StratisHealth

QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2011

The Effect of Health Reform

Jennifer P. Lundblad, PhD, MBA
President and CEO, Stratis Health

"How has health reform affected your organization?" Fielding this question at a recent panel discussion prompted me to reflect on how Stratis Health is working differently today within the rapidly changing context of health care. Compared to even two years ago, we have...

A sharpened focus on value. For most of our 40-year history, Stratis Health has focused on clinical and organizational changes that improve health and health care quality, with payment and cost issues on the periphery. Today, improving value is central to our work—the combination of cost, quality, and experience that we have come to know as the Triple Aim. Stratis Health's efforts help health care providers across the continuum of care be successful in a value-driven environment, whether through technical assistance in data collection and reporting, using data to drive improvement, or leading organizations through clinical and organizational change.

Reframed our work across the continuum of care. Stratis Health has long worked across the continuum of health care—acute care, primary care, nursing homes, home health care, among others; but our work often reflected the silos of care delivery. Today, we are leading efforts to put communities and patients at the center of care improvement and break down the silos. Our rural palliative care initiative focuses on building community capacity. In our recently launched Medicare adverse drug event project, we first identified a group of patients with multiple chronic conditions and medications, then developed a project based on their network of providers across settings of care.

Our work now actively encourages providers to include the patient and family as valuable members of the team, identifying their wishes and needs, jointly developing a care plan, and empowering them to make decisions and be active in their health care.

Intensified our role as a trusted interpreter of federal policy and programs to local needs and opportunities. Stratis Health works to serve as a proactive information resource regarding local and national health care quality priorities. In addition to the two federal programs we lead locally—the Medicare Quality Improvement Organization and the Health Information Technology Regional Extension Center, today, we are in the know about the wide range of initiatives and opportunities rapidly emerging from federal agencies. Lately, this has been a lot about the Centers for Medicare and Medicaid Innovation, Partnership for Patients, and proposed health reform rules on ACOs and health insurance exchanges. Initiatives also include HRSA's Medicare Beneficiary Quality Improvement Project, the CDC's healthcare associated infection efforts, and AHRQ's national quality reports. We are a resource for providers, partners, and policy makers, wisely interpreting federal policies and programs, while serving as a conduit for local innovation and feedback to federal agencies and policy makers.

The first two changes in Stratis Health's work enable the providers we work with to build a foundation that supports success in a redesigned health care system, including shared savings programs, changing processes to reduce unnecessary readmissions, and implementing a health care home, as well as innovative ideas and approaches not yet on the horizon. The third change ensures that Stratis Health is actively seeking and sharing information, staying attuned to local needs and opportunities, and helping our community be smart about and be a leader in the new world of health care.

THIS ISSUE

Implementing Health Care Reform in Minnesota – the Time is Now

Perspective from
Michele Kimball,
Stratis Health Board member

The next state legislative session may present the last opportunity for Minnesota to control our own health care destiny.

Michele Kimball is a member of the Stratis Health Board of Directors and is state director for AARP in Minnesota. She currently serves as an advisor to the long-term care chair at the University of Minnesota and is a member of the Minnesota Council on Aging.

Less than two years after it was passed into law, the Affordable Care Act (ACA) is already having a significant impact on the quality and reliability of care for more than one million Minnesotans over the age of 50. Increased access to free preventive care, improved transparency, pay-for-performance, and decreases in the cost of prescription drugs are all critical areas where the new health reform law is improving the lives of Minnesotans.

In order to continue this momentum and capitalize on all the ACA has to offer, it will be critical to achieve consensus at the State Capitol during the upcoming legislative session. With a hotly contested election on the horizon, politics could hamper everything from the creation of a health care purchasing exchange to implementation of grant programs that improve care and capture more federal resources.

