StratisHealth
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QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2019

Converging on Improved Care for People with Serious Illness

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President and CEO, Stratis Health

The Stratis Health team is cheering the convergence of interest and activity in improving care for those with serious illness.

Stratis Health has a deep-rooted emphasis on improving care for seniors and for underserved populations, who together make up many of those with serious or advanced illness. We have long worked to change care delivery and payment to better support these patients. Through our Medicare quality improvement efforts, our rural palliative care initiatives, and many projects aimed at addressing one or more chronic conditions, we have been a leader in this area. We are excited about the increasing momentum and attention. I'll share a few examples of where interest and activity are converging.

The Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine) launched a Roundtable on Quality Care for People with Serious Illness in 2016, addressing a range of policy and research issues. This highly regarded group prioritized five areas:

1. Delivery of person-centered, family-oriented care
2. Communication and advance care planning
3. Professional education and development
4. Policies and payment systems
5. Public education and engagement

Workforce needs in serious illness care are its 2019-2020 priority.

The Agency for Healthcare Research and Quality (AHRQ) is currently shaping its strategy and resources to address patients with multiple chronic conditions. Jane Pederson, Stratis Health's chief medical quality officer, was selected to be an Aging and Health Policy Fellow this past year by the John A. Hartford Foundation. Her project placement with AHRQ aligned with its planning for multiple chronic conditions. Jane brings her national-level insights to all of Stratis Health's initiatives.

Medicare has developed new payment options increasingly intended to reward value and quality in caring for those with serious and advanced illness. This shift started with the care coordination codes in the physician fee schedule available a few years ago and continued with the growing number of ACOs with serious illness programs. Now, the movement is toward the new Primary Care First Model launching in 2020, which has a serious illness focus.

The Coalition to Transform Advanced Care (C-TAC) has been building its programs and policy agenda in recent years. Its annual summit in Minneapolis this October shined a spotlight on innovative approaches in serious illness care in Minnesota.

And if I could get a drumroll please…at the C-TAC summit, we were thrilled to announce the formation of a Minnesota serious illness coalition, led jointly by Stratis Health and the Minnesota Network of Hospice and Palliative Care. Stay tuned for more details as the coalition develops.

THIS ISSUE

The Genevive Family Conference

Supporting Patients with Serious Illnesses

Perspective from
Ruby Schoen
Stratis Health Board member

The family conference is an important part of Genevive's philosophy, as our geriatric medical practice and care management organization provides comprehensive care for 5,500 older adults in Minnesota. Our expert, compassionate value-based primary care and care coordination have a proven track record of improving quality outcomes.

Our family conference is a structured five-step process led by the physician and nurse practitioner team in conjunction with the patient and family. The discussion aims to identify patient-centered goals of care, negotiate reasonable acute care plans, and review the chronic care plan considering the identified goals.

> Our family conference is key to establishing individualized goals of care.

A family conference is offered to all our long-term care and home-based patients. We provide care to a large population of people enrolled in publicly subsidized health care programs, many with a complex interplay of multiple co-morbidities. These conditions make treatment decisions difficult and create a fine balance of risk versus benefit in any chosen management plan.

Patient centered

During the conference, we talk through complex medical decisions in the context of the patient's personal choices, reducing the need to make rushed, less-informed decisions during a crisis. We use coaching techniques, like asking "If you could go back in time to when your Mom was living independently 10 years ago and gave her a crystal ball, and she could see her current life, how would she want us to treat her?"

An advance care plan (ACP) is written to ensure patients receive care that reflects their values, goals, and preferences.

Improve health care and lower costs

Reducing hospital readmissions, improving quality of life in advance illness, and deprescribing are national priorities for payers, providers, and policy makers seeking to improve health care and lower costs.

The family conference addresses all these concerns, while personalizing treatment decisions for each patient.

During a Genevive family conference, we elicit goals of care to improve end-of-life. We discuss with patients and families recommended tests and procedures, and discourage superfluous ones. This can reduce excessive or unwanted medical treatment, tests, and procedures, especially those that do not alter the outcome or improve quality of life.

We discuss the potential of reducing medications to focus only on those that meet patient goals and are of benefit considering the patient's clinical profile and functional status. Polypharmacy is problematic in our older patient population, and decreasing their drug use has both medical and economic benefits.

Structured for patient-centered care

Genevive's innovative clinical model incorporates clinician ACP education and allows time to facilitate family conferences. We are paid on how well our patients are managed, and patient volume is not the primary driver.

