radel is the Director of the Care Copilot Institute, part of the Division of Applied Research. She has been with Allina Health since 2005. The Care Copilot Institute partners to transform care delivery through the use of lay healthcare workers. The Care Copilot Institute is based on a research program care model redesign, focused on the impact that lay healthcare workers, care guides, have on the care people receive for chronic disease. This work has led to presentations at eight national conferences, resulted in at least ten regional and national publications (3 peer-reviewed articles), and most importantly, has led to multiple healthcare organizations implementing lay healthcare worker models.

Before joining the Division of Applied Research, Kim held hospital and system-wide leadership roles in information systems, emergency preparedness and community engagement at Allina Health. She received her BA in management, minor in Spanish from the College of St. Benedict and Master of Healthcare Administration from the University of Minnesota – Carlson School of Management. Kim resides in Minnetonka and enjoys spending time with family, traveling, and being active outdoors.

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**Paige Bingham, MBA**

Paige Bingham is the Director of LifeCourse, a program in the Division of Applied Research, which aims to improve care for people in the last three years of life. By reshaping healthcare to focus on what matters most to the individuals, LifeCourse creates a new level of engagement for care teams, caregivers, friends and family. The next phase is to take this clinically and economically successful model “to scale” by moving beyond research and into the community.

Before joining Allina Health, Paige held senior positions at Medtronic, General Mills, and Deloitte (where she earned her CPA). She holds an MBA from The Wharton School at the University of Pennsylvania, and a BA in Economics from Claremont McKenna College. A long time Minneapolis resident, Paige serves on the board of the YWCA of Minneapolis, Twin Cities Rise! and WomenHeart—The National Coalition for Women with Heart Disease.

## **1. Brief Project Summary**

**A Supportive Care Approach for Patients Late in Life:** LifeCourse will demonstrate a system of supportive care to improve the care experience of patients, their families, and caregivers. Attention is given to creating a sustainable, scalable model that provides both clinical and economic value.

### **Background: The reason for this initiative**

Individuals living with chronic illness in its later stages confront some staggering challenges:

- They and their families are often at a loss when seeking support from the health care system, particularly with non-medical concerns.
- Families find themselves in the role of primary managers of medical care, coordinating multiple physicians and often delivering sophisticated medical treatments at home.
- Clinicians lack standardized, reliable systems to integrate late life supportive care services into primary and specialty care, despite their desire to do so.

### **Goals**

LifeCourse has built and is testing a person-centered approach that addresses these challenges. If successful, the trial will demonstrate the ability of this new care model to:

1. Reliably address patients' and families' goals, reflecting the needs of the whole person,
2. Maintain or improve overall quality of life for patients and families,
3. Improve the care experience of individuals and their families.

As a consequence, LifeCourse will:

4. Improve utilization of palliative care and hospice while avoiding undesired hospital admissions,
5. Lower total costs of care, and
6. Maintain or improve job satisfaction of team members.

### **The LifeCourse Model**

LifeCourse utilizes trained lay health care workers, care guides, to establish regular contact with patients and their loved ones. Visits are structured to fulfill a core set of tasks that promote the goals of supportive care, while allowing for individualized attention to what matters most. Care guides ensure that each individual can express their goals and wishes, and that the important medical and non-medical aspects of their lives are reliably addressed.

The model operationalizes three concepts:

1. The **Guiding Principles** (e.g., "Listen to me") assure that patients and families are respected partners in care.

2. Attention to the **whole person** addresses both medical and nonmedical needs.
3. The care guide's visits are structured around **best of practice protocols and key competencies**, such as Advance Care Planning.

### Study Design

- The first (pre-pilot) phase enrolled 23 patients. This phase included many patients from our long term care partners.
- The pilot phase runs from spring 2013 through 2015, enrolling 300-400 patients and their families, plus 300 or more comparison patients and families, for a total 1,200 to 1,500 study participants.
- Participants are identified through the electronic medical record. These individuals have at least one of ten common serious chronic illnesses, such as heart failure, dementia, advanced cancer, or chronic obstructive lung disease.
- Patients come from Allina Health hospitals and clinics, including Abbott Northwestern Hospital, Mercy Hospital, Unity Hospital, and St. Francis Regional Medical Center, as well as the Minneapolis Heart Institute, Virginia Piper Cancer Institute, Walker Methodist in Minneapolis, and Augustana Care Center in Minneapolis. Comparison patients come predominantly from United Hospital and its associated hospital-based clinics.
- After participants and family caregivers are enrolled, they take baseline surveys to measure quality of life and care experience. They receive follow up surveys every three months.
- The business model evaluates utilization of key resources, such as hospital stays, hospice, and palliative care. It also tracks total cost of care. Attention is given to creating a sustainable, scalable model that provides both economic and clinical value.

### Timeline

- January-October 2012: Model development, first iteration
- October 2012-May 2013: Pre-pilot phase, 15-30 participants (23 enrolled)
- June 2013-December 2015: Pilot phase, 300-400 participants

### 2. Update on 2014 LifeCourse Activities

#### Enrollment

As of February 13, 2015, LifeCourse has enrolled 333 intervention patients. Of these, 201 are still active, and 132 are inactive (61 have died, 71 are inactive for other reasons). LifeCourse has enrolled 439 intervention key friends and family members (KFFs), of whom 218 are active and 221 are inactive (KFFs are inactivated when the patient they are attached to passes away). As of the same date, LifeCourse has enrolled 185 comparison patients; of these, 156 remain active and 29 are inactive (14 have died, 15 are inactive for other reasons). LifeCourse has enrolled 166 comparison KFFs, 141 active and 25 inactive.

## Staffing

LifeCourse currently has 8 care guides and 6 clinicians (2 registered nurses, social worker, marriage and family specialist, chaplain, and pharmacist). The social worker is also the clinical manager. Current caseloads for care guides range from 28 to 36 patients, depending on experience level of the care guide and complexity of the patients.

Top=45 (aim)  
might go up a bit

## Model Development

The LifeCourse model continues to include three key elements--an expanded set of palliative care domains to explore whole personhood, guiding principles to support ongoing relationship and engagement, and five key activities that provide structure to the daily work - whole person, storytelling, individualized planning, normalizing and collaborating. These key elements position the model to demonstrate how to support patients and families living with serious illness and how to yield an improvement in the individual care experience, the quality of care received, and the work life of those who provide care, all at a reduced net cost to society compared to the current healthcare cost burden.

The intervention has been refined and prepared for reliable deployment. A standard visit framework for the care guide is organized around what matters most and individual goals, an exploration of whole person, early family involvement, and unique visits focused on supportive care conversations, advance care planning, and shared decision making. Care guides focus on two to three areas of the palliative care domains each visit, using consistent scripting and documentation. This added structure allows for sequencing and increases our ability to proactively support patients and families through the illness trajectory.

## Economic Value & Business Model

Key utilization metrics are collected for all patients and controls (i.e., emergency department admissions, inpatient days, palliative care visits, hospice enrollment, and hospice days). In addition, for those patients and controls for whom data are available, as obtained through Allina's total cost of care and risk sharing agreements with CMS and local payers, total cost is being analyzed ongoing. Economic and utilization data are highlighted in the 'Data' section.

## Public Engagement

### National Advisory Committee (NAC)

In March 2014, the LifeCourse National Advisory Committee came to Minneapolis. The NAC joined the LifeCourse team, patients, caregivers, other healthcare and community professionals to launch the Twin Cities Public Television documentaries at a well-attended (n=115) event at the TPT studios. In discussions after seeing the first TPT documentary, NAC members commented: "It's hard to get images of what it's really like to live like this." "How could we get this shown nationally?" "I loved hearing their stories. Will we get to hear, 'What Matters Most?'" "It's about dosing." "Does Randy [the patient profiled by TPT] graduate?"

In the full day discussion with the NAC advisors, highlights included attending to the evolution of the model ("The world changes as we budget for it, so the models need to be

updated as the rest of the world evolves."), involving payers in the business model conversation ("Get payers at the table before you propose the payment methodology."), and understanding how deeply the interdisciplinary team needs to be involved with all patients ("How will you think about Interdisciplinary team time? Just for high-risk? Regular case review? Just in time discussions?").

Feedback on the quantitative data collection activities included the need to see the total cost of care analysis, understand the effect of component parts of the intervention on outcomes, add to the systems outcome data collection, and revisit the power calculation to understand ability to detect effects. Feedback on the qualitative data collection activities included a recognition of the need to understand how much and how often clinicians were used and what community resources and partners were relied upon most. NAC reviewed the 8 expansion initiatives proposed for 2015 and narrowed the list to 5 - major mental health, honesty conversations, expansion of diseases, electronic advance care planning, and cultural community focus.

Expansion  
in 2015

#### Twin Cities Public Television (TPT)

In 2014, TPT produced 5 videos around "re-imagining late life care." The series included:

- Redefining Care
- Beyond the Doctor
- Meaning and Legacy
- Living with Chronic Disease
- Language of Health

With each episode, we invited the community of patients, families, and organizations to join us for a premiere event. The Language of Health event had over 100 people that represented the diverse communities featured in this documentary including the Wilder Program, CLUES, and the American Indian Center. TPT will continue to connect with and showcase a diversity of cultural responses to late life as part of their 2015 initiatives.

#### AMPERS

In 2014, LifeCourse partnered with AMPERS, diverse radio for Minnesota communities. "Caregiving Conversations" featured salient messages from racially and ethnically diverse individuals who had personal experience with caring for someone in the later years of life. In addition, AMPERS stations advertised upcoming TPT documentaries. The cultural diversity work is continuing with "Community Conversations" and an April 23<sup>rd</sup>, 2015 event with KMOJ in North Minneapolis. KMOJ has the largest African American listening audience.

#### MinnPost

A series of 12 "late-in-life" articles were published by this partner, including "Innovations Focus on Care Coordination and Late Life Support." Connecting Minnesotans with needed conversations around policy and care helped support the development of public awareness for LifeCourse.