Real benefits are already being realized

The ACA has been in effect for less than two years, but already Minnesota seniors are beginning to benefit in improved coverage, quality, and access under Medicare. The new law improves Medicare in at least three important ways:

- **Free preventive care:** Beginning this year, all Medicare beneficiaries are able to access free preventive and wellness benefits, such as immunizations and screenings for cancer and diabetes. Additionally, Medicare beneficiaries can now get a free annual health assessment from their doctor.
- **Reducing the cost of prescription drugs:** Each year approximately 67,000 Minnesotans enrolled in Medicare Part D reach the so-called "donut hole"—a more than $3,000 gap—where they pay 100 percent of all drug costs themselves. In 2010, this "hole" began to shrink, and seniors falling into it each received a $250 rebate. In 2011, the hole shrinks again, but beneficiaries instead receive a 50 percent discount on brand name drugs and a seven percent discount for generics purchased in the hole. The hole continues to shrink until 2019, when it closes permanently.
- **Extends the life of Medicare:** By reforming how Medicare pays for care and requiring more of private insurers who offer Medicare Advantage plans, the life of the Medicare Trust Fund is extended by 12 years.

Now it is time to focus on those under 65

While things are improving for Medicare beneficiaries, progress may be limited for those under age 65 unless state leaders can agree on key implementation elements.

The biggest impact takes place in 2014 thanks to establishment of a state based health purchasing exchange where the uninsured (and Members of Congress who are now required to participate) can purchase affordable coverage. As a national leader on health care quality and efficiency, Minnesota is uniquely positioned to create an exchange that increases transparency, promotes competition and empowers consumers. Despite the fact that such disparate groups like AARP, the Chamber of Commerce, and the Minnesota Hospital Association support it, state leaders have yet to agree.

The next state legislative session may present the last opportunity for Minnesota to control our own health care destiny. The Governor's recently established task force is a great start, and there is hope that we will be able to demonstrate that we have a plan for an exchange that can be operational by January 2014. If we fail to do so, the U.S. Department of Health and Human Services will do it for us.

The ACA presents Minnesota with a unique opportunity to build upon our own state reforms of 2008, to reward quality over quantity, reduce costs, and improve coverage for everyone, regardless of pre-existing conditions. It is an opportunity we cannot afford to miss.

Stratis Health Leads National Demonstration Project to Improve Care in Nursing Homes

The University of Minnesota and Stratis Health are leading 17 nursing homes in California, Florida, Massachusetts, and Minnesota in a Centers for Medicare & Medicaid Services (CMS) demonstration project to develop and test prototypes of a national Quality Assurance Performance Improvement (QAPI) program for nursing homes.

A QAPI program is a comprehensive, structured program used by health care organizations to assess the quality of care provided to their patients/residents and to improve the care they provide.

The Affordable Care Act requires that all nursing homes develop QAPI programs to meet national quality standards currently being developed by CMS. From this demonstration and its evaluation, CMS expects to refine tools and resources and assemble best-practice examples to assist in the national QAPI rollout. This initiative will align nursing homes with other health care programs—such as dialysis units, hospice, and hospitals—which have a QAPI requirement.

The QAPI initiative in nursing homes represents a step in moving the quality process from one based on assessment of inadequacies to one focused on improvement. Under the new QAPI approach, quality assurance will continue to play an important role, while nursing homes simultaneously are engaged in more intensive activity rooted in performance improvement.

"QAPI ushers in new possibilities for nursing homes to develop comprehensive, proactive performance improvement programs tailored to their own programs and needs," said Jennifer Lundblad, PhD, president and CEO, Stratis Health. "This work will take nursing homes beyond compliance with rules. It will engage whole organizations in programs that aspire to ever-improving quality."

> "QAPI ushers in new possibilities for nursing homes."

The nursing homes participating in the demonstration project will receive individualized technical assistance and form a learning collaborative for collective sharing of challenges and strategies to launch QAPI programs. The demonstration will run from September 2011 through August 2013.

CMS has developed a common framework for a QAPI program. The framework is made up of five elements: 1) Design and Scope, 2) Governance and Leadership, 3) Feedback, Data Systems, and Monitoring, 4) Performance Improvement Projects, and 5) Systematic Analysis and Systemic Action.