Our patient-centered family conference is key to establishing individualized care plans. This engagement has been shown to improve clinical outcomes and quality of life.

Genevive's mission is to treat patients like they are our own loved ones. It's rewarding to know we are following patient wishes and goals of care that are consistent with their beliefs. The goal is not to cure, but to provide comfort and maintain the highest possible quality of life through the end.

Family Conference Five Steps

Together, Genevive clinicians, patients, and family talk through these steps.

1. **Tell the Story:** Ask the patient to share their journey from independence to dependence.
2. **Summarize:** Reflect back the big picture of the patient's story.
3. **Elicit Goals of Care:** Confirm the patient's current quality of life and prognosis, then elicit goals of care with simple hope statements and focusing on patient preferences.
4. **Write an Advance Care Plan:** Write orders for an acute care plan on the POLST form.
5. **Review the Chronic Care Plan:** Discuss the agreed-upon goals of care and the risk-benefit of all interventions. This includes reviewing labs and appropriate subspecialty interventions, and potentially deprescribing medications after assessing for indication, efficacy, safety, and cost.

Ruby Schoen, APRN, CNP, is a member of the Stratis Health Board of Directors. She is medical director and geriatric long-term care nurse practitioner at Genevive. Genevive is a stand-alone organization co-owned by Allina Health and Presbyterian Homes & Services.

Multiple Chronic Conditions Require Us to Restructure Health Care Delivery

Jane Pederson, MD, MS
Chief Medical Quality Officer, Stratis Health

Caring for individuals with multiple chronic conditions will require fundamental changes to our health care system. The current health care model is ideally suited to address conditions that generally result from a single cause. Current evidence and many of the tools, such as clinical guidelines, are single disease focused. Simply applying multiple single disease-focused guidelines to an individual with multiple chronic conditions leads to a lack of coordinated care and increases the potential for adverse outcomes such as medication interactions.

Chronic condition management needs to extend well beyond continuing care over time. There are social and psychological elements to living with a chronic condition—a greater impact on family and caregivers, financial burdens, as well as employment and lifestyle considerations. Addressing these broader needs over time requires a team-based approach to care that can draw on the skills of clinicians, as well as other disciplines in the community.

The mismatch between our current model of care and the needs of a growing number of individuals with multiple chronic conditions calls for new approaches to care that support ongoing monitoring and management of chronic conditions with the goal of optimizing quality of life and wellbeing.

Patient leadership

One of the biggest shifts that needs to occur in the management of multiple chronic conditions is who is setting the goals of care and leading the health care team. In the management of acute conditions, leadership falls to the clinicians who diagnose the problem and stabilize the acute disease process by initiating treatment. In chronic conditions, leadership of the health care team needs to transfer to the person that is intimately impacted by the chronic condition—the patient. This paradigm shift is well beyond what is often referred to as patient engagement. Patient leadership means the individual sets the goals of care, guided by other members of the health care team who apply their knowledge, expertise, and access to services to achieve those goals and adjust them over time.

New care delivery approaches

This shift requires many other new ways of thinking about care delivery, including:

- **Location of care.** People live with and manage multiple chronic conditions in their homes and workplaces, not in a clinic exam room. To best support the person with chronic conditions, team members need to make recommendations in the context of the patient's life. The team needs to go to the patient, instead of the patient coming to them.
- **Coordinated and consistent communication.** Electronic record systems must communicate fully and efficiently. Patients need ready access to all team member communication, which means documentation supports care-related communication. Language influenced by billing requirements often is not in line with what the patient needs or wants.
- **Predictive data.** Real-time patient derived data combined with historical data from the health care record should be used to monitor chronic conditions to stave off the need for interventions. The health care team's workflow must be designed to support prompt identification and intervention.

> We have a mismatch between our current model of care and the needs of a growing number of individuals with multiple chronic conditions.

- **Optimizing individual care.** An evidence base and performance measures are needed to optimize care for individuals rather than single disease states. Research is needed to determine how resources, such as clinical guidelines, can address multiple chronic conditions. Performance measures need to be restructured to remove disincentives for clinicians to optimize care for individuals with multiple chronic conditions.
- **Remote access.** Technology should be used to eliminate barriers to communication. Some patients have challenges meeting face-to-face with members of the health care team because of distance or lack of transportation. Workflow and reimbursement must adapt to make the use of remote technology, such as video conferencing, common practice.