## Dissemination

Dissemination of LifeCourse findings are targeted this year at national health services, palliative medicine, and geriatrics meetings. Further, the team has targeted 14 high priority manuscripts for submission in 2015, one of which has already been accepted for publication ("Building new teams for late life care: Lessons from LifeCourse," accepted by *American Journal of Hospice and Palliative Care*) and another that is being revised after submission feedback ("Standing on the shoulders of giants: Late life supportive care for patients and families living with chronic illness," submitted to *Journal of Palliative Medicine*).

## Data

Below we describe data from patients and key family members and friends (KFFs). These data include demographics of enrolled participants, quality of life indicators, care experience, and system outcomes. Data are presented for 325 intervention patients and 176 comparison patients; and for 402 intervention KFFs and 152 comparison KFFs.

### Demographics

#### *Patient*

Approximately half of the patients enrolled in the LifeCourse intervention and in the comparison group are females (LifeCourse 50%, comparison 56%;  $p=0.212$ ). Most are white (91% LifeCourse, 95% comparison;  $p=0.124$ ). Approximately half of the patients enrolled in the LifeCourse intervention and in the comparison group are married (LifeCourse 46%, comparison 51%) and one-quarter to one-third are widowed (LifeCourse 30%, comparison 22%).

LifeCourse patients are slightly older than comparison patients -- median age for LifeCourse patients is 78 years old; for comparison patients, median age is 74 ( $p$ -value=0.001). Education level for both groups is highlighted, along with the primary diagnosis. Comparison patients (mostly from the eastern portion of the Twin Cities area, centered in St. Paul) are slightly less well educated than LifeCourse patients. LifeCourse patients include more individuals with dementia as a primary diagnosis, as compared to comparison patients, likely the result of nursing home relationships. Comorbidity scores (a measure of the complexity of a particular patient) are consequently higher for LifeCourse patients than for comparison patients (5.16 versus 4.69,  $p=0.015$ ).

| Patient Characteristics | Intervention |         | Comparison |         | P-Value |
|-------------------------|--------------|---------|------------|---------|---------|
|                         | N            | Percent | N          | Percent |         |
| Education               |              |         |            |         | 0.042   |
| No HS/Some HS           | 25           | 8%      | 13         | 7%      |         |
| HS/GED2                 | 70           | 22%     | 57         | 32%     |         |
| Some College            | 94           | 29%     | 40         | 23%     |         |
| College Graduate        | 61           | 19%     | 25         | 14%     |         |
| Graduate/Professional   | 59           | 18%     | 26         | 15%     |         |
| Unknown                 | 16           | 5%      | 15         | 9%      |         |
| Primary Diagnosis       |              |         |            |         | <0.001  |
| Cancer                  | 50           | 15%     | 20         | 11%     |         |
| Dementia                | 77           | 24%     | 14         | 8%      |         |
| Heart Failure           | 198          | 61%     | 142        | 81%     |         |

While we are striving to assemble a set of comparable patients in our comparison group, we find that while on many characteristics individuals in these groups are not distinctly different, there appear to be predictable differences due to geographic distributions of education, as well as advanced illness among LifeCourse patients, reflective of a meaningful attempt to enroll patients in the intervention who are truly 'sick enough'.

#### *Key Friends and Family (KFF) Members*

Approximately two-thirds of the key friends and family members enrolled in LifeCourse and the comparison group are female (63% LifeCourse, 61% comparison,  $p=0.226$ ). Median age is the same for both groups (62 years;  $p=0.657$ ). Slightly more than three-fourths of KFFs are white (86% LifeCourse, 80% comparison;  $p=0.684$ ) and approximately three-fourths are married/partnered (74% LifeCourse, 72% comparison;  $p=0.012$ ). Slightly more KFFs live with the patient in the comparison group than in the LifeCourse group (36% LifeCourse, 41% comparison;  $p=0.001$ ). Reflecting the same trend as above in geographic distribution of education, we see the following:

| KFF Characteristic    | Intervention |         | Comparison |         | P-Value |
|-----------------------|--------------|---------|------------|---------|---------|
|                       | N            | Percent | N          | Percent |         |
| Education             |              |         |            |         | 0.036   |
| No HS / Some HS       | 5            | 1%      | 4          | 3%      |         |
| HS / GED              | 44           | 11%     | 24         | 16%     |         |
| Some College          | 115          | 29%     | 48         | 32%     |         |
| College Graduate      | 93           | 23%     | 26         | 17%     |         |
| Graduate/Professional | 101          | 25%     | 25         | 16%     |         |
| Unknown               | 44           | 11%     | 25         | 16%     |         |

Approximately one-third of KFFs are full-time employed (LifeCourse 36%, comparison 30%) and approximately one-third are retired (LifeCourse 34%, comparison 38%;  $p$ -value

0.037). More than half of KFFs have contact with the patient daily (LifeCourse 53%, comparison 61%) and another one-quarter to one-third have contact weekly (LifeCourse 32%, comparison 24%; p-value 0.006). Approximately one-third of our KFFs are spouses/partners to patients (LifeCourse 29%, comparison 34%) and slightly more than one-third are children of patients (LifeCourse 38%, comparison 37%; p-value=0.051). Overall, the KFFs are reasonably comparable across LifeCourse and the comparison group, with differences in expected areas.

### Quality of Life

#### *Patient*

Intervention and comparison patients complete the Functional Assessment of Chronic Illness Therapy – Palliative version (FACIT-Pal) quality of life tool upon enrollment and at every 3 months thereafter. Sufficient data have accumulated to both describe the longitudinal nature of the quality of life of LifeCourse patients, as well as compare the first 6 months of quality of life scores for LifeCourse patients with comparison patients.

The table below outlines differences in quality of life scores for comparison patients as compared with LifeCourse patients. For example, social wellbeing scores are 1.00 points lower for comparison patients as compared with LifeCourse patients, from baseline to six months. In other words, comparison patients experienced a decrease in social wellbeing during that time, as compared with LifeCourse patients. These scores have been adjusted for gender, age, education, marital status, race, proxy status, diagnosis, and death (that is to say, none of the effects seen in the table are due to the adjustment variables). Further, these scores have been adjusted for baseline values, so differential starting points for LifeCourse and comparison patients are well managed.

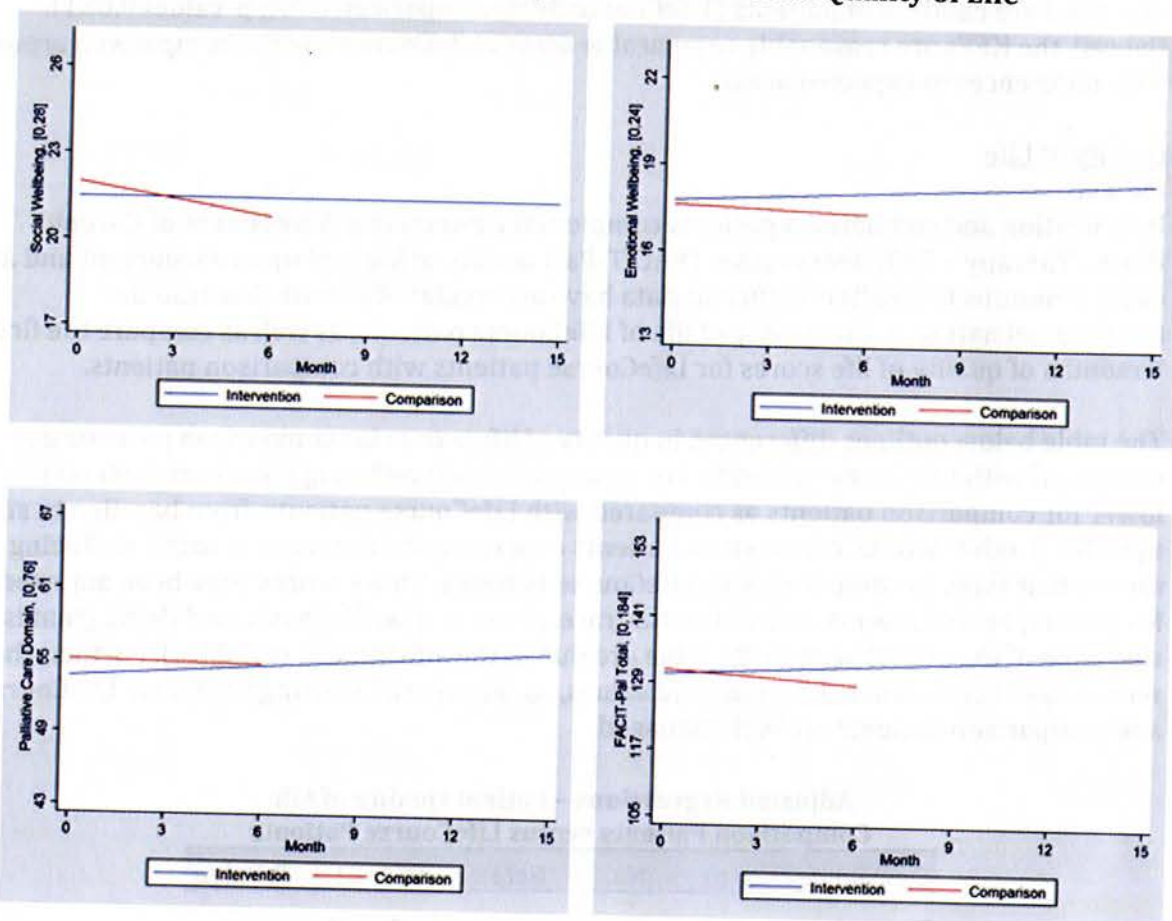
**Adjusted Regressions – Patient Quality of Life  
Comparison Patients versus LifeCourse Patients**

| Domain     | No. | Beta  | 95% CI      | P-Value      |
|------------|-----|-------|-------------|--------------|
| Physical   | 214 | -0.38 | -1.82, 1.06 | 0.605        |
| Social     | 202 | -1.00 | -2.31, 0.30 | <b>0.131</b> |
| Emotional  | 206 | -0.91 | -2.04, 0.22 | <b>0.114</b> |
| Functional | 206 | -0.60 | -2.09, 0.89 | 0.428        |
| Palliative | 219 | -2.29 | -4.85, 0.27 | <b>0.079</b> |
| FACIT-Pal  | 186 | -4.34 | -9.88, 1.19 | <b>0.123</b> |

**We see several trends approach statistical significance – comparison patients have lower quality of life, over time, in the areas of social wellbeing, emotional wellbeing, and in the palliative domain, than LifeCourse patients.** We are starting to witness the hypothesized ‘maintenance of quality of life’ by LifeCourse patients. We would not anticipate effects in the physical or functional wellbeing areas, as it is unlikely LifeCourse would have such effects. In the overall FACIT-Pal score (combined domains), comparison

patients have a 4 point lower quality of life. Below we include graphs of the most significant trajectories for quality of life:

### Graphs of Significant Trajectories for Patient Quality of Life



#### Key Friends and Family Members

Intervention and comparison key friends and family members (KFFs) complete the Patient Reported Outcome Measurement Information System 29 question survey (PROMIS-29) upon enrollment and at every 3 months thereafter. Again, sufficient data have accumulated to both describe the longitudinal nature of the quality of life of LifeCourse KFFs, as well as compare the first 6 months of quality of life scores for LifeCourse KFFs with comparison KFFs.