CMS is sensitive to the differences in nursing homes where residents live for long periods of time and have unique challenges related to quality of life, environmental quality, and individual choice. The five elements have been customized for nursing home QAPI. The program integrates safety and high quality clinical interventions with autonomy and choice in daily life for residents.

Both the University of Minnesota and Stratis Health are steeped in quality assurance and quality improvement, with long histories of research and direct assistance to improve care in nursing homes. Stratis Health offers nursing homes expertise on quality improvement, culture change, and organizational change, as well as facilitates improvement in clinical areas.

Nursing Homes Participating in QAPI Demonstration Project

The following nursing homes are participating in the QAPI demonstration project:

California
- Cedar Crest Nursing and Rehabilitation Center, Sunnyvale
- Lincoln Glen Nursing Facility, San Jose
- Mercy Retirement & Care Center, Oakland
- San Miguel Villa, Concord

Florida
- Habana Health Care Center, Tampa
- The Home Association, Tampa
- Oak Manor Healthcare and Rehabilitation, Largo
- St. John's Nursing Center, Lauderdale Lakes

Massachusetts
- D'Youville Life and Wellness Community, D'Youville Senior Care, Lowell
- Julian J. Leavitt Family Jewish Nursing Home, Longmeadow
- Liberty Commons, North Chatham
- Stonehedge Rehabilitation and Skilled Care Center, West Roxbury

Minnesota
- Benedictine Health Care Center, Duluth
- Ecumen Parmly LifePointes, Chisago City
- Good Samaritan, Ambassador, New Hope
- Perham Living, Perham
- Sterling Park Health Care Center, Waite Park

Opportunities Aimed at Improving Quality and Value Abound

Finding focus and avoiding burn out

Partnership for Patients, Million Hearts, RARE, Home Health Quality Improvement National Campaign—the campaigns, initiatives, and other efforts aimed at improving health care quality and value abound. With the changes flowing from health reform, ever more improvement offerings are being made available. That leaves health care organizations to sort through numerous invitations to participate and to be cautious of engendering quality improvement burnout among staff.

Attendees at the RARE celebratory event sign a poster to show their organizations' commitment to the campaign goals.

The Centers for Medicare & Medicaid Services (CMS) is working toward large-scale change in America's health care system. And, campaigns and initiatives hold promise for facilitating great impact. Well-developed campaigns and initiatives, based on evidence and best practice, that can be adapted to fit an organization's culture and practice are most likely to succeed. A recent *Journal for Healthcare Quality* article noted that the literature widely supports the value of continuous learning networks to maximize workforce improvement capability and of social networks to generate motivation and increase energy for improvement.[1]

Campaigns can shorten the performance improvement process by pulling together evidence-based practices and measurement strategies, and offering interventions along with technical assistance and support. "By participating in campaigns, our wish list of initiatives become actual projects," said Marilyn Grafstrom, director of quality and risk management at LifeCare Medical Center, a 25-bed hospital with two nursing homes and a home health agency.

For some organizations, participating in campaigns can change how they view quality. Cokato Manor Home Health participated in the Home Health Quality Improvement National Campaign through Stratis Health's home health collaborative from 2005 to 2008. Its staff now looks at trends for the year and conducts one to two initiatives where they have identified opportunities. "This laid the groundwork for how we approach quality improvement," said Nancy Deiter, director of nursing.

Unifying the calls for quality

Recognizing the sea of seemingly disconnected campaigns and initiatives, some quality leaders are working to unify efforts. Nationally, CMS is leading change in health quality by using all of the levers within its means to facilitate large-scale improvement. The agency is mobilizing people across the country to improve care by aligning incentives, measurement systems, regulations, and its quality improvement initiatives—through its Quality Improvement Organizations (QIO) like Stratis Health, Partnership for Patients, and Million Hearts. These all flow from the Department of Health and Human Services' National Quality Strategy for better care, healthy people and communities, and affordable care.

"All of these initiatives are coming from the same place, from the new broad vision," said Kelly Anderson, lead for the CMS Office of Clinical Standards and Quality Communications Team. "The CMS quality initiatives are all intended to ignite a spark, to have the key influencers and trusted voices spreading outwards to patients."