Positive changes are occurring in the health care system to improve the care for individuals with chronic conditions, and payment models are evolving to meet these needs. Putting the patient in a leadership role on the health care team and creating models where team members work in conjunction rather than in a vacuum or at odds with one another will require significant changes in how team members work and interact with each other. The growing number of individuals with multiple chronic conditions necessitates accelerating progress toward well-coordinated care that is aligned with the individual's goals of care.

How National Leaders Are Approaching Chronic Conditions

Six in 10 adults in the U.S. have a chronic disease, and four in 10 have two or more. In high-income countries, approximately 75 percent of deaths are caused by progressive advanced chronic conditions.

Costs for direct health care treatment of chronic health conditions in the U.S. totaled $1.1 trillion in 2016, according to the Milken Institute. Adding the indirect cost of lost economic productivity bumps the total cost to $3.7 trillion.

Many chronic diseases are caused by a short list of risk behaviors: tobacco use and exposure to secondhand smoke, poor nutrition, lack of physical activity, and excessive alcohol use.

Obesity: the greatest risk factor

In January 2019, a think tank of The Aspen Group, including Kathleen Sebelius and Tommy G. Thompson, declared that "obesity is the primary driver of our chronic disease crisis."

Obesity is by far the greatest risk factor contributing to the burden of chronic diseases in the U.S. For the fastest growing chronic diseases, like diabetes and hypertension, their causes are rooted in obesity.

Obesity is underdiagnosed, making it difficult to manage as a comorbidity. A 2016 Cleveland Clinic study found that one in four patients with morbid obesity did not have a formal diagnosis. "Obesity is very prevalent and yet underdiagnosed, which is one of the top barriers to patients getting the best care," said Bartolome Burguera, MD, director of Obesity Programs at Cleveland Clinic. More effort should be focused on helping patients with the primary problem of being overweight.

Health care: the right culture

An organizational culture that supports quality improvement and supportive managerial and medical leadership are two of the top facilitators of chronic care management processes cited by leaders of physician organizations.

A consensus is forming, based on evidence and outcomes, that person-centered care is needed to drive better outcomes and lower utilization costs. Organizations employing patient-centered models of care are improving the quality of care for patients with multiple chronic conditions.

Patients with both physical and mental health diagnoses included in an accountable care organization (ACO) report better physical functioning when the practices have patient-centered cultures. Medicaid beneficiaries with multiple chronic conditions enrolled in a Patient Centered Medical Home were more likely to receive eight recommended disease-specific mental and physical health services. In Minnesota, clinics participating in the Health Care Home model of care outperformed other clinics on quality measures.

An expert panel of the American Geriatrics Society identified eight key elements of person-centered care (see sidebar). When The Commonwealth Fund analyzed promising care models for adults with complex needs, nearly 70 percent of the models incorporated all eight key elements. More than 80 percent had at least seven.

The top three challenges to chronic disease management identified by executives, clinical leaders, and clinicians directly involved in health care delivery, noted in a NEJM Catalyst report, were lack of time for clinicians to see patients with chronic conditions (selected by 44% of respondents), insufficient care coordination to ensure best outcomes (39%), and lack of patient resources for self-management (27%).

To remove these barriers, patient-centered cultures need to be supported by payment

Key Elements of Person-centered Care

- Individualized, goal-oriented care plan based on a person's preferences.
- Ongoing review of a person's goals and care plan preferences.
- Care supported by an interprofessional team in which the person is an integral team member.
- One primary or lead point of contact on the health care team.
- Active coordination among all health care and supportive service providers.
- Continual information sharing and integrated communication.
- Education and training for providers and, when appropriate, for the person receiving services and those important to that person.
- Performance measurement and quality improvement using feedback from the person receiving services and their caregivers.

models that allow clinicians to prioritize disease prevention over treatment. Organizations with larger revenue and infrastructure can be proactive in treating chronic diseases because they have more-comprehensive programming and are more able to take risk in pilot programs. Smaller health care delivery organizations may not have the scale or resources to be as proactive, indicated Eric Weil, MD, director of population health at Beth Israel Deaconess Medical Center, in the NEJM report.

Chronic care management is facilitated by an organizational culture that supports quality improvement.

Organizations working in value-based care models are more likely to be providing proactive and preventive care versus reactive care. Value-based care and capitated models, and direct payment for chronic care management services, like Medicare reimbursement, are allowing health care organizations to offer more proactive patient care for chronic diseases.

Individuals: removing barriers

Seven in 10 Americans say chronic diseases are usually due to factors and circumstances beyond a person's control, according to a 2018 Kaiser Health Tracking Poll. Health care organizations are building workflows to identify patient risk factors based on social determinants, such as socioeconomic and physical environment factors, then link patients to resources that can address these issues.