We see one trend at statistical significance – anxiety. **Comparison KFFs are witnessing an increase in anxiety over the first 6 months as compared to LifeCourse KFFs. In addition, the global health rating by comparison KFFs is decreasing over that 6 month period (rather than the desired increase).** The remaining trends do not demonstrate any significant differences between the quality of life of comparison and LifeCourse KFFs.

These scores have been adjusted for gender, age, education, marital status, race, and frequency of contact between KFF and patient. Further, these scores have been adjusted for baseline values, so differential starting points for LifeCourse and comparison KFFs are well managed.

**Adjusted Regressions – KFF Quality of Life  
Comparison KFFs versus LifeCourse KFFs**

|                             | No. | Beta  | 95% CI      | P-Value      |
|-----------------------------|-----|-------|-------------|--------------|
| <i>Lower scores better</i>  |     |       |             |              |
| Anxiety                     | 183 | 2.41  | 0.01, 4.80  | <b>0.049</b> |
| Depression                  | 184 | 0.50  | -1.83, 2.83 | 0.670        |
| Fatigue                     | 180 | 0.97  | -1.44, 3.38 | 0.427        |
| Sleep Disturbance           | 180 | 0.02  | -1.99, 2.02 | 0.985        |
| Pain Interference           | 180 | -0.33 | -2.51, 1.85 | 0.768        |
| Global – Pain               | 170 | 0.25  | -0.39, 0.89 | 0.440        |
| <i>Higher scores better</i> |     |       |             |              |
| Physical                    | 185 | -0.64 | -2.36, 1.08 | 0.465        |
| Social                      | 179 | 0.84  | -1.85, 3.52 | 0.538        |
| Global - Health             | 177 | -0.19 | -0.41, 0.04 | <b>0.100</b> |
| Global – QOL                | 177 | -0.03 | -0.27, 0.21 | 0.798        |

### Experience

#### *Patient*

Intervention and comparison patients complete a specialized patient experience tool developed specifically for LifeCourse upon enrollment and at every 3 months thereafter. Again, sufficient data have accumulated to both describe the longitudinal nature of the care experience of LifeCourse patients, as well as compare the first 6 months of care experience scores for LifeCourse patients with comparison patients.

Comparison patients have a consistently lower care experience over time than those patients enrolled in LifeCourse, although this trend is not yet statistically significant. **In the areas of 'repeat myself', 'goals', and 'trust', it appears the differences are beginning to approach significance – in other words, comparison patients experience a decrease in their care experience over time in these areas, as compared to LifeCourse patients. In addition, LifeCourse patients are rating their overall support and their total experience as higher over time than comparison patients.** All of these analyses are adjusted for gender, age, diagnosis, education, race, proxy status, and death. In addition, they are controlled for starting values, so differences in baseline levels do not influence these results.

**Adjusted Regressions – Patient Experience  
Comparison Patients versus LifeCourse Patients**

|                          | No. | Beta  | 95% CI      | P-Value      |
|--------------------------|-----|-------|-------------|--------------|
| Repeat Myself            | 165 | -0.36 | -0.93, 0.22 | <b>0.226</b> |
| Personal                 | 151 | -0.28 | -0.85, 0.29 | 0.330        |
| Goals                    | 154 | -0.31 | -0.85, 0.23 | <b>0.255</b> |
| Unanswered Questions     | 153 | -0.16 | -0.49, 0.17 | 0.352        |
| Conflict / Frustration   | 168 | 0.17  | -0.18, 0.51 | 0.346        |
| Choice                   | 133 | -0.01 | -0.80, 0.78 | 0.982        |
| Trust                    | 165 | -0.21 | -0.60, 0.18 | <b>0.285</b> |
| Time                     | 166 | -0.09 | -0.57, 0.39 | 0.719        |
| Global – Care            | 178 | -0.20 | -0.65, 0.25 | 0.377        |
| Global – Support         | 179 | -0.35 | -0.77, 0.06 | <b>0.097</b> |
| Patient Experience Total | 126 | -1.82 | -4.51, 0.86 | <b>0.182</b> |

System Outcomes

*Advanced Directives*

While fewer patients in the LifeCourse group had advance directives prior to enrollment, a **substantial increase in the percent with advance directives has occurred since enrollment, significantly different from the experience of comparison patients.**

| Patient Characteristics   | Intervention |         | Comparison |         | P-Value           |
|---------------------------|--------------|---------|------------|---------|-------------------|
|                           | N            | Percent | N          | Percent |                   |
| Prior to Enrollment       | 139          | 43%     | 95         | 54%     | 0.016             |
| Since Enrollment          | 91           | 28%     | 9          | 5%      | <b>&lt; 0.001</b> |
| Total Advanced Directives | 230          | 71%     | 104        | 59%     | <b>0.008</b>      |

*Emergency Department Visits*

Mean emergency department visits in the 12 months prior to enrollment were 1.59 and 1.43, respectively and not significantly different, among LifeCourse and comparison patients. **Since enrollment, LifeCourse patients have averaged fewer emergency department visits compared to comparison patients. This pattern is statistically significant among patients still living and trending positively for those who have died.**

| Patient Characteristics  | Intervention |                  | Comparison |                 | P-Value      |
|--------------------------|--------------|------------------|------------|-----------------|--------------|
|                          | N            | Mean $\pm$ SD    | N          | Mean $\pm$ SD   |              |
| ED Visits                |              |                  |            |                 |              |
| 12 Mo Prior Enroll       | 325          | 1.59 $\pm$ 1.82  | 176        | 1.43 $\pm$ 1.77 | 0.321        |
| 12 Mo Since Enroll       |              |                  |            |                 |              |
| Among those still living | 258          | 1.05 $\pm$ 1.81  | 161        | 1.62 $\pm$ 2.74 | <b>0.019</b> |
| Change                   | 258          | -0.35 $\pm$ 2.01 | 161        | 0.19 $\pm$ 2.71 | <b>0.015</b> |
| Among those who died     | 67           | 1.60 $\pm$ 1.94  | 15         | 1.80 $\pm$ 1.93 | 0.715        |

### *Inpatient Palliative Care Visits*

The proportion of patients at Allina and at Abbott Northwestern Hospital who generally receive inpatient palliative care visits is approximately 5.7%. **For LifeCourse patients, 11.6% (a two fold increase) have received inpatient palliative care visits.**

### *Inpatient Days*

Prior to enrollment, the median inpatient days ('average length of stay') for LifeCourse and comparison patients were similar. **In the 12 months since enrollment, the median inpatient days for LifeCourse patients is lower than for comparison patients, although this has not yet reached statistical significance. For those patients in the last six months of life, it appears that LifeCourse patients have substantially fewer days in the hospital,** although this trend must be interpreted cautiously, as relatively few comparison patients have died.

| Patient Characteristics | Intervention |              | Comparison |              | P-Value      |
|-------------------------|--------------|--------------|------------|--------------|--------------|
|                         | N            | Median (IQR) | N          | Median (IQR) |              |
| Inpatient Days (ALOS)   |              |              |            |              |              |
| 12 Mo Prior Enroll      | 325          | 5.16 ± 8.38  | 176        | 4.89 ± 7.31  | 0.705        |
| 12 Mo Since Enroll      | 258          | 2.80 ± 7.85  | 161        | 3.38 ± 6.85  | 0.431        |
| Change                  | 258          | -1.57 ± 8.59 | 161        | -1.09 ± 8.08 | 0.566        |
| Last 6 Mo of Life       | 57           | 19.3 ± 22.2  | 14         | 42.6 ± 46.2  | <b>0.088</b> |

### *Hospice Enrollment*

**Approximately 31% of Allina patients have been admitted into hospice since January 1, 2012. At Abbott Northwestern Hospital, 32.5% of patients have been admitted into hospice. For LifeCourse patients, 50% have been admitted into hospice;** for comparison patients, 40% have been admitted into hospice. These percentages are potentially biased, however, as we only have the ability to examine Allina hospice enrollment and not all hospice enrollment in Minnesota.

### *Total Cost of Care*

Examination of the 'total cost of care' (i.e., cost of care covered by external payers) is possible because of Allina's at-risk contracts (e.g., accountable care organization contracts, and total cost of care agreements). Utilization and expenditure information was obtained from claims files shared by the Centers for Medicare and Medicaid, BlueCross BlueShield of Minnesota, and Health Partners. Patients included in this analysis had to have insurance information available 6 months prior to ('pre') and 3 months after their enrollment date.

Control patients for this analysis were directly matched to intervention participants on their primary condition within the three study conditions, as well as whether or not the patient was in hospice during the pre-period and whether the patient died within a year of their enrollment date. The two most similar control patients for each study participant were then selected using propensity scores that took into account age, sex, marital status, the number of chronic conditions during the pre-period, the number of unique drugs

during the pre-period, the total expenditures in the pre-period, the total expenditures in the pre-period incurred for the 3 study conditions, and inpatient expenditures 1 month prior to the enrollment.

**Preliminary findings show the LifeCourse intervention patients had larger decreases in total and inpatient expenditures compared to the matched controls in terms of both absolute and percent change. These differences were seen using both 3- and 6-month post-periods.** (In the table, 'IP' = inpatient, 'SNF'=skilled nursing facility, 'ED'=emergency department.)

