StratisHealth
We make lives better.

QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Fall 2013

Act Big, While Focusing Locally

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

As Stratis Health is ever more deeply immersed in supporting quality, safety, and value in a rapidly changing payment and care delivery environment, we have started to think about the opportunities and challenges in new ways. We have started to describe how health care will need to recreate itself, building around a new dichotomy:

> The power of acting big and being connected while simultaneously focusing on local communities and individuals.

Big and Connected

The first part of this dichotomy is about the power of big and connected. A health care organization does not have to be big. Instead, it needs to find ways to act big and be connected, which can be through networks, affiliations, or partnerships.

Acting big allows health care and community-based organizations to increase their buying power for a variety of services and support and to harness market demand.

Acting big is about thinking big. It enables connectivity by leveraging technology in ways that include patient care and health information exchange. It enables rapid learning and sharing of best practices and knowledge about risks and potential errors,

and it provides mechanisms to use complementary services and skills.

Local Focus

At the same time, health care organizations must find ways to focus on local communities and individuals. In a health care environment shifting toward a population health focus, financially incented by shared savings and similar changes, knowing and treating each patient as an individual, and honoring preferences and values, is essential.

Focusing on local communities includes deeply understanding community and population health needs, including cultural, linguistic, and disease-related needs. Local and individual emphasis is often best supported by creating strategic local partnerships within and outside of health care.

Risk in this Health Care Dichotomy

We see risks along this path toward acting big and connected while focusing on local communities and individuals. First, a health care organization may be tempted to chase the ACO, or whatever the latest and greatest trend is. The focus may be contract driven rather than patient and Triple Aim focused.

A second risk is that health systems and new affiliations will build rather than partner to gain the comprehensive medical and psychosocial services their patients need. This is the old make-or-buy decision, now framed as build-or-partner. We risk expanding the hospital and health system walls, rather than breaking down the walls to engage expert, trusted, cost-effective community-based partners and services.

Lastly, data—accompanied by careful and thoughtful analysis and interpretation—is essential to good decision making. Risks come into play when decision makers lack access to strong data and the skill to analyze it to make wise, well informed, strategic, and patient and community-centered decisions.

Alert to these risks, we can turn this seeming dichotomy into the power for change in health reform.

THIS ISSUE

Changing role of health care consumers – the perspective of two Medicare consumers

Perspective from **Dee Kemnitz and Ruth Stryker-Gordon Stratis Health Board members, serving as Medicare consumer representatives**

We're glad to know Medicare is accounting for experience of care in the value equation.

Dee Kemnitz has spent more than 45 years at Carlson Companies, a global leader in the marketing, travel, and hospitality industries.

Ruth Stryker-Gordon, MA, RN is an author, teacher, and long term care expert. Her professional roles have included teaching long term care administration at the University of Minnesota's School of Public health, serving as director of nursing education at Sister Kenny Institute, and consulting on long term care.

The health care landscape has changed dramatically since we became responsible for managing our own health care and that of our families over 50 years ago. The health care system has become increasingly complex and people generally know little to nothing about how the system works. As consumers, we are asked to wade through insurance choices, ultimately weighing probabilities about developing conditions or experiencing health care events against our finances.

Until the day the health care system is as easy for people to learn as traffic rules, consumers will have many challenges to contend with.

Patient Satisfaction

Poor experiences have driven patients to have lower expectations for care than they used to have. Rushed five-minute doctor visits leave patients with unanswered questions and physicians who are stressed and frustrated. Talking with a doctor, who was a fellow health system board member, he said, "I saw 43 patients yesterday." Our systems are setting providers up for failure.

When my (Ruth's) husband needed emergency care, we went to the nearest hospital. After 11 hours waiting in the ER before seeing a doctor, the doctor entered the room saying "We're going to keep him. Did you bring your living will?" No. "Well do you want paddles?" This type of insensitive interaction continued throughout his hospital stay. A series of low quality interactions revealed a need to overhaul the organization's culture.

We're glad to know Medicare is accounting for experience of care in the value equation through value-based purchasing. We challenge health care leaders to set the right organizational tone—framed on quality—which impacts patient satisfaction.