"Several companies are pilot testing tools and methodologies for health care organizations to calculate return on investment for addressing social determinants of health," said Sue Severson, Stratis Health vice president of health information technology. "We are excited to be weaving these tools into our work with health care organizations."

The same Kaiser poll indicated that half of respondents say individuals themselves should play the largest role in preventing chronic disease. Behavior change is hard, which makes personal care plans all the more important for activating and engaging patients. Facebook uses 98 personal data points to target ads. Organizations should assess whether they use enough individual data to build personal care plans.

Health care staff need to be skilled at eliciting what matters to each individual and be able to connect how a patient's health supports their quality of life. Staff also need to be able to assess a patient's confidence in their ability to change behaviors and address perceptions of their capability. Individualized, goal-oriented care plans that break big goals into near-term achievable sub-goals can build patient confidence to continue their path to increased wellness.

Studies indicate that more than 10 hours of patient self-management support is beneficial to improve chronic conditions. The health care industry needs to find the most effective ways to target that support.

Several organizations are exploring the use of composite data about individual behaviors, feelings, and beliefs to tailor interventions for chronic disease prevention and management. Gathered from extensive interviews, this data is used to develop a set of patient personas, fictitious people who characterize patients with significant similarities. Interventions are then built or bundled to meet the needs of those representative personas to accelerate patient support. Patients might equate to a Struggling Sam or a Coping Clare, two of The Commonwealth Funds personas for individuals with three or more chronic conditions. Participants using persona-tailored learning have reported high levels of satisfaction with their online user experience and increased levels of activation about their health.

New and focused approaches to reduce the burden of chronic conditions are imperative for the health of individuals and for the health of our country.

IN BRIEF

New Serious Illness Coalition Launching in Minnesota

The Minnesota Network of Hospice & Palliative Care and Stratis Health announced a joint commitment to launch a new Minnesota serious illness coalition during the 2019 Coalition to Transform Advanced Care (C-TAC) Summit in Minneapolis, on October 9.

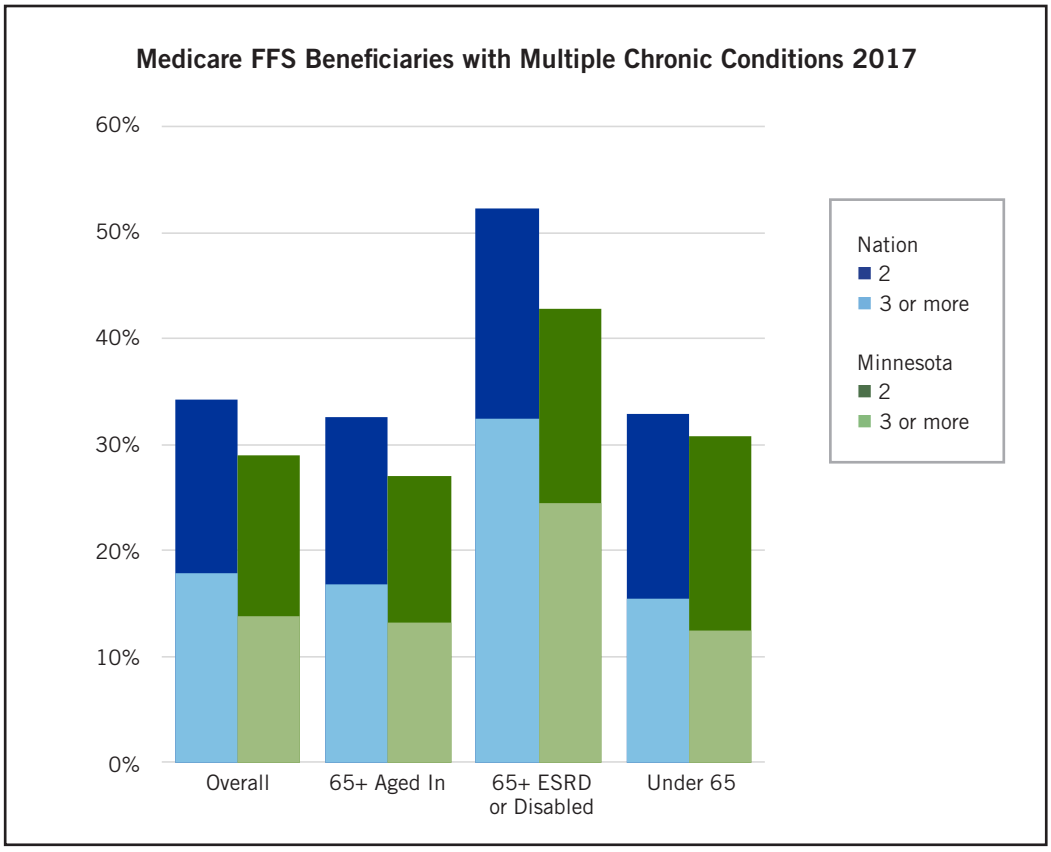
Minnesota's coalition will bring together stakeholders who are working independently on serious illness activities to create a unified statewide vision to improve care for the seriously ill. It will be a valuable source of information for education and awareness building, as well as provide a vehicle to drive advocacy, legislation, and regulation. The coalition will tackle big issues that cannot be addressed by one organization alone.