**Preliminary Impact of LifeCourse on Expenditures for Selected Services  
First 90 Days**

|                                      | Patients | Total \$ | IP \$    | Hospice \$ | SNF \$ | ED \$ |
|--------------------------------------|----------|----------|----------|------------|--------|-------|
| <b>Pre- to Post- Absolute Change</b> |          |          |          |            |        |       |
| LifeCourse                           | 41       | -\$1,755 | -\$1,575 | \$0        | -\$132 | \$0   |
| Matched Controls                     | 82       | -\$806   | -\$826   | \$106      | -\$91  | -\$40 |
| <b>Pre- to Post- Percent Change</b>  |          |          |          |            |        |       |
| LifeCourse                           | 41       | -37%     | -52%     | 0          | -55%   | 0%    |
| Matched Controls                     | 82       | -20%     | -33%     | +          | -50%   | -59%  |

**Preliminary Impact of LifeCourse on Expenditures for Selected Services  
First 180 Days**

|                                      | Patients | Total \$ | IP \$    | Hospice \$ | SNF \$ | ED \$ |
|--------------------------------------|----------|----------|----------|------------|--------|-------|
| <b>Pre- to Post- Absolute Change</b> |          |          |          |            |        |       |
| LifeCourse                           | 31       | -\$3,115 | -\$2,553 | \$0        | -\$112 | \$1   |
| Matched Controls                     | 69       | -\$1,231 | -\$981   | \$77       | -\$126 | -\$44 |
| <b>Pre- to Post- Percent Change</b>  |          |          |          |            |        |       |
| LifeCourse                           | 31       | -63%     | -76%     | 0          | -48%   | 3%    |
| Matched Controls                     | 69       | -35%     | -46%     | +          | -66%   | -74%  |

To estimate potential savings, we can apply the percent decrease in total expenditures experienced by the control group to the intervention group and compare it to what the intervention group actually experienced. This yields  $\$4,926 \times .35 = \$1,724$ , which compared to a \$3,115 per month, is a difference (savings) of \$1,391 per month. If you multiply this by 31 patients over 6 months, that totals \$258,726 in savings. Were we to extrapolate these savings to the total LifeCourse enrollment for a 6 month period, estimated savings would be \$2,779,218. Of course that estimate should be interpreted with significant caution, but it begins to paint the picture of the potential magnitude of total cost effect.

### 3. Unanticipated Results & Lessons Learned

#### Balancing Complexity of Late Life Against Need for Simplified Deployment

As we analyze our qualitative and quantitative data, it is abundantly clear that the experience of late life is complex for patients and families. This fact alone highlights the need for person-centered care; our publications on this topic will help provide impetus and give practical direction to others. In the early months of the intervention, we intentionally let the care guide-patient relationship flow organically, and in so doing discovered the issues of late life as experienced from the user's perspective. We have used the last year to collate the work, establish a needed standard of practice, and refine the care guide role.

That role is now leaner; it devotes more time to a set of clear deliverables that mesh with Allina's clinical strategies. The challenge going forward will be to use the simplicity of the deliverables to make the care guide role universally accessible, while retaining a true sense of relationship among care guides, patients, and families. We are carefully testing and sequencing the set of care guide tasks with this in mind.

#### Team Evolution

Over the first three years of model development, team dynamics and interactions have focused inward on the small group of LifeCourse team members, moving toward a high functioning team and optimizing interactions between participants, families, and fellow team members. A deeper understanding of individual roles, responsibilities, relationships and their interdependencies have positioned the team to now turn outward to the health system in anticipation of embedding care guides within existing care teams. As we transition toward scaling the model across the system, care guides and team members will take these lessons and integrate internal team processes into the variety of teams where LifeCourse will ultimately be deployed.

#### National Alignment

We find increasing evidence that LifeCourse is well positioned to contribute significantly to the national landscape around late life and end of life care. In 2014, two noteworthy publications were released. First, the Institute of Medicine report "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life" was released by the Committee on Approaching Death: Addressing Key End-of-Life Issues. Serving on this committee was LifeCourse national advisor, Diane Meier, MD, and reviewing the report was another advisor, Joanne Lynn, MD. In addition, Atul Gawande's book, *Being Mortal: Medicine and What Matters in the End*, hit the top of the *New York Times* non-fiction bestseller list. Frontline's episode focusing on the issue yielded a retweet of a LifeCourse post. In a speech Diane Meier gave at the National Summit for the Center to Advance Palliative Care, she highlighted these publications and other significant trends that indicate the tipping point of reform for late life care is at hand.

#### Preview of 2016-2018

In 2015, the LifeCourse team continues to focus on patient and KFF enrollment, rich analysis of data, and expansion initiatives. In addition, given the promising nature of the outcomes data to date and the positive qualitative feedback from patients, KFFs, and care team members, we are preparing both a Phase II funding proposal for the Robina

Foundation, as well as developing a plan to take the model to scale across Allina Health. This proposal and plan will include a shared ownership of the cost of expansion, an enhancement of community partnership and a focus on diverse patients and families, and a sustainable deployment model that layers LifeCourse across the organization without requiring a silo staffing model. Given previous experience deploying care improvement and care innovation across Allina, tailoring scaled deployment to the different units and teams within the organization will be critical.

#### 4. Expense Statement

The total budget for 2014 was \$4,274,541. The actual expenditure was \$3,957,830. The project was \$316,711 under budget in 2014 which results in being \$914,273 under budget for the pilot phase to date.

| Account                                        | 2014<br>(Year 3)    |                     | 2012-2014<br>(Cumulative Total) |                     |
|------------------------------------------------|---------------------|---------------------|---------------------------------|---------------------|
|                                                | Budget              | Actual              | Budget                          | Actual              |
| Salaries                                       | \$ 2,334,106        | \$ 2,139,162        | \$ 5,199,471                    | \$ 4,887,203        |
| Benefits                                       | 647,715             | 557,979             | 1,557,406                       | 1,309,226           |
| Supplies                                       |                     | 19,224              | 54,500                          | 51,505              |
| Equipment/Facilities                           | 70,000              | 7,651               | 140,000                         | 45,481              |
| Printing/Postage                               | 10,000              | 10,243              | 81,000                          | 16,992              |
| Purchased Services <sup>1</sup>                | 100,000             | 232,655             | 493,500                         | 401,543             |
| Consulting/Contractual Agreements <sup>2</sup> | 867,720             | 925,543             | 2,800,602                       | 3,081,555           |
| Education                                      | 100,000             | 24,100              | 288,000                         | 45,161              |
| Travel                                         | 130,000             | 32,270              | 205,000                         | 71,758              |
| Food                                           | 15,000              | 4,069               | 42,250                          | 25,839              |
| Miscellaneous                                  |                     | 4,934               | 15,000                          | 26,193              |
| <b>TOTAL</b>                                   | <b>\$ 4,274,541</b> | <b>\$ 3,957,830</b> | <b>\$ 10,876,729</b>            | <b>\$ 9,962,456</b> |
| <b>Total Variance</b>                          |                     |                     | <b>(Under budget)</b>           | <b>\$ 914,273</b>   |

<sup>1</sup> Purchased Services includes C-TAC and CAPC contributions, IRB fees

<sup>2</sup> Consulting/Contractual Agreements includes partners (TPT, University of Minnesota, Augustana, Walker Methodist), as well as Patient and Caregiver Advisory Council members, National Advisory Committee members, and other consultants/training.

Respectfully submitted,

Eric W. Anderson, MD, Principal Investigator

# Directions & Parking

Mondale Hall is located on the West Bank of the University of Minnesota's Minneapolis Campus. The address is 229 19th Ave. South, Minneapolis, MN 55455

## Parking

Parking for events at Mondale Hall is available at a variety of locations on the U. of M. West Bank campus:

- **Surface Lot C86**, north of Mondale Hall; entrance on 2nd St. S.

## Driving Directions:

### From the South:

- Take I-35W north to 3rd St. exit (exit 17C) toward the U of M West Bank
- Turn right onto Washington Ave. S.
- Take immediate left at next stoplight to follow Washington Ave. (15th Ave. S. goes to right)
- Go one block to Mondale Hall, at intersection with 19th Ave. S.

### From the North:

- Take I-35W south to Washington Ave. exit (exit 17C)
- Turn left onto Washington Ave. S.
- Turn left again onto Washington Ave. S.
- Turn left onto 19th Ave. S. and proceed to Mondale Hall, 229 19th Ave S.

### From the East:

- Take I-94 west to Riverside Ave. exit (exit 235A)
- Take slight right onto Riverside Ave.
- Turn right onto 19th Ave. S. and proceed to Mondale Hall, 229 19th Ave S.

### From the West:

- Take I-394 east toward Minneapolis
- Merge onto I-94 going east via exit 8
- Merge onto I-35W going north via exit 233C on left
- Follow 35W north to 3rd St. exit (exit 17C) toward the U of M West Bank
- Turn right onto Washington Ave. S.
- Take immediate left at next stoplight to follow Washington Ave. (15th Ave. S. goes to right)
- Go one block to Mondale Hall, at intersection with 19th Ave. S.



## Center for New Americans

We look forward to Robina's visit to the Law School on April 29<sup>th</sup>. You will see first-hand some of the impressive early results we have achieved through our collaborative new model for clinical legal education. By working together with our law firm and non-profit partners we are already driving transformational change in U.S. immigration law and legal education—change that stands to benefit countless immigrants and law students.

We are pleased to provide this brief summary of our progress, along with an update on emerging trends that impact our priorities. We also offer our vision for a permanent Binger Center for New Americans, with an estimate of the resources needed to make that vision a reality. An agenda and other information for the April 29<sup>th</sup> visit are attached.