Savvy Patients Needed

Personal responsibility is an important part of maintaining the best health possible. Google gives patients the opportunity to better understand their conditions and bring these insights into the exam room.

Patients are less passive recipients of care and they no longer assume a provider is all knowing. A friend bypassed the primary care physician when he downplayed her husband's dementia-related symptoms. The neurologist diagnosed the husband with Alzheimer's. Savvy patients are able to find good health care. Consumers have to take the next step if they feel they are not getting good care. They need to change their hospital, doctors, or nurses.

We do not know how anyone survives who does not know how health care works from the inside. When you are ill, you need to have an advocate, someone listening on your behalf.

Fighting an Unhealthy American Culture

The Affordable Care Act making health care coverage universally available is only one part of the equation to improving the health of our country. With rates of obesity and chronic conditions at all time highs, we need a major shift in American culture to create an environment in which the whole population is willing and able to take care of itself.

Years ago, I (Dee) organized a company sponsored 10-day intensive program for diabetics with an after-care support program as a demonstration project to both help improve employee lives and enhance top management understanding of health benefits from improved patient self-management. The support program ended after six months. Within a year, all the participants had backslid into unhealthy habits.

Surrounded by influences of advertising and sometimes unhealthy family lifestyles, we are encouraged to pick foods that are good for our comfort, not good for us. No one would think about putting kerosene in our gas tanks, but we put unhealthy items into our bodies.

The challenges in our health system are many. Health care organizations need to keep striving to improve quality and consumers need to stay committed to maintaining their own health.

Center for Community Health Aims to Amplify Impact

A collaboration of health plans, hospitals, and local public health

Health plans, hospitals, and local public health agencies are coming together through the Center for Community Health (CCH), a voluntary collaboration to improve health in the Twin Cities seven-county metropolitan area. It aims to align the community health assessment process and action plans across the sectors.

The Affordable Care Act set a new requirement for nonprofit hospitals to submit community health needs assessments to the IRS every three years, as a way to affirm their charitable status. Individual Minnesota health plans and local public health agencies were already meeting to coordinate on similar assessments, mandated by the state for every four and five years respectively. Wanting to avoid duplication and improve the effectiveness of these assessments, leaders across the three sectors voluntarily came together to form the Center for Community Health.

"Health plans and local public health have been working together on community assessments for years. With the new hospital requirement, it only made sense for all of the sectors to come together," said Janny Brust, director of medical policy and community health at the Minnesota Council of Health Plans.

From the seven health plans, 10 city and county public health departments, and 18 hospitals serving the metro area, over 40 individuals are participating in the collaboration. CCH hosted its first full member meeting in May 2013.

Value of Coming Together

CCH aims to amplify impact on agreed upon priority issues and increase organizational effectiveness. First, it plans to reduce redundancy by working together to meet each sector's assessment requirements and mandates. A top priority will be developing a common framework for conducting a community health assessment, based on the most effective methods, that member organizations can use to meet community needs.

The group anticipates cost savings from leveraging resources. Coordinating individual community surveys into a metro-wide survey is expected to cut costs and will increase usefulness of the data. Ultimately, the collaboration will foster coordinated interventions on priority issues to accelerate community impact and achieve outcomes.

"We all will be looking at community health in a more planful manner," said Joan Pennington, system director for community outreach for HealthEast Care System. "Coming together is the right thing to do for HealthEast as well other hospitals, local public health, and health plans so we do not duplicate efforts. More importantly, it's the right thing to do for the communities we serve together."

> " It's the right thing to do for the communities we serve together."

Real Change at the Community Level

"Public health has always been a convener and facilitator on difficult health issues," said Lowell Johnson, director of Washington County's Department of Public Health and Environment. "Through CCH, we're all going to be talking about the best interest of the community, patients, and the health care system as a whole. We'll be sharing common messages and putting our money where there can be the best outcomes."

At its core, CCH is about developing meaningful partnerships across the three health sectors to support better community health. Members will share data, tools, and templates to build on success and learn from experience.