Stratis Health's work on reducing patient risk factors for cardiac disease aligns with Million Hearts. Our work in healthcare associated infections; pressure ulcers, physical restraints, and other nursing home concerns; and care transitions aligns with Partnership for Patients.

Locally, many organizations are working together to support the national priorities. Stratis Health as Minnesota's QIO, the Minnesota Hospital Association, and the Institute for Clinical Systems Improvement have joined forces to lead RARE (Reducing Avoidable Readmissions Effectively), a statewide campaign to prevent 4,000 avoidable hospital readmissions across Minnesota between July 1, 2011, and December 31, 2012. The three operating partners are using evidence-based best practices from the leading initiatives. They are mobilizing a broad base of stakeholders across the care continuum to address the readmissions challenges that stem from fragmentation in health care. Over 70 individual hospitals and six health systems have signed on to achieve the campaign goals.

"RARE has felt coordinated," said Eva Gallagher, Park Nicollet Health Services senior director, nursing quality, research and care innovation. "It pulls the best practices from other readmissions focused initiatives so that participants do not have to sift through them all and decide what we should participate in."

Selecting initiatives

Health care organizations have developed different strategies for how they evaluate the many quality improvement offerings. Some larger organizations have quality committees that evaluate initiatives brought before them. Some quality leads use cost-benefit analysis spreadsheets to compare opportunities.

Criteria used to evaluate whether to participate in an initiative include effectiveness, cost, compatibility with goals, ease of use, and ability to modify interventions to fit the organization—including being able to integrate with ongoing continuous quality improvement efforts.

> " For us, the question is where are we putting our patients at risk."

"When presenting new initiatives to staff, we need to be careful not to be presenting the flavor of the month," said Gallagher.

For smaller organizations unable to have dedicated quality staff and with fewer staff overall to test changes, evaluating and integrating external efforts is a greater challenge. "In a small hospital, we can only focus on one big project at a time, while doing other smaller projects," said Susan Swan, performance improvement and risk management director at Sanford Tracy Medical Center. The 25-bed hospital set a three-year plan to participate in the American Stroke Association's Get with the Guidelines, to ensure they did the work well.

Many organizations, especially rural and smaller providers, turn to outside trusted advisors and colleagues for guidance on an initiative's ability to provide value. "If Stratis Health and the state association are aware of and supporting an initiative, that lends more weight," commented Deiter.

"For us, the question is where are we putting our patients at risk," said Linell Santella, director of infection prevention and control service, Park Nicollet Health Services. "When I select a campaign or initiative to participate in, I always look for it to align with decreasing risk and with improved patient safety."

1. Rocco J. Perla, Elizabeth Bradbury, Christina Gunther-Murphy. Large-Scale Improvement Initiatives in Healthcare: A Scan of the Literature, Journal for Healthcare Quality, 2011.

PDSA - ASAP

Health reform, with its focus on value and pay for performance reimbursement, has created a heightened awareness of the need for quality improvement. For the country to move from having one of the most costly health care systems in the world while lacking overall quality, health reform needs to be a disruptive change—a change that alters how we look at quality.

The responsibility for quality needs to expand to include all health care staff. Fundamentally, organizations will need to have a culture of quality in which shared beliefs, values, attitudes, institutions, and behavior patterns support continuous quality improvement. At the top, administrators need to embrace quality improvement, setting the expectation that all staff share in the culture of quality.

To transform health care, 80 to 100 percent of staff need to be involved in active improvement efforts, according to a study of the National Health Service in England. That percentage was in stark contrast to the fewer than 10 to 15 percent who actually were involved.[1]

Reaching the level of involvement that will facilitate tranformative change requires a shift in thinking about how we engage staff in quality improvement. "We cannot restructure American health care from cubicles in Washington," said Kelly Anderson, CMS. "We need to mobilize people at the bedside."

We need to take our analysis of aggregate patient data and turn each quality issue into a person who should have received better care. "We need to go to the individual level and look at the whole patient and their experience," said Dawn Ekstrom, director of quality management at HealthEast Home Care.