### CURRENT PROGRESS AND EMERGING TRENDS

- **Building the Center for New Americans:** Our new immigration clinics are now finishing their first full academic year and we continue to integrate them with the existing Immigration and Human Rights Clinic. All three clinics were fully enrolled this year, as well as next year, with significant waiting lists. This year the Center also teamed with the Advocates for Human Rights to launch a new year-long Immigration Education and Outreach externship course. In all, the Center for New Americans has quadrupled the number of immigration-related experiential learning opportunities from 10 to 40.
- The **Federal Immigration Litigation Clinic** continues to engage students and our partners in cutting-edge litigation before courts across the country, and we have reached our year-two benchmark by collectively handling over 18 cases. Students played key roles in our first U.S. Supreme Court case, *Mellouli v. Holder*, and enjoyed the unprecedented opportunity to attend the oral argument in January with our litigation team, led by Faegre Baker Daniels and joined by the Immigrant Law Center of Minnesota. Other students are leading prominent asylum litigation, challenging the U.S. government's policy of deporting Central American youth who are fleeing persecution from criminal gangs. Our asylum litigation has drawn *amicus curiae* support from Harvard University, the American Immigration Lawyers Association, and other national allies. Dorsey & Whitney joined the clinic this year to develop new resources for immigrants and bring *habeas corpus* actions challenging their unlawful detention.
- **Detainee Rights Clinic** students are working with our partners to expand representation for detained immigrants. Together we are on track to meet or exceed our year-two benchmarks for representation in bond hearings (50) and merits hearings (40). Our students won important victories for jailed immigrants suffering from mental illness and

led training for over 30 area attorneys representing mentally ill detainees. Our new Legal Orientation Program has provided 100 detainees with early access to legal advice.

- Our **Education and Outreach Program** teaches noncitizens about their rights and trains lawyers to provide high-quality pro bono services to New Americans, working with an impressive network of allies within the Law School, across the university, and in the community. Our Translation and Interpretation Program boasts over 90 volunteers fluent in 16 languages. Medical school faculty are now evaluating our asylum clients as part of their new forensic psychiatry residency program. In January, we hosted our first Federal Immigration Litigation conference for over 50 pro bono attorneys. In April, we co-hosted an immigration policy symposium with The Advocates for Human Rights, the Humphrey School of Public Affairs, and the Immigration History Research Center, drawing 300 attendees. With the Law School's Tax Clinic we have launched a new program to educate low-income immigrants on avoiding tax scams.

While we expect to meet or exceed our benchmarks, two interrelated trends have altered the needs of our partners and the immigrant communities we serve. The first is the Obama Administration's plan to use prosecutorial discretion to protect from deportation millions of undocumented youth and parents of U.S. citizen children. As new enforcement priorities are implemented, the number of detained immigrants scheduled for hearings in local courts has declined, while those who remain detained tend to have more challenging profiles of criminal history and eligibility for relief from deportation.

The second is a simultaneous surge of Central American families and unaccompanied children arriving at our southern border. The federal government has detained tens of thousands of vulnerable individuals and placed them in deportation proceedings. Many are eventually released on bond or to family members across the country, with hundreds of cases now pending before the immigration court in Minnesota. This has created a severe spike in demand for pro bono legal help. The Center is assisting our partners in a collective effort to meet this demand through collaborative outreach and education and we intend to shift some of our resources into direct representation of these clients.

## OUR VISION: THE BINGER CENTER FOR NEW AMERICANS

Consistent with the original proposal for the Center, as we approach the fourth year of our pilot period the Law School plans to request an additional \$25 million to permanently endow the program. Our original budget is attached here as appendix C, although we may make some modifications to that budget in light of the trends described above.

In an era of declining law school applications and increased emphasis on experiential learning, the Center for New Americans provides a model for a new generation of high-impact law clinics. The collaborative approach to legal education and public service that defines the Center sets it apart from all other law school clinics. We believe our progress is extraordinary and that we are building the premiere clinical immigration program in the U.S. The investments of our partners are a powerful statement of their long-term dedication to this project. The pro bono legal services that our three partner law firms have invested in the

Center already exceed one million dollars, while our non-profit partners have contributed invaluable time and expertise to our cases and outreach efforts.

A permanent Binger Center for New Americans will be an extraordinary legacy for generations of law students and help transform immigration law to the benefit of countless immigrants and their families in decades to come.

#### APPENDICES

- Appendix A –** Agenda for April 29<sup>th</sup> visit
- Appendix B –** Information about participants
- Appendix C –** Budget for endowment of a permanent Binger Center for New Americans.

**Robina Foundation Listening Tour**  
Wednesday, April 29, 2015  
University of Minnesota Law School  
229 19<sup>th</sup> Avenue South, Minneapolis, MN 55455  
Lindquist & Vennum Conference Room – Third Floor

**AGENDA**

**8:30 a.m. – 8:45 a.m. Arrival; coffee and light breakfast served**

**8:45 a.m. – 9:15 a.m. Overview of Robina-funded programs at the Law School**

Dean Wippman will discuss the role of the various Robina-funded programs in the context of the overall challenges facing legal education in general and the Law School in particular.

**9:15 a.m. – 10:15 a.m. Robina Public Interest Scholars Program and scholarships**

Amanda Furst, Assistant Director of Public Interest, will provide a short overview of the success of the program in supporting students in public interest careers and in attracting high quality public interest students to the Law School. Selected Robina Scholars will speak about their experiences in the program.

**10:15 a.m. – 1:00 p.m. Center for New Americans**

Board members will engage in conversation with the Center's students, clients, partners, staff and volunteers through a series of interactive presentations.

**10:15 – 11:00 a.m. Meet with Center staff and partners**

Center staff and representatives from all six of our law firm and non-profit partner organizations will provide a short overview of our initiatives, describe trends affecting the immigrant communities we serve, and field questions about our collaborative work and progress.

**11 a.m. – Noon Small group breakouts (2 conversations, 30 minutes each)**

After a brief tour of the Center's new clinic space, Board members will divide into smaller groups and take part in two 30-minute breakout sessions led by Center clients, students, volunteers, and partners.

***Breakout 1: Detainee Rights: clinical and volunteer initiatives***

Breakout 1 will highlight new clinical and volunteer programs that engage our students in public service to detained immigrants. Board members will meet a second-year law student from the Detainee Rights Clinic and the client she successfully represented in immigration court. First-year law students will share their experiences assisting non-citizens through the Center's Translation and Interpretation Program and as part of our winter break service-learning trip to a major detention center at the U.S./Mexico border.

***Breakout 2: Asylum: defending victims of persecution***

Breakout 2 will focus on our representation of asylum seekers, and how these cases impact clients and the clinical students who represent them. A second-year student will describe her role in prominent federal litigation that could impact thousands of youth fleeing persecution by Central American gangs. A client from Guinea will be joined by a third-year student and a law firm volunteer who helped litigate the case all the way to the U.S. Supreme Court, and won.

Noon – 1:00 p.m.

**Lunch hour presentation: Supreme Court litigation, *Mellouli v. Holder***

The Center's litigation of the *Mellouli* case before the U.S. Supreme Court was an extraordinary collaboration led by Faegre Baker Daniels LLP and assisted by the Immigrant Law Center of Minnesota. Current and former students who played key roles on our litigation team will join Teaching Fellow Kate Evans for a discussion of *Mellouli* and the potential impact a victory in this case could have for thousands of immigrants nationwide. The presentation will feature audio highlights from the January 14<sup>th</sup> oral argument that our students were able to attend in person.

**ROBINA FOUNDATION LISTENING TOUR  
APRIL 29, 2015  
PARTICIPANTS**

**David Wippman, Dean of the Law School and William S. Pattee Professor of Law**

**CENTER FOR NEW AMERICANS STAFF**

**Benjamin Casper, Center Director and Director, Federal Immigration Litigation Clinic**

Benjamin joined the faculty in July, 2013. He teaches the Federal Immigration Litigation Clinic, which engages students in strategic impact litigation on behalf of immigrants and refugees.

**Linus Chan, Director, Detainee Rights Clinic**

Linus joined the faculty in December of 2013. Prior to joining the Center for New Americans, he taught at the DePaul College of Law in Chicago and at the DePaul Asylum and Immigration Law Clinic. He has practiced immigration law for more than 10 years with a focus on representing people who are detained by Immigration and Customs Enforcement.

**Stephen Meili, Director, Immigration and Human Rights Clinic**

Stephen is the Vaughan G. Papke Clinical Professor in Law and Director of the Center's Immigration and Human Rights Clinic, where students represent asylum-seekers and detained individuals in various immigration and appellate court proceedings.

**Kate Evans, Teaching Fellow**

Kate joined the Center in October 2013. She was in private immigration practice as an adjunct clinical professor at the University of St. Thomas from 2012–2013. Earlier she clerked for the Honorable Diana E. Murphy, Circuit Judge, United States Court of Appeals for the Eighth Circuit, as well as the Honorable Harriet Lansing and the Honorable Thomas Kalitowski of the Minnesota Court of Appeals. She graduated from NYU School of Law.

**Meghan Heesch, Teaching Fellow**

Meghan joined the Center in October 2013. Before that she clerked at the Orlando Immigration Court as a Department of Justice Honors Program attorney. Heesch is a graduate of Harvard Law School. This summer she will return to the U.S. Department of Justice as an assistant U.S. Attorney.

**Kjerstin Sanden, Program Coordinator**

Kjerstin joined the Center in January 2014. A graduate of Concordia College, she previously worked for a human rights organization in Argentina serving immigrants and refugees. Kjerstin coordinates all three of the Center's clinics, trains students as well as Center volunteers, and facilitates education and outreach programming. Kjerstin also founded and now directs the Center's volunteer Translation and Interpretation Program (TIPs) which provides the Center's clinics and partners with essential services in over 15 foreign languages.

## LAW STUDENTS

### **Anna Finstrom '15**

Anna is third-year student with the Center's Federal Immigration Litigation Clinic. Last year she was a student in the clinic and this year she returned to serve as one of our student directors. During her two years with us Anna has been an important member of our litigation teams in two appeals to the U.S. Supreme Court: *Goromou v. Holder* and *Mellouli v. Holder*. On April 29<sup>th</sup>, Anna will participate in our second break-out session along with her client, Pe Goromou, whose case we successfully settled, resulting in a grant of asylum. She will also help lead our noon hour presentation on the *Mellouli* litigation. Next year Anna will clerk at the Minnesota Court of Appeals.

### **Caitlinrose Fisher '15**

As a third-year student Caitlinrose also worked on the *Mellouli v. Holder* team, but as an extern with our partner, the Immigrant Law Center of Minnesota, which was co-counsel in the case along with the law firm Faegre Baker Daniels. During our lunch hour presentation, she will describe her work on the case as well as the opportunity to attend oral argument at the Supreme Court. After graduation, Caitlinrose will gain additional experience in Supreme Court litigation in a coveted position with the Office of the U.S. Solicitor General.