"CCH embodies the collaboration we need to see in health care to make real change at a community level," said Kim McCoy, Stratis Health program manager working on community health issues.

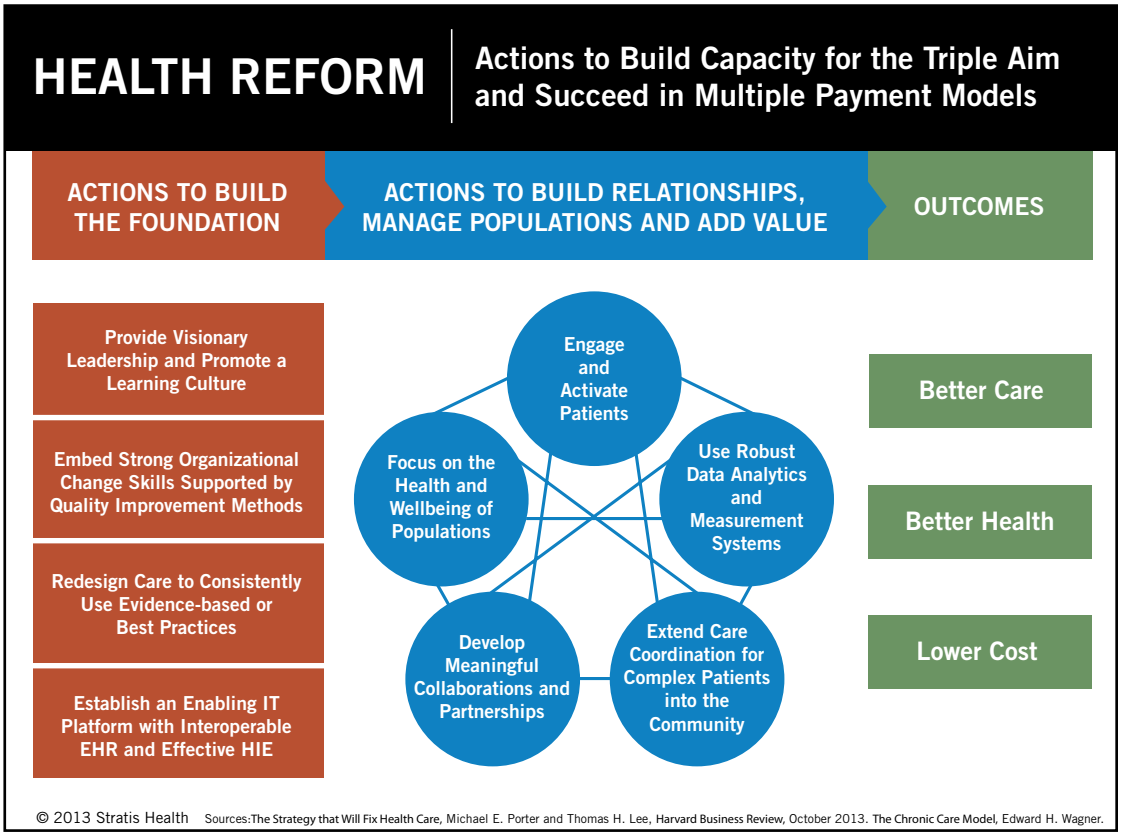
As part of its Building Healthier Communities community benefit program, Stratis Health provided CCH support by leading a strategic planning process to define its vision and value.

An Actionable Model for Health Reform

Preparing for the future of health care

Health care delivery organizations are under pressure to transform care due to changes driven by federal and state health reform and marketplace demands. The changes for health care organizations run deep into how they function and wide across all services and operations. We must truly transform how patient care is delivered and be accountable for the health of a population. The status quo will not be sufficient.

Many organizations are struggling with how to create a new vision for themselves that meets the expectation of transforming health care, set forth in health reform. Stratis Health is increasingly asked to translate into actions the magnitude of what is required of them.



"Leaders are seeking to understand how to take the concepts laid out in health reform policy, these sometimes abstract ideas, and build them into their business strategies," said Jennifer Lundblad, Stratis Health president and CEO. "Leaders across care settings and in community organizations, are asking us 'How does health reform apply to my organization? What should we be doing to be successful in this rapidly changing environment?'"