The rate of change needs to accelerate. We need to look at change management and accelerate how interventions are accepted. Partnership for Patients encourages organizations to:

- Set expectations for a fast-moving, iterative work environment using quick-cycle iterations—like Plan-Do-Study-Act (PDSA)—in which new ideas are fleshed out, tested, studied, refined, and retested within short time frames.
- Prepare to make improvement measure results available internally and with a quick turnaround, within days not months.[2]

"The rate of change is not going to decrease. This is the new normal," said Nadine M. Paitich, home care executive, HealthEast Home Care. Leadership and quality managers must take on a supportive coaching role and facilitate staff empowerment, to see a positive result. The ideal future state is when staff identify a problem, bring it forward, do a pilot to test improvement, and roll out successful changes that can be sustained over time."

"This will be transformational when it does happen."

1. Bate, SP and Bevan, H and Robert, G. Towards a Million Change Agents. A Review of the Social Movements Literature: Implications for Large Scale Change in the NHS. NHS Modernisation Agency: Leicester, 2004.

2. Partnership for Patients, http://www.healthcare.gov/compare/partnership-for-patients/safety/prepare.html.

Hospitals and Providers in Minnesota Starting to Receive HIT Incentive Payments

The hard work of implementing an electronic health record (EHR) system is starting to pay off, literally, for critical access hospitals and providers in Minnesota. Medicare incentive dollars, totaling $23,191,582, have gone to Minnesota organizations, as of the end of October.

Heidi Engle and Leslie Murdock of Glacial Ridge Health System participated in Glacial Ridge Health System's meaningful use recognition event.

Clients of the Regional Extension Assistance Center for HIT (REACH), the federal health information technology (HIT) extension center serving Minnesota and North Dakota, are starting to successfully attest to meaningful use—documenting that their providers are able to meet the Centers for Medicare & Medicaid Services (CMS) criteria for using their EHR to improve patient care.

Minnesota critical access hospital attests to meaningful use

Glacial Ridge Health System is the first REACH client in Minnesota to successfully attest to meaningful use. The system has a 19-bed critical access, trauma hospital in Glenwood, Minnesota, within Pope County, with clinics in Brooten and Glenwood.

"We've made meaningful use a priority within our system. Staff have worked hard, planning for and implementing a new electronic system. We're now using our EHR to focus on what really matters—improving the care we offer our patients," said Kirk Stensrud, Glacial Ridge Health System CEO.

Heidi Engle, CIO for Glacial Ridge Health System, noted that the EHR helps with care delivery in many ways, such as drug-drug and drug-allergy checking and quick access to patient care guidelines, as well as all the historical patient information.

Minnesota clinic attests

Christopher J. Wenner, MD is one of the first providers in Minnesota to attest to meaningful use for the Medicare EHR Incentive Program. As a solo family physician, Dr. Wenner operates a comprehensive family medicine clinic in Cold Spring, Minnesota, that is certified as a health care home.

For busy clinicians, negotiating the specifics of the meaningful use rules and attestation process is difficult. Dr. Wenner used the federally subsidized services of REACH, which saved him a lot of time by interpreting the meaningful use rules, helping organize his data needed for attesting, and assisting throughout the attestation process.

Dr. Wenner intends to use his EHR to continue to improve patient care. Reminders for preventive screening and immunizations, as well as registry features to aid in chronic disease management, will be used to support his practice as a medical home. The meaningful use and medical home requirements dovetail well to facilitate better patient care.

$1.2 billion in incentive payments nationwide

Nationwide, over $1.2 billion dollars have been paid out in Medicare and Medicaid incentive payments. To date, the average payment per eligible professionals under the Medicare program was $18,000 and $21,023 for the Medicaid program. A greater number of eligible professionals are pursuing Medicare incentives over Medicaid incentives—104,684 have registered under Medicare and 31,265 under Medicaid, as of the end of October.

The Medicaid incentive program is not yet available in Minnesota. By June 2012, over 35 percent of REACH priority primary care providers anticipate successfully attesting to meaningful use.