### **Kerry McGuire '16**

Kerry McGuire is a second-year student with the Detainee Rights Clinic. During our first break-out sessions Kerry will join one of her former clients, who was detained and facing imminent removal from the United States until the two met in the jail as part of the Center's new Legal Orientation Program, which provides incarcerated immigrants early access to counsel and legal advice. Kerry will return to the Detainee Rights Clinic as student director next year.

### **Nadia Anguiano-Wehde '17**

Nadia is finishing her first year as a law student and as a volunteer with the Center's Translation and Interpretation Program (TIPs). Next year she will be a student attorney in the Federal Immigration Clinic. Nadia will put her interpretation skills to work at our first break out session.

### **Kristen Hathaway '17**

Kristen is a first-year student, who will also join our first break-out session to discuss her volunteer experience during winter break traveling with Center faculty and partners for a service-learning trip that included a visit to one of the nation's largest immigration detention facilities. Kristen will join the Detainee Right Clinic as student attorney next fall.

### **Anne Dutton '16**

As a second-year student in the Federal Immigration Litigation Clinic, Anne, played a leading role in prominent federal litigation before the U.S. Court of Appeals for the Ninth Circuit that could impact the rights of thousands of youth fleeing persecution by Central American gangs. In our second break-out session, Anne will talk about the case and her decision to return to the Clinic as a student director next year.

## **PARTNER REPRESENTATIVES**

### **Faegre Baker Daniels LLP**

#### **Dianne Heins, Pro Bono Counsel**

Dianne serves as the Faegre Baker Daniels' pro bono counsel and leads the professional team which manages and supports the firm's pro bono practice and community service activities. She serves on the Center's advisory committee.

#### **Aaron Van Oort, Partner**

Aaron is a distinguished litigator who co-chairs the Faegre Baker Daniels appellate advocacy group. He previously clerked for Justice Antonin Scalia at the United States Supreme Court. Aaron and his colleagues have teamed with the Center and our partners on a number of important appeals, including the Supreme Court case, *Mellouli v. Holder*.

### **Robins Kaplan LLP**

#### **Sally Silk, Counsel**

Sally is a member of the Center's advisory committee and serves on the pro bono committee at Robins Kaplan. The Center has invited Sally to serve as an adjunct faculty member with the Federal Immigration Clinic in 2015-16. Sally has won numerous awards for her pro bono advocacy on behalf of immigrants and refugees. She has co-counseled a number of cases with the Center and our partners, including our recent U.S. Supreme Court appeal in *Goromou v. Holder*.

### **Dorsey & Whitney**

#### **Larry McDonough, Pro Bono Counsel**

Larry coordinates pro bono work performed by Dorsey lawyers firm-wide. Before joining Dorsey in 2013, he worked for our non-profit partner, Mid-Minnesota Legal Aid, as the Managing Attorney of their Housing Unit, and also served as an adjunct clinical professor at the Law School where he directed our Housing Law Clinic. Larry serves on the Center's advisory committee.

#### **Kirsten Schubert, Associate**

Kirsten Schubert is an associate in the Trial Group at Dorsey & Whitney, and she has extensive pro bono experience litigating habeas corpus petitions on behalf of death row inmates. Kirsten now serves as an Adjunct Associate Professor with the Center's Federal Immigration Litigation Clinic and has helped us build capacity to litigate habeas petitions challenging the unlawful detention of immigrants by the Department of Homeland Security.

## **The Advocates for Human Rights**

### **Robin Phillips, Executive Director**

Robin serves on the Center's advisory committee. She is a respected human rights advocate with expertise in the areas of trafficking in women, employment discrimination, sexual harassment and domestic violence. Robin has conducted fact-finding missions to document human rights violations around the globe and has organized international conferences and trainings on human rights and NGO development issues. In addition, Robin has taught courses on human rights at the Law School and University of St. Thomas Law School.

### **Deepinder Singh Mayell, Director, Refugee and Immigrant Program**

Deepinder is a member of our advisory committee and leads The Advocates' free representation to asylum seekers and refugees. Deepinder has served as co-counsel with the Center and our partners in a number of cases, including the Supreme Court litigation, *Goromou v. Holder*.

### **Emily Good, Staff Attorney, Research, Education & Advocacy**

Emily is a staff attorney working in The Advocates' Research, Education and Advocacy Program. She is a graduate of the Law School and currently serves as an Adjunct Associate Professor with the Center's Immigration and Human Rights Clinic.

### **Michele Garnett McKenzie, Director of Advocacy**

Michele is a 1996 graduate of the Law School. She is responsible for policy advocacy and community and coalition engagement around The Advocates' priority issues, including human trafficking and refugee and immigrant rights. Michele is now an Adjunct Associate Professor at the Law School where she teaches the Center's new Immigration Education and Outreach externship course.

### **Sarah Herder, Director of Education**

Sarah is a graduate of the University of Minnesota's Hubert H. Humphrey Institute of Public Affairs. She has conducted research on many human rights topics and has also worked on legislative advocacy and community education around local and national immigration policy. She trains teachers in human rights education. As an Adjunct Professor at the Law School, Sarah also co-teaches the Center's new Immigration Education and Outreach externship course.

## **The Immigrant Law Center of Minnesota**

### **John Keller, Executive Director**

John is a leading advocate for immigrants' rights across Minnesota and the nation. He is a former Adjunct Clinical Professor at the Law School and in 2008 founded ILCM's impact litigation project, a project that would later serve as a cornerstone for the proposal to create the Center for New Americans. John has co-counseled many cases with the Center and our partners, including *Mellouli v. Holder*. He serves on our advisory committee.

**Sheila Stuhlman, Program Director**

Sheila is a 2000 graduate of the Law School and a leading expert on the immigration consequences faced by noncitizens convicted of crimes in Minnesota. Sheila also serves on the Center's advisory committee. She was co-counsel in *Mellouli v. Holder*, supervised law student participation in that case, and joined the litigation team in Washington D.C. for the oral argument in January.

**Julia Decker, Staff Attorney and Robina Fellow**

Julia graduated from the Law School in 2014. She was a student attorney with the Center's Immigration and Human Rights Clinic during her second year, a student director with the Federal Immigration Litigation Clinic during her third year, then received a Robina fellowship to work as a staff attorney at the Immigrant Law Center in Minnesota this past year. In her last year of law school Julia helped prepare the successful certiorari petition to the U.S. Supreme Court, and at ILCM she was an invaluable member of the team at the merits stage. Julia will be one of our presenters for the lunch hour session on *Mellouli*. We are extremely pleased that Julia will be returning to the Center as our next teaching fellow this summer!

**Mid-Minnesota Legal Aid****Greg Marita, Deputy Director**

Greg graduated from the Law School in 1991 and is a member of the Center's advisory committee. He accepted the position of Deputy Director of Mid-Minnesota Legal Aid's Minneapolis office in 2011 and oversees the office's immigration law unit.

**Margaret Russell, Managing Attorney**

Margaret also serves on our advisory committee and is the long-time leader of Mid-Minnesota Legal Aid's immigration unit in Minneapolis. She is widely respected for her tireless dedication expanding legal services to our state's most underserved immigrant and refugee communities.

**Rebecca Scholtz, Staff Attorney**

Rebecca Scholtz joined MMLA after clerking for the Honorable Diana E. Murphy, Circuit Judge, United States Court of Appeals for the Eighth Circuit. She is the state's leading expert on the intersection of immigration and family law as it affects juveniles, and has been a leader in our community's collective response to the recent surge of undocumented youth and families fleeing violence in Central America. The Center has invited Rebecca to serve as an Adjunct Clinical Professor in the 2015-16 school year.

Foundation : 20043

BINGER CENTER FOR NEW AMERICANS

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|                                                      | Year 1<br>2014 | Year 2<br>2015 | Year 3<br>2016 | Year 4<br>2017 | TOTAL     |
|------------------------------------------------------|----------------|----------------|----------------|----------------|-----------|
| N. Cook: 50% buy out (salary @ \$153,240)            | 108,003        | 111,244        | 114,581        | 118,018        | 451,846   |
| Ben Casper                                           | 170,800        | 175,924        | 181,202        | 186,638        | 714,563   |
| Linus Chan                                           | 170,800        | 175,924        | 181,202        | 186,638        | 714,563   |
| Co-Partner: Immigrant Law Center of Minnesota (ILCM) | 50,000         | 50,000         | 50,000         | 50,000         | 200,000   |
| Co-Partner: Advocates for Human Rights (Advocates)   | 50,000         | 50,000         | 50,000         | 50,000         | 200,000   |
| Co-Partner: Mid-Minnesota Legal Assistance (MMLA)    | 50,000         | 50,000         | 50,000         | 50,000         | 200,000   |
| Teaching Fellows (2 @\$70,000)                       | 193,740        | 193,740        | 193,740        | 193,740        | 774,960   |
| Meghan Heesch                                        |                |                |                |                |           |
| Katherine Evans                                      |                |                |                |                |           |
| Adjuncts (6 @ \$6,000)                               | 36,000         | 36,000         | 36,000         | 36,000         | 144,000   |
| Student Clinic Directors (8 @ \$2,500)               | 20,000         | 20,000         | 20,000         | 20,000         | 80,000    |
| Program Associate (@ \$50,000)                       | 70,050         | 77,055         | 77,055         | 77,055         | 301,215   |
| Outreach Activity (Includes Web based activity)      | 30,000         | 30,000         | 30,000         | 30,000         | 120,000   |
| General Supplies/Operations                          | 50,000         | 50,000         | 50,000         | 50,000         | 200,000   |
| Space Renovations                                    | 350,000        | 3,000          | 6,090          | 9,272          | 368,362   |
| SUBTOTAL                                             | 1,349,393      | 1,022,887      | 1,039,869      | 1,057,361      | 4,469,510 |

|                  |            |
|------------------|------------|
| ENDOWMENT AMOUNT | 25,000,000 |
| 4.5% payout      | 1,125,000  |



## Robina Public Interest Scholars Program & Bridge Fellowship Program

We look forward to discussing with the board two related and highly successful Robina-funded programs—the Public Interest Scholars Program and the Bridge Fellowship Program—that we hope to continue in the future with the Foundation’s support. We have invited current Robina Public Interest Scholars and alumni to discuss their experience with this program: how it drew them to the Law School and made possible the realization of their public interest career goals. We will also discuss the critical role bridge fellowships play in assisting many graduates’ transition to full-time employment. Together, these programs have positioned the Law School as a committed training ground for public interest lawyers, as well as a national model for supporting students in pursuing their long-term career goals.