Stratis Health has developed a model to assist organizations with their visioning and planning for health reform. The model gives health care and community organizations an image of how to respond to the changing marketplace and incentives, and successfully transform care delivery.

This model can help health care leaders:

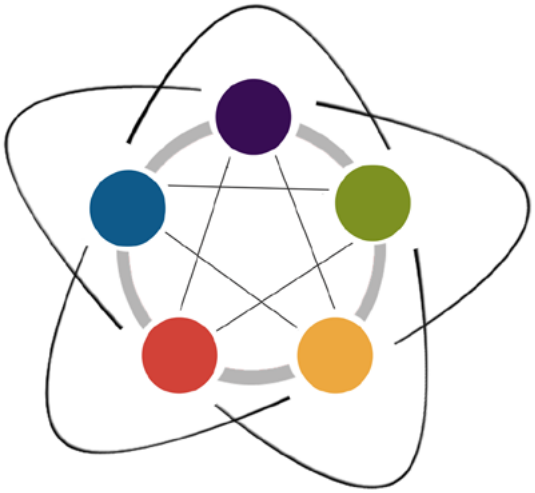
- Understand the full scope of actions required to build the foundation and relationships, manage populations, and add value to achieve the Triple Aim.
- Assess their own organization's strengths and weaknesses, and readiness for health reform relative to where they are today and where they need to be in three to five years.
- Understand organizational gaps and needs, set priorities, and allocate resources.
- Identify the essential components to assist with defining a vision for their organization in the new marketplace.
- Define strategies for the next three years.
- Layout action steps their organization can take now.

The model illustrates the full scope of transformation required by health care organizations. The components apply to health care organizations across the continuum that care for patients and receive payment for care.

The high level framework of Stratis Health's health reform model illustrated above is augmented with more information on the characteristics of transforming care in the community and steps for how organizations can take action now. The actions were written with health care organizations in mind, but they also can guide systems, individuals within organizations, and community-based organizations.

More at www.stratishealth.org/health-reform.

QAPI—an Approach Supporting Nursing Home Success in Health Reform



Quality Assurance Performance Improvement (QAPI) is a proactive, data-driven, systems-based approach that prepares nursing homes well to provide care with better outcomes—improved quality of life, care, and services.

The Affordable Care Act outlined the requirement to develop QAPI regulations and technical assistance for the nursing home setting. QAPI's performance improvement focus builds on the strong foundation of quality assurance practices already used by nursing homes.

How QAPI Drives Improvement

Like Total Quality Management and Six Sigma, which are widely adopted across business sectors, QAPI is a foundational quality management philosophy.

Monitoring and improving quality are major elements of QAPI. Nursing homes should establish benchmarks for performance and monitor how well they are performing against them. They need to objectively collect meaningful data on performance and proactively look for improvement opportunities.

When performance varies from a standard or goal set by the nursing home, staff perform an in-depth analysis and develop a plan for performance improvement.

Robust data helps nursing homes prioritize potential areas for improvement, know when they achieve their aims, and whether outcomes were met.

QAPI aims to shift everyone working in long term care to creating quality proactively. When QAPI is implemented, quality becomes a shared responsibility of all staff at the nursing home, with problem-solving that involves staff across all disciplines and departments, as well as residents and their families.

"Organizational change skills allow nursing homes to make complex changes, which are more likely to be sustained," sai Jane Pederson, Stratis Health director of medical affairs and geriatrician with Allin Senior Care Transitions.

Implementing Systems-based Change for Improving Care

The University of Minnesota and Stratis Health developed a QAPI technical assistance program and tested it with 17 nursing homes across the county from 2011 to 2013, on behalf of the Centers for Medicare & Medicaid Services (CMS). The intensive pilot offered insights about how nursing homes can implement and leverage QAPI to enhance care.

"Administrators and nursing staff are adept at looking at data to improve individual resident care. They have less experience applying quality improvement methods and using data to plan for system-based performance improvement," said Pederson.