Currently, eight states have similar statewide coalitions. In addition to Minnesota, four others are interested in starting one.

Stratis Health is a member of C-TAC, an alliance of more than 140 national health care stakeholders dedicated to the idea that all Americans with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person-centered care that is consistent with their goals and values, and honors their dignity.

C-TAC has identified key areas across the nation that could benefit from state-level activity on serious illness, including: requiring education, outreach and referral to palliative care in inpatient and long-term care settings; addressing workforce and skills shortages; insurance coverage of palliative care; having clear payment mechanisms; beefing up collaboration with public health on awareness building and education; ensuring practice standards are implemented across care delivery settings; and implementing quality metrics.

Looking at the numbers: Medicare Beneficiaries with Multiple Chronic Conditions



Source: Medicare Quality Innovation Network National Coordinating Center, Medicare Snapshot: Chronic Conditions by Entitlement Category among Full FFS Beneficiaries in 2017.

In a snapshot of Medicare data for multiple chronic conditions for calendar year 2017, Minnesota fares better than the nation. Although the state's 375,864 fee-for-service (FFS) beneficiaries have lower rates of multiple chronic conditions than the national average, they carry a significant disease burden.

Chronic conditions in this analysis included diagnoses of Alzheimer's disease and dementia, coronary artery disease, congestive heart failure, chronic kidney disease (CKD), chronic obstructive pulmonary disease, cerebrovascular disease, prediabetes and diabetes, and mental health.

Nationally, 34 percent of all FFS beneficiaries have at least two chronic conditions compared to 29 percent in Minnesota. With a difference of five percent, Minnesota's population carries a lower disease burden. For FFS beneficiaries with three or more multiple chronic conditions, the gap narrows to four percent, with 18 percent nationally and 14 percent in Minnesota.

Of all FFS beneficiaries who have two chronic conditions, approximately half of them in both the U.S. and Minnesota have three or more of these health issues to contend with.

FFS beneficiaries 65 and older who have end stage renal disease (ESRD) or a disability status have far higher rates of multiple chronic conditions than their peers.* They are 20 and 16 percent more likely, respectively, to have two or three or more multiple chronic conditions. In Minnesota, they are 11 and 16 percent more likely. Diabetes and hypertension are strongly associated with CKD and ESRD.

Chronic conditions a Medicare priority

With more than a third of Medicare FFS beneficiaries living with two or more chronic conditions, Medicare has made increasing chronic disease management one of its five priority national quality improvement aims.

Interventions focused on prevention and treatment of diabetes and hypertension could have a significant impact on reducing the number of people who have multiple chronic conditions.

*FFS beneficiaries 65 and older excluding people with ESRD or disability status.

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety.

Latest News on the Medicare Quality Program

The Centers for Medicare & Medicaid Services (CMS) launched its next five-year Quality Innovation Network-Quality Improvement Organization (QIN-QIO) program cycle on November 8. The work is planned to run November 2019 through November 2024.

Stratis Health, as part of the Superior Health Quality Alliance, will work in Michigan, Minnesota, and Wisconsin, to advance CMS's priority national quality improvement aims:

1. Improve Behavioral Health Outcomes, focusing on decreased opioid misuse
2. Increase Patient Safety, including reducing adverse drug events
3. Increase Chronic Disease Management, focusing on cardiac/vascular health, diabetes, and chronic kidney disease
4. Increase Quality of Care Transitions, including reduced hospital readmissions
5. Improve Nursing Home Quality

This work includes a major focus on rural and underserved populations and communities, as well as patient and family engagement. QIN-QIOs across the country will initiate improvement efforts focused on quality and patient safety at the community level. Facilities across the continuum of care—hospitals, clinics, nursing homes, home health agencies, pharmacies, and others—are invited to participate. Superior Health is engaging with stakeholders and partners in our region to align with ongoing initiatives and priorities.