### PROGRESS TO DATE AND EMERGING TRENDS

**Robina Public Interest Scholars Program:** We have just finished our third year of the Robina Public Interest Scholars Program. The program offers students scholarships, summer internship funding, post-graduate fellowships, and loan repayment assistance. With 36 current Scholars and two classes of graduated Scholars, the Program has demonstrated remarkable success in attracting to the Law School exceptionally talented students committed to public service, moving those students into public interest careers, and making those careers affordable.

- **More students now choose public interest careers.** Almost 25% of our graduates now enter public service or public interest work. This is up from just under 15% of our graduates in 2012. Additional graduates enter public service after a post-graduate judicial clerkship. *why?*
- **The Program has enhanced the Law School’s reputation for supporting public interest.** The program has attracted high-quality students who are securing competitive public interest positions. These students are deeply engaged in the School and in the local nonprofit and government community, increasing the visibility of the Law School’s support for public interest to employers, prospective students, and alumni. The Law School has supplemented the Robina Scholars program with strong experiential learning, clinical, and pro bono programs, which allow students to graduate with significant experience in their field of interest.
- **The Program has attracted other public interest donors.** The success of the Robina Public Interest Scholars Program has inspired other donors to support public interest opportunities. We have received a number of gifts for summer internships and a large gift to create the Saeks Fellowship program. The Saeks program will allow students an opportunity to work full time at a government agency or nonprofit for credit during their

third year of Law School and will ensure them a paid, year-long post-graduate fellowship at the same organization.

**Bridge Fellowship Program:** We are in our sixth year of the Bridge Fellowship Program, which provides graduates with short-term post-graduate fellowships at a government agency or nonprofit organization, launching students' careers in public service while they are waiting for bar exam results. This bridge program enables many students still seeking employment to transition successfully to high quality, full-time paid positions. Last year, we awarded 40 Bridge Fellowships to graduates and we anticipate doing so again this year.

- **Most Bridge Fellows continue in public service careers.** Almost 75% of bridge fellows enter public service careers after their fellowship ends. Many of these graduates work in states that hire public defenders and government attorneys after bar results in late fall. Other fellows obtain prestigious late-breaking fellowships, such as the Equal Justice Works AmeriCorps Legal Fellowships.

## **PROPOSED EXTENSION OF THE ROBINA PUBLIC INTEREST SCHOLARS AND BRIDGE FELLOWSHIP PROGRAMS**

The Robina Foundation's philanthropy has allowed the Law School to support passionate students as they pursue public interest careers. We are attaching proposed budgets that would extend both the Robina Public Interest Scholars Program and the Bridge Fellowship Program. The last three years has greatly increased the number of our graduates entering public service and has given the Law School a national reputation as a strong supporter of public interest careers. Funding for the Bridge Fellowship Program has already ended, and funding for the Public Interest Scholars Program will end soon. Extending both programs for five years would allow us to support even more high-quality graduates in public service work and provide our local and national public interest community with passionate, long-term leaders.

Because we believe the Public Interest Scholars program has the potential to attract even more committed students than we can currently fund, our budget requests an increase in the number of Scholars funded from twelve to eighteen.. Each year, around 60 applicants apply to be Robina Scholars, with 20-30 of them very strong candidates. Increased scholarship support would allow us to admit more students into the Law School as Robina Scholars. Our budget also requests additional funding for summer fellowships and conference funding, since we have found those components of the program to be very successful in moving students into quality public interest positions.

\* We have omitted a request for additional LRAP funding and decreased the budget line for post-graduate fellowship support, because we have found these components of the program to be less important than we originally anticipated. The program has been so successful in attracting highly talented students that the graduates are mostly finding paid public interest positions without need for Law School funding for their initial post-graduate year. Similarly, with paid employment and assistance from their own employers' LRAP programs, there is also less need for Law School LRAP support than we originally expected.

We also seek support to extend the Bridge Fellowship Program, so that we can continue to offer recent graduates \$5,000 for 400 hours of unpaid work at a government agency or nonprofit organization. Our Career Center would continue to work with individual students and employers to find strong placements for our fellows. Fellowships would begin in early fall, after the bar exam, and continue throughout the fall. We would require regular check-ins with the Law School's Career Center to provide support for the graduate's job search.

An extension of the Robina Public Interest Scholars Program and Bridge Fellowship Program would provide our committed public interest students the financial support and other resources they need to embark on transformative careers in public service.

## **Appendices**

Appendix A – Speakers

Appendix B – Proposed Budget – Robina Public Interest Scholars Program – Extended

Appendix C - Proposed Budget – Bridge Fellowship Program – Extended

## **Appendix A: Robina Public Interest Scholars Program & Bridge Fellowship Program Speakers**

### **Amanda Furst, Assistant Director of Public Interest**

Amanda joined the Career Center staff in 2012 as its inaugural public interest coordinator, a position funded by a generous gift from the Robina Foundation. Amanda is now Assistant Director, Public Interest. She manages the Law School's summer and post-graduate programs to support public interest careers, provides counseling and resources to students interested in public service, and builds relationships with public interest employers. Amanda, a 2008 graduate of the University of Iowa College of Law, started her career as an Equal Justice Works AmeriCorps Legal Fellow where she developed a Medical-Legal Partnership Project. She served as staff attorney in the Employment and Public Benefits Unit, then in the Housing Law Unit, of Southeast Louisiana Legal Services in New Orleans. She is currently the Committee Chair for Equal Justice Works' National Advisory Committee.

### **Student & Alumni Speakers**

Julia Decker, Class of 2014, Robina Public Interest Scholar & current Fellow at the Immigrant Law Center of Minnesota

Julia Zwak, Class of 2015, Robina Public Interest Scholar

Allison Kvien, Class of 2016, Robina Public Interest Scholar

Ian Jackson, Class of 2016, Robina Public Interest Scholar

Kerry McGuire, Class of 2016, Robina Public Interest Scholar

John Bruning, Class of 2017, Robina Public Interest Scholar

**Appendix B: Proposed Budget – Robina Public Interest Scholars Program – Extended**

|                                                         | <b>Year 1<br/>FY 2017</b> | <b>Year 2<br/>FY 2018</b> | <b>Year 3<br/>FY 2019</b> | <b>Year 4<br/>FY 2020</b> | <b>Year 5<br/>FY 2021</b> | <b>TOTAL</b>     |
|---------------------------------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|------------------|
| <b><u>Public Interest Scholarships</u></b>              | <b>270,000</b>            | <b>540,000</b>            | <b>810,000</b>            | <b>810,000</b>            | <b>540,000</b>            | <b>2,970,000</b> |
| Class of 2018 (12@ \$10,000 for 3 years)                | in current                | in current                |                           |                           |                           |                  |
| Class of 2019 (18@\$15,000 for 3 years)                 | 270,000                   | 270,000                   | 270,000                   |                           |                           |                  |
| Class of 2020 (18@\$15,000 for 3 years)                 |                           | 270,000                   | 270,000                   | 270,000                   |                           |                  |
| Class of 2021 (18@\$15,000 for 3 years)                 |                           |                           | 270,000                   | 270,000                   | 270,000                   |                  |
| Class of 2022 (18@\$15,000 for 2 years)                 |                           |                           |                           | 270,000                   | 270,000                   |                  |
| <b><u>Summer Internships</u></b>                        | <b>0</b>                  | <b>100,000</b>            | <b>100,000</b>            | <b>100,000</b>            | <b>100,000</b>            | <b>400,000</b>   |
| Rising 2L & 3L (20 @ \$5,000)                           | in current                | 100,000                   | 100,000                   | 100,000                   | 100,000                   |                  |
| <b><u>Post-Graduate Public Interest Fellowships</u></b> | <b>0</b>                  | <b>0</b>                  | <b>70,000</b>             | <b>70,000</b>             | <b>70,000</b>             | <b>210,000</b>   |
| (\$35,000/graduate, 2 graduates May 2018)               |                           |                           | 70,000                    |                           |                           |                  |
| (\$35,000/graduate, 2 graduates May 2019)               |                           |                           |                           | 70,000                    |                           |                  |
| (\$35,000/graduate, 2 graduates May 2020)               |                           |                           |                           |                           | 70,000                    |                  |
| <b><u>Program Support</u></b>                           | <b>0</b>                  | <b>86,688</b>             | <b>94,188</b>             | <b>96,688</b>             | <b>99,188</b>             | <b>376,752</b>   |
| Program Coordinator 100% full time                      | in current                | 86,688                    | 89,188                    | 91,688                    | 94,188                    |                  |
| Conference funding and other networking activities      | in current                | in current                | 5,000                     | 5,000                     | 5,000                     |                  |
| <b>TOTALS</b>                                           | <b>270,000</b>            | <b>726,688</b>            | <b>1,074,188</b>          | <b>1,076,688</b>          | <b>809,188</b>            | <b>3,956,752</b> |

[illegible][illegible]

4/28/15 Alma Abbott

Jenny W.

Transform HC as we know it.

Challenge - fin. success doesn't necess. track <sup>of</sup> health of patients.

Strat

- ① Use org to align payment better w/ outcomes
- ② Use info - put in hands of those who need it. Caregivers etc. Give patients tools

Change  
Care  
model.

- ③ Foster <sup>principle</sup> rel. of patients w/ docs. Prim. care - from chg care model & primary care.
- ④ Mental health
- ⑤ Support for people in late life. Serve diverse grps.

Come from position of strength - readmission rate = low. Doing fairly well financially. Gives stature to elevate wk of LC.

BBW - Hosp. evolving. Tradition of innovation. Extend reach of Abbott. Tech. expert. but also compassion. Extend beyond walls.