A comprehensive approach like QAPI can seem daunting, especially when implementation competes with numerous other priorities. Through the pilot, nursing homes identified the greatest opportunities of QAPI as:

- Promoting engagement and commitment of all staff in QAPI
- Supporting an ongoing culture of QAPI, despite changes in leadership
- Involving residents and families in QAPI in a meaningful way
- Using systems thinking in all quality efforts
- Understanding and using data to inform and drive meaningful action
- Using root cause analysis effectively
- Making changes at a system and process level
- Committing to a QAPI plan that evolves with the needs of the nursing home

Building the Foundation for Success

Understanding the changes needed for QAPI, and building support and skills across staff takes time and thoughtful planning.

Nursing homes that have participated in other quality programs, such as the American Health Care Quality Award Program or the Baldrige Performance Excellence Program, will find the QAPI framework familiar. For other nursing homes, QAPI may not come naturally.

The available educational activities, tools, and resources provide structure and guidance to help build skills. From the CMS QAPI demonstration project, Stratis Health found that tools are not sufficient for embedding a new organization-wide quality improvement philosophy. Training and technical assistance may be needed at a corporate or facility level.

Stratis Health is working with nursing homes to implement QAPI. Many are excited about this shift to a culture of continuous improvement.

Striving to meet best practices will not only improve outcomes for nursing homes, but it will position them well for meaningful collaborations and partnerships across care settings and with the community to impact population health.

EHR is Essential Tool in Patient Centered Medical Home

Federally qualified health centers aim to transform primary care delivery

Patient centered medical home (PCMH) is a model of primary care that emphasizes care coordination and communication. It is being explored nationwide as a method of practice for transforming primary care delivery. Federally qualified health centers (FQHCs), which serve seniors, immigrants, and others in underserved communities, are participating in PCMH demonstrations.

Six Standards for Patient Centered Medical Home Recognition

1. Enhance access and continuity
2. Identify and manage patient populations
3. Plan and manage care
4. Provide self-care support and community resources
5. Track and coordinate care
6. Measure and improve performance

National Committee for Quality Assurance, 2011.

Health Information Technology Enables PCMH

The Agency for Healthcare Research and Quality lists health information technology as one of three foundational supports for PCMH, along with a strong primary care workforce and provider compensation for care coordination.

The National Committee for Quality Assurance (NCQA) has six standards with 28 elements for PCMH recognition. The standards can all be mapped to health IT functions which support optimal patient care, performance measurement, patient education, and enhanced communication enabling providers to:

- Collect, store, manage, and exchange relevant personal health information, including patient-generated data. (Standards 3, 5)
- Enhance or facilitate communication among providers, patients, and the patients' care teams for care delivery and care management. (Standards 2, 3, 5)
- Collect, store, measure, and report on the processes and outcomes of individual and population performance and quality of care. (Standards 2, 3, 5, 6)
- Support provider decision making on tests and treatments. (Standard 3)
- Inform patients about their health and medical conditions and facilitate their self management with input from providers. (Standard 1, 4)

FQHC Medical Home Demonstrations

Across the country 476 FQHCs are participating in a project, led by the Centers for Medicare & Medicaid Services, to evaluate PCMH for improving care, promoting health, and reducing the cost of care provided to Medicare beneficiaries. The three-year effort kicked off in 2011.

FQHCs are expected to achieve the highest level of NCQA PCMH recognition, with most practices demonstrating medical home transformation. The clinics are expected to help patients manage chronic conditions and actively coordinate care for patients. FQHCs are paid a monthly care management fee for each eligible Medicare consumer receiving primary care services under the PCMH model.

Valley Community Health Centers in North Dakota is participating. "Staff are starting to see the end result of improved patient care," said Stacey Jacobson, RN clinical coordinator at the clinic. "When viewed from the patient perspective they see how patient centered medical home really makes sense."

PCMH Pilot Project in North Dakota

Valley Community Health Centers also is participating as one of three FQHCs across six sites in North Dakota in a rapid change process to make progress in six to eight months toward serving as a patient centered medical home. The project is being led by the Regional Extension Assistance Center for Health Information Technology (REACH) and Blue Cross Blue Shield of North Dakota. The project has helped them to communicate more clearly about the changes with PCMH and its value, and to further its use of a patient portal.