Serving more than 3,000 providers

REACH has signed up the following providers in Minnesota and North Dakota as of October 31, 2011:

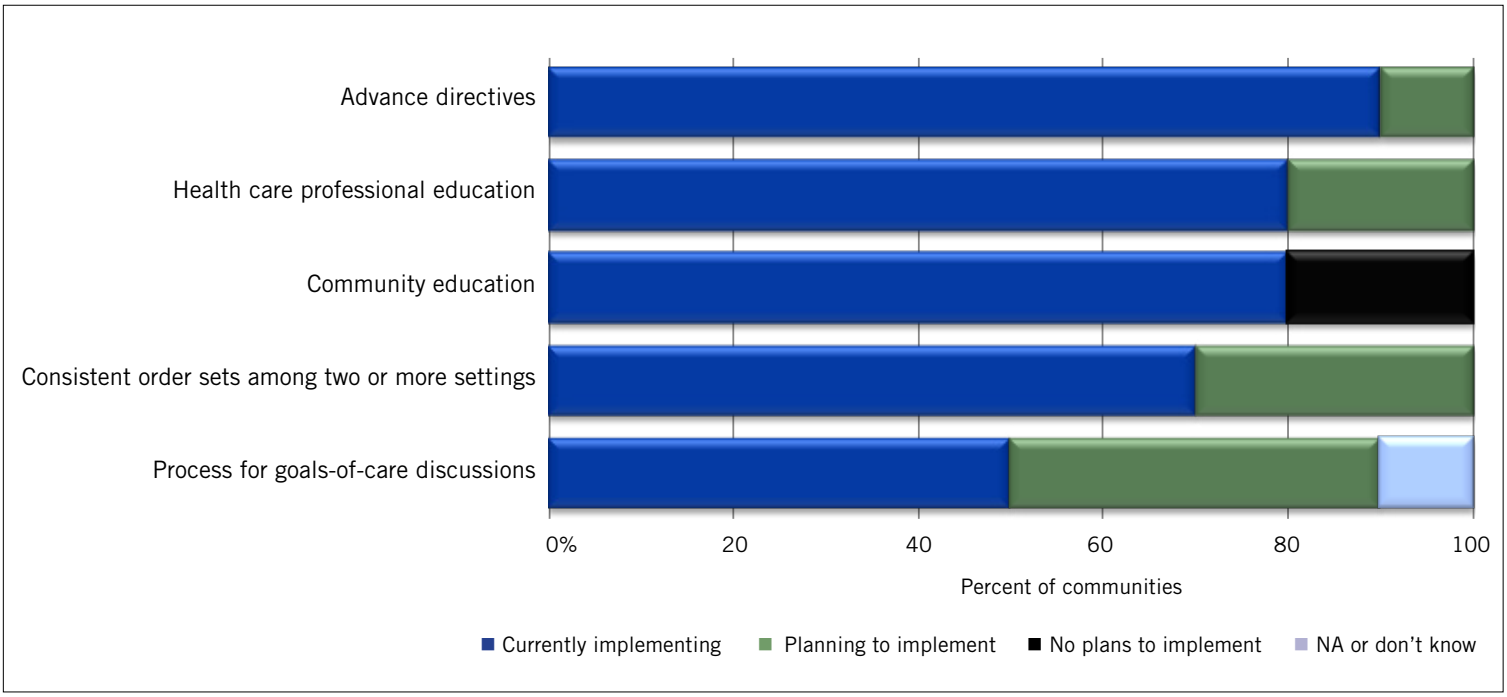
- 3,414 priority primary care providers (95% of goal)
- 85 critical access/rural hospitals (70% of eligible hospitals)

The federal government will soon close the sign-up window for REACH services. Providers and hospitals can still sign up to participate. They can wait to start work until they are ready—even six to nine months from now.