Big unit - Primary Care Teams

HC - Benchmarking w/ others -

Hospice - # of days

Hosp - # of days - last 6 mos

Avail of palliative care  
Key orgs - Kaiser (7 models)

End of life scorecard - Allins  
Prer of Gunderson  
Adv. care planning

PK - suff. understandg of what's going on elsewhere?  
= Center of Adv. Palliative Care - LC there every

yr.  
EA - looks at others

SS - key platforms: Dartmouth  
↳ measuring

Not tech. prob = cultural prob. Need to talk abt  
end-of-life ↳ slower to change  
Care coordination is not cheap - need to scale  
operations up.

SL - LC - wks w/ faith grps  
lawyers + financial adv. - wld be gd prers.  
Allins - gd. connector

## LC Overview

EA

- LC - re-imagine care.

Needed to trans relationships

Do away w/ pt. + families & control

LC - not for the sickest

HBrutt - River analogy

PB - NAC comments - No mems

Eric Coleman - goals of indiv.

Lynne

Meier → imp. b/c w/leg of people who aren't  
in hosp. or hospice

EIA -

Context

→ Rt time to make LC pt. of care.

Dying  
America

> MMA - imp. docs. understanding  
MM Bar int. - end-of-life issues  
Diane M - palliative care = forevercare

SS

> Can be done. How do? Need sustainable  
approach. Care Guide - interdiscip team.

Others doing similar wk but in trad. setting.

IOM Rept. Imp.

Family

Rt. ed. + training

Policy

LC interventions: High touch / High tech

What matters?

Whole person

Care guide - structure: 1/mo.

Other orgs doing but short-lived. LC - over long time.

Not giving less care  
Doing things before crisis

Health equity - whole person gets to culture

PK - for assess status of ~~pop~~ patients

SS - structured approach of ?s

PW-

EA-

Deliverables - structure for CG - 4 visits over  
domains Focused interview. Trainable / transferable /  
Sustainable

What  
matters  
most?

① Fund of health ② Supp Sup. ③ Concerns ④ Adv  
care planning ⑤ Assess tools re cognition  
larger # of pat. / CG

HB-

What learned?

Q of life

care exp

Sep. outcomes - hosp. visits, etc. lower costs

Seeing savings

What isn't working -

Wanted bigger imp on fr. + fam. Decrease of  
anxiety

SB - Diff based on nursing home vs home or  
ethnities

Dementia - start at lower qual. of life

HB - Drop Off - enrollment -

382 - total pat.

240 - active (68%)

142 - inact.

Reasons - 69 died; pat. change - 31 (8%); prog demands - 14 (4%)  
8 - didn't re-consent (2%); 5 (1%) ~~data~~ too much data;  
5 - not elig. (1%); KFF dec - 4 (1%); other -

Research activity

Ask CR re: predicted drop-outs

Patients = sick enuf. (w-morbidity)

> Nursing Home - 15%

SS: Expected vs. Results

SL: Diversity: Among

\* ↳ SB - What is goal?

PK - Next step + expansion -  
Form pshups

Scott Flissta

5 yrs ago - Team Care: 3 nurses, 2 docs  
Goal - more eff.

## Adv. Care Directives

## Allms Board??

18 mos. ago - Shared Panel model. Goal - hi qual, deliver qual. care. 2 nurses

1 yr. ago - Primary Care. \$30M to re-invent.

Personal  
Primary  
Care Team

Fall - design mtg. How wlk today, how need to wlk

Major Goal - Best place to for care

Team of 7 : Need: ① new culture ② bld team

③ chg way wlk ~~clinical~~ clinical asst. Continuity loop = key  
Care management : clinical asst + provider +  
patient. broader

Primary Care = fdn. for integrated care.

7 ~~team~~ doc, n.p., m, 4 cl. assts

RN = rich. Care moment role → Care Guide

Care Guide - may be added - phase 2. ? = where fit

Personal relationship

PWR - CG being dissem in various way.

BBW - Cld CNA <sup>may take on</sup> ~~become~~ CG. role.

How anchor LC w/in All<sup>ne</sup>?

LC Impact

June 3

4/28/15 Salovey  
Engineering - small

Bio Eng } good  
Env. Eng }

Computer Sc. - in demand

Merged into Eng. Adds 20 profs to Eng  
Focuses hiring on comp. sc.

Big Ideas - Excited for all

Started late 1970s → ① Sch. of Mgm - differentiator  
Vision - most interest.

Break even: 4 charges SOM for has to  
raise \$

② Forestry - diversifying, env. justice  
Science + public policy

Inst for  
Network  
Science

③ Yates - Nicholas C - rainmaker

Uses network to solve social problems

Got start-up \$. To wk on press, must raise \$

④ David Blight - Slavery. Spectacular tch.

Fundg running out, but Yates wants to continue

⑤ Law School → Sustainable? Strategy?

COAP

SL - Matching grants?

PS → Fundraising capacity of ↑

INS - Fdn support. .com world

Forestry - undergrad int.

Match from Yates End?

4/29/15

DW - 22%  $\rightarrow$  77% State Aid

Tuition  $\rightarrow$  50k

Debt - 90-100k debt

30k jobs 46k graduates

Class size 190 (down from 240?)

More transfer studs.

Masters - Patent law

Minor for Bus studs - possible

Fed. Loan Progs. -

Can cap loan payments - pub. interest  
10 yrs. - debt forgiven (taxable event)

Bridge Fellowship Progs. - very helpful - \$  
Alabama ended

Public Int. Sch. - gd for recruiting

Center for New Americans - 4 yrs. 3 yrs - benchmarks

Amanda Furst -  
Public Int.

Center for New Americans

Creating comprehensive "firm" to work w/ immigrants

law firms -  $\geq \$1M$  probono w/  $\sim 1$  yr.

Model - 1<sup>st</sup>, compr. center. Compr. reach

Comprehensive + continuity

Scale + reach across field + profs (rather than adjuncts)

Entity permits new collaborations

Wholistics

Law firm - new apps

SL - Mechanics of oper. of  $\$$  Center - Wkg out this.

Overtime - prob more structure.

Goal = involve more law firms.

Apps filtered thru set of priorities

Students see range of situations

Center <sup>is</sup> creating momentum.

Center unique b/c focuses on systematic change

Developing practitioners guide

Robens doing Sommer Project

Center create generations of students in  
unim law

Robina Foundation Listening Session  
Allina Health  
Agenda  
April 28<sup>th</sup>, 2015

| Timing      | Topic                        | Lead           | Team                               |
|-------------|------------------------------|----------------|------------------------------------|
| 8:00-8:15   | Welcome ( <i>Breakfast</i> ) | Penny Wheeler  | All                                |
| 8:15-8:45   | Strategic Overview           | Penny Wheeler  | Ben Bache-Wiig<br>Tim Sielaff      |
| 8:45-9:45   | LifeCourse Overview          | Eric Anderson  | Heather Britt<br>Sandy Schellinger |
| 9:45-10:00  | Break                        |                |                                    |
| 10:00-11:00 | LifeCourse Integration       | Ben Bache-Wiig | Scott Flaata<br>Tim Sielaff        |
| 11:00-12:00 | LifeCourse Impact            | Heather Britt  | Paige Bingham<br>Kim Radel         |
| 12:00-1:00  | Discussion ( <i>Lunch</i> )  | Penny Wheeler  | All                                |



LifeCourse<sup>TM</sup>  
*Listen. Honor. Guide.*

# Building New Teams for Late Life Care: Lessons From LifeCourse

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## Abstract

This article details team development within a longitudinal cohort study designed to bring team-based, whole person care early in the course of serious illness. The primary innovation of this approach is the use of nonclinically trained care guides who support patients and family members by focusing care around what matters most to patients, linking to resources, collaborating with other providers, and offering continuity through care transitions. By describing the development of this team, we document the kinds of questions others may ask during the process of team creation.

## Keywords

teams, interdisciplinary, hiring, training, innovation, support

## Introduction

Hospice is frequently thought to be the “gold standard” in team-based end-of-life care. It is the most comprehensive, high touch model in the last weeks to months of life, improving the experiences of patients and their family members.<sup>1</sup> One of the central tenets of hospice care is an interdisciplinary team approach that includes physicians, nurses, chaplains, social workers, home health aides, and other staff, who work with patients’ caregivers and existing providers to develop a holistic care plan.<sup>2</sup> Interdisciplinary teams are able to provide comprehensive care when they integrate diverse expertise, share responsibility for care that includes medical and nonmedical needs, create a productive team culture, and are able to sustain a commitment to care through their working relationships with one another.<sup>3-5</sup> Patients and their family members benefit from the use of team-based holistic care focused on understanding individuals’ own values, goals, and preferences as medical and nonmedical needs arise.<sup>6</sup>

A limitation of hospice team-based care, however, is that through Medicare reimbursement, it is restricted to persons expected to live 6 or fewer months. Given the benefits of hospice and demographic changes to the United States that will sharply increase the proportion of Americans living with serious illness, some have argued for moving hospice and palliative services earlier in the course of illness.<sup>7</sup> These attempts have primarily focused on separating palliative care from end-of-life and integrating the palliative approach across the life course.<sup>8,9</sup> Earlier implementation is often hindered by the cost of team-based care and limitations on reimbursement for individuals who are still seeking curative therapies along with palliation.<sup>10-13</sup>

Is it possible to design a team-based approach that closes the gap between when one might benefit from a hospice-like approach and when they are eligible? Might this team use the tenets of hospice and palliative care, but avoid feasibility issues? This article documents one such attempt, called LifeCourse, highlighting challenges and opportunities in the process of forming, hiring, training, and working with this team, as well as reaffirming why creative thinking is necessary given current health care challenges.

## Team-Based Care

In considering how to implement teams earlier in the lives of patients, several unanswered questions become apparent. Definitions of teams vary widely across settings and studies, as does the terminology used to describe them.<sup>14,15</sup> Although hospice and palliative teams are typically called interdisciplinary, other health care teams have adopted terms like transdisciplinary, multidisciplinary, or collaborative instead. Subtle distinctions exist between these terms; however, most studies of teams do not provide enough detail about the structure of the team or the context under which the team works to fully understand what makes some team approaches work better than others.<sup>16,17</sup> Furthermore,

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