"The health care system has to undergo some fairly radical transformation to achieve the benefits of the Triple Aim," said Nancy Miller, REACH program manager st Stratis Health. "We need patient centered medical home and community based care coordination. Real change won't happen without transforming the way people interact for the benefit of the patient."

Jacobson noted, "There's such a push for improving quality and decreasing redundancy of tasks, who doesn't want that?"

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: Low hospice use for Medicare consumers in Minnesota

Medicare is supporting efforts to increase appropriate use of the hospice benefit, with the aim of improving experience of care at end of life and potentially improving affordability of care by decreasing often unwanted, intensive interventions. Nationally, the average spending per chronically ill Medicare patient in the last two years of life increased 15.2 percent: from $60,694 in 2007 to $69,947 in 2010.[1]

Stratis Health is leading a one-year special innovation project in the state, funded by the Centers for Medicare & Medicaid Services (CMS), to increase appropriate referrals, use of hospice, and the number of days of hospice care per patient.

Medicare hospice use: Minnesota compared to U.S.

While coverage for hospice services is generously available through Medicare, it is underused by Medicare consumers across the country, including in Minnesota.

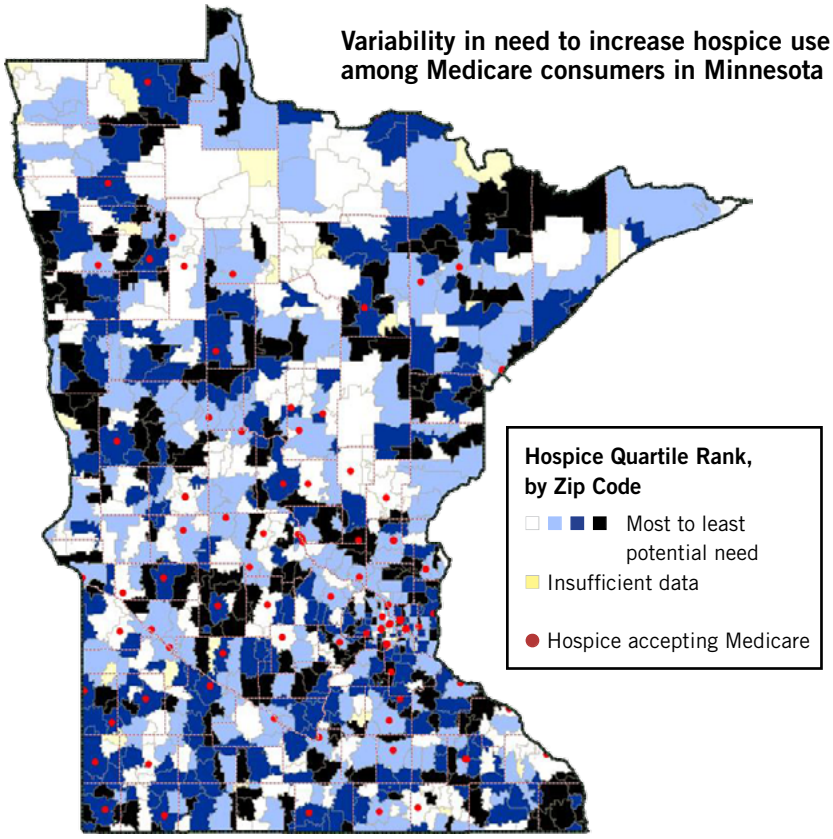
3.65% highest
2.45% average
2.26% Minnesota
0.64% lowest

Based on Stratis Health's calculations from available Medicare data, the 2010 national Medicare hospice utilization rate was 2.45%, with states ranging from as low as 0.64% (Alaska) to as high as 3.65% (Arizona). Minnesota's rate was 2.26%. A Medicare hospice utilization rate reflects the number of patients referred to hospice care, and is calculated by the number of hospice patients divided by the total Medicare eligible population.