As a partner in Key Health Alliance, Stratis Health co-leads REACH along with the National Rural Health Resource Center and The College of St. Scholastica. www.khaREACH.org

Looking at the numbers: key program components in palliative care

Rural Communities Using Key Processes or Systems to Support Palliative Care at the Conclusion of the Minnesota Rural Palliative Care Initiative



Ten rural Minnesota communities participated in an 18-month learning collaborative, led by Stratis Health, to design a palliative care program model or focus for their communities and receive education to improve skills in palliative care. At the conclusion of the Minnesota Rural Palliative Care Initiative in early 2011, the 10 communities were well on their way to having in place most of the key components of a fully operational palliative care program.

Palliative care is an approach to managing chronic disease or life-limiting illnesses that centers on relieving suffering and improving quality of life for patients and their families.

Of the processes or systems needed to support palliative care, goals-of-care discussions are the heart of palliative care. Having a process in place to promote these discussions is essential for patients and their families to be able to meet with their care providers to establish the patients' individual goals, such as being well enough to walk to the mail box or spend time with their children. This shared decision making process leads to a care plan based on a patient's wishes regarding quality of life and clarifies whether or not to pursue the most aggressive treatment possible.

Palliative care is supported by advance directives and consistent clinical order sets, such as orders for constipation management/bowel care if opioids are prescribed. Communities participating in the initiative worked to standardize advance directive forms across settings of care.

The general population often has no knowledge about palliative care. Many health care professionals have limited knowledge as well. Education for the community and health care professionals is essential to build support for and use of a palliative care program.

Six of the 10 communities participating in the initiative were providing palliative care services when the initiative concluded in early 2011. The other four were focusing their efforts on standing orders, advanced care planning, and education to health care professionals and the community—all components that build a foundation for palliative care services.

Stratis Health is working to establish or strengthen palliative care programs in rural communities. We assist with building skills and developing processes to improve care planning, symptom management, communication, coordination, and delivery of care to improve the quality of life. Across Minnesota, 16 rural communities have successfully advanced their palliative care offerings by participating in these initiatives. From January 2012 through spring 2014, Stratis Health will be working with an additional six to eight rural communities.

The *Minnesota Rural Palliative Care Initiative* report (June 2011) is available online at www.stratishealth.org/palcare.

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety. We led this palliative care project with financial support from UCare.

STRATIS HEALTH NEWS

Jennifer Lundblad, Jane Pederson, and Margaret LeDuc honored Michael Daly for his years of service as a Stratis Health's CME program medical director.

University of Minnesota School of Public Health awarded Stratis Health a "Community Partner" award recognizing our contributions to—and in partnership with—the School. Stratis Health's service, time, energy, and ideas have been important in helping to advance its programs.

The Minnesota Alliance for Patient Safety, a Minnesota collaborative that works to ensure the safety of patients in health care organizations, has hired its first executive director. Nancy Kielhofner, RN, will office at Stratis Health, a key MAPS leader.

Stratis Health recently honored Michael Daly, MD, a long-time Stratis Health board member and current Community Outreach Committee member, for nearly 15 years of service as medical director of the Stratis Health Continuing Medical Education Program.

Stratis Health welcomes new staff members. Joining our quality improvement staff,

Kathie Nichols, BSN, RN, CRRN, nursing home liaison, supports quality improvement in nursing homes, including work in Quality Assurance Performance Improvement.

Deepika Sharma, BHMS, MHI, research analyst, provides analytic support across a variety of projects including health information technology, care transitions, hospital reporting, and prevention.

Paul Kleeberg, MD, REACH clinical director, gave federal testimony in October before the Office of the National Coordinator for Health Information Technology Policy Committee, Meaningful Use Workgroup, on the providers perspective in working towards Meaningful Use Stage 3.

Betsy Jeppesen, Stratis Health vice president of Program Integrity, was elected network chair of the Beneficiary and Family Centered Care Network for the American Healthcare Quality Association. She convenes and facilitates discussions of Medicare QIO case review staff nationwide.

Jennifer Lundblad, Stratis Health president and CEO, authored the article "Rethinking Patient Safety Regulation: A Framework for Evaluating Regulatory Tools," published in the Hamline Journal of Public Law & Policy, spring 2011.

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 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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