Initiatives will foster better coordination and communication between organizations and among clinicians, as patients transition from one setting of care to another. Several specific large-scale goals are outlined for the work. Community coalitions will improve quality of care for the majority of Medicare beneficiaries in the region, and at least half of those beneficiaries will represent rural or underserved populations. The work aims to increase access to behavioral health services for people who need but are not currently receiving them. QIN-QIOs will work with at least 70 percent of the nursing homes in their regions. Person and family engagement will improve, as measured by patient activation.

Stratis Health will be reaching out in the next few months to health care organizations and other stakeholders to participate in and support these quality improvement initiatives.

Clinician Quality Improvement

Medicare also is launching a clinician quality improvement initiative, which will address Aims 1-4. Stratis Health, as part of Superior Health, has submitted a proposal to lead a portion of this work. CMS's clinician quality initiatives may be state-based in approach than the QIN-QIO initiatives and more focused on affinity groups with similarities in practice, such as rural or associated with a health system.

We expect these CMS awards to be announced late 2019, with actual work to begin in winter 2020.

Superior Health Quality Alliance

Superior Health Quality Alliance aims to improve the quality of health and health care for health care consumers, patients, clinicians, health care organizations, and communities. Superior Health is a consortium of eight organizations with proven success driving achievement of Medicare quality improvement program goals. The members are Illinois Health and Hospital Association, MetaStar, Michigan Health & Hospital Association, Midwest Kidney Network, Minnesota Hospital Association, MPRO, Stratis Health, and Wisconsin Hospital Association.

SUPERIOR HEALTH Quality Alliance

Through Superior Health, Stratis Health continues our long-standing tradition of improving quality of care for Medicare beneficiaries.

Superior Health Quality Alliance website: www.superiorhealthqa.org.

STRATIS HEALTH NEWS

Jennifer Lundblad and Craig Svendsen, board chair, recognize outgoing board members Gary Wingrove (top center), Beth Monsrud and Myron Falken.

The Minnesota Community Health Worker Alliance (MNCHWA) has strengthened its internal capacity by working with Stratis Health. Now co-located with Stratis Health, MNCHWA gains dedicated office space and leverages our administrative services. With this new arrangement, the two mission-aligned organizations will work more closely together, strengthening their relationship, and possibly pursuing collaborative programming.

National Virtual Quality Improvement Mentors named by Stratis Health. Eight leading critical access hospital (CAH) quality improvement staff will serve as virtual mentors through a new initiative that aims to broadly transfer knowledge from leading CAH quality improvement staff to others across the country. The initiative is organized through Rural Quality Improvement Technical Assistance (RQITA), a program of Stratis Health supported by the Federal Office of Rural Health Policy (FORHP).

Stratis Health thanks outgoing board members Connie Delaney, dean of the School of Nursing at the University of Minnesota; Myron Falken, retired epidemiologist at the Minnesota Department of Health and former director of the Isanti/Mille Lacs County Public Health Agency; Beth Monsrud, senior vice president and chief financial officer of UCare Minnesota and Gary Wingrove, president of the Center for Leadership, Innovation and Research in EMS and government affairs specialist of Mayo Clinic Ambulance Service.

Sarah Brinkman, Stratis Health program manager, was selected for the National Rural Health Association's Rural Health Fellows Program of 2020. This is a year-long, intensive program that develops leaders who can articulate a clear and compelling vision for rural America.

Mary Lou Haider retires from Stratis Health after nearly 20 years of service as vice president of contract management and internal quality. We will miss her leadership in connecting Stratis Health and CMS in our Medicare Quality Improvement Organization (QIO) work.

Kim McCoy, Stratis Health senior program manager, was selected by Superior Health Quality Alliance to lead its new Medicare Quality Innovation Network-QIO work.

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works toward its mission through initiatives funded by federal and state government contracts, and community and foundation grants, including serving as Minnesota's Medicare Quality Innovation Network - Quality Improvement Organization.

Stratis Health works with the health care community as a quality improvement expert and clearinghouse, educator and trainer, consultant and supporter, convenor and facilitator, and data resource.

Contact us to see how we can assist you with your quality improvement needs. Call 952-854-3306 or 1-877-787-2847 (toll-free) or email us at info@stratishealth.org.

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