Minnesota served 17,540 Medicare hospice patients in 2010 and nationally ranked in the third quartile for utilization. If Minnesota were to be among the higher use states (first quartile), an estimated 24,600 patients would have been referred to hospice, or more than 7,000 additional patients than actually served.

Compounding the low rate of referrals to hospice, once referred, Medicare consumers receive fewer days of care than afforded by the benefit—which is two 90-day periods or longer. The national average in 2010 was 70 days per patient. Minnesota Medicare hospice patients received an average of only 56 days of care per patient. The median length of stay is considerably lower than the average.

Variability in need to increase hospice use among Medicare consumers in Minnesota



Hotspotting to identify areas of greatest potential need for hospice

Stratis Health analyzed data to identify areas of greatest potential need for increased hospice use among Medicare consumers in Minnesota. The hotspotting map above ranks zip code areas into quartiles based on a roll-up score including:

- Utilization (median/mean length of stay in hospice, percentage of beneficiaries in hospice, overall readmissions to the hospital across all patients, and hospital discharges into hospice, adjusted for population size)
- Overall hospital admissions and readmissions per 1,000 Medicare consumers for cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), dementia, and codes that include debility and failure to thrive

This information is being used to identify communities to work with to increase hospice use.

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety.
Sources: CMS Data Compendium 2011 and Medicare Enrollment Database (April 2012 through March 2013).
1. The Dartmouth Institute brief June 2013.

STRATIS HEALTH NEWS

Bill Jacott, board chair, and Jennifer Lundblad CEO (back center) recognize outgoing board members Michele Kimball, Alison Page, Dee Kemnitz, and Ruth Stryker-Gordon, whose terms end in December 2013.

New board members. Four new members were recently elected to the Stratis Health Board of Directors, with terms effective January 1: Myron Falken, PhD, MPH, retired, was a Minnesota Department of Health epidemiologist and director of the Isanti/Mille Lacs County Public Health Agency. Ken Johnson, MBA, retired, worked in local government economic development and public finance activities, most recently serving as president and CEO of the Saint Paul Port Authority. Jan Malcolm is president of Courage Kenny Foundation and VP Public Affairs for Allina Health. Stella Whitney-West, MBA, is CEO of NorthPoint Health & Wellness Center a federally qualified health center with medical, dental, behavioral health, and human services, which is part of Hennepin County.

Paul Kleeberg, MD, FAAFP, FHIMSS, Stratis Health Chief Medical Informatics Officer (CMIO) and REACH Clinical Director, presented to the Senate Finance Committee on meaningful use at the request of Healthcare Information and Management Systems Society (HIMSS). Key topics included the widening digital divide affecting rural hospitals and facilities, and staying the course of supporting meaningful use.

He also participated in a President's Council of Advisors on Science and Technology (PCAST) workshop in Washington, DC, on leveraging system engineering to improve health care quality and safety with a focus on small practices. Kleeberg focused on the needs of rural and underserved populations.

National Pilot Project to Improve Emergency Department Transfer Communication. Critical access hospitals in eight states will be working to improve transitions of care during emergency department transfers. Stratis Health is leading a one-year national special innovation project funded by CMS.

Health Information Technology Toolkits. To assist organizations with adopting health information technology and maintaining a current understanding of technology best practices to support care delivery, Stratis Health is updating its HIT toolkits and developing new toolkits for behavioral health and local public health. What's new: integrating health information exchange into planning, training strategies to aid provider buy-in, and EHR advances such as cloud-based components and meaningful use integration. The toolkit can be used to implement a comprehensive HIT or EHR system, to overhaul existing systems, or to acquire individual applications. www.stratishealth.org/expertise/healthit

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.

Quality Update is published twice a year by Stratis Health for Minnesota health care leaders.

Jennifer P. Lundblad, PhD, MBA
President and CEO
jlundblad@stratishealth.org

Debra McKinley, MPH, Editor
Director of Communications
dmckinley@stratishealth.org

Stratis Health
2901 Metro Drive, Suite 400
Bloomington, MN 55425-1525

952-854-3306 • 952-853-8503 (fax)
Email: info@stratishealth.org
www.stratishealth.org