



QUALITY UPDATE

Health care quality
issues for Minnesota's
health care leaders

Fall 2015

Emerging Health Professionals: Today's Opportunity

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We find ourselves in a time with a set of aspirations, policies, and programs that offer a unique opportunity for emerging professionals. Community health workers and community paramedics are playing key roles in improving health and health care across settings of care.

The federal Affordable Care Act has led to new payment models that reward provider systems for better outcomes and favor approaches that incorporate innovative workforce strategies to meet the three-part aim. The January 2015 announcement of national Medicare payment goals sets a clear direction and fast pace toward alternative value- and population-based payment. This ramped up the expectation for health care organizations to address their patients' needs more comprehensively and to take accountability in new ways—attentive to both cost and quality. The Medicare payment goals are achieved through emerging models such as Accountable Care Organizations (ACOs), advanced primary care medical home models, new models of bundling payments for episodes of care, and integrated care demonstrations for Medicare-Medicaid enrollees. These programs give ample opportunity to leverage new roles and responsibilities, and to re-conceptualize team care and support.

At the state level, Minnesota law and regulatory changes in recent years have opened doors to payment and reimburse-



ment which supports emerging professionals. The Minnesota State Innovation Model builds on the innovations already underway and supports an environment of testing and experimentation to better understand what improves health outcomes including using emerging health care workers.

As further acknowledgement of the changing health workforce, the highly regarded Institute of Medicine released a report in September 2015 that offers alternative approaches to the traditional health care workforce and captures a debate of the pros and cons.

We see significant momentum behind the payment transformation from volume to value: care delivery is being redesigned around population health, care coordination, and team care; and new governance approaches. The volume-to-value transition is shifting payment to reward achieving outcomes through high quality, efficiency, and positive patient experiences.

The transition is the impetus for new care delivery approaches—re-thinking how care is organized, and going beyond the traditional walls of a hospital, clinic, or health system, recognizing the importance

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of social determinants and community support.

Community health workers and community paramedics have the opportunity to play a significant role as part of the health care team in this new environment. They function as liaisons between health and social services and communities to facilitate access to coverage and care, improve the quality and cultural competence of service delivery, and build individual and community capacity for better health. Community health workers and community paramedics serve as advocates, facilitators, liaisons, community brokers, and resource coordinators, roles which are often exactly what is needed for patient care to be patient-centered and integrated.

As we move forward, it is important to understand how emerging professions fit in the rapidly changing care delivery and payment context, and to create a compelling (and data driven) vision and value proposition understood by all stakeholders. This is an exciting time to turn the vision of team-based care into reality. ○

Silos to Circles: Valuing the Whole Continuum



Perspective from
Jan Malcolm
Stratis Health board member

With the budget trajectory of health and human services spending threatening to consume an ever-larger share of the state budget, we need to draw on these improvement and collaboration skills at an even higher level.

Jan Malcolm, is president, Courage Kenny Foundation and vice president, public affairs for Allina Health. Ms. Malcolm served as a senior program officer for the Robert Wood Johnson Foundation, and as Commissioner of Health for the State of Minnesota.

OUR COMMUNITIES ARE WORKING TO BETTER INTEGRATE HEALTH CARE AND SOCIAL SERVICES as part of the evolution of new care delivery approaches. Such new models must become the norm if we are to meet the Triple Aim challenge of better quality, better population outcomes, and lower total cost. For the health of our people and our economy, the Triple Aim is more than an aspirational goal, it is an imperative. Health services research in Minnesota, the U.S., and internationally has produced compelling and accumulating evidence that the relationship between health care spending and population outcomes is often not what we expect, and that the resulting value gap is a problem and an opportunity.

We have a culture of improvement in Minnesota, and Stratis Health is a big part of that culture. Our institutions and organizations across the state have a tradition of collaboration for the public good. Leaders embrace collaboration to advance quality of care that supports individuals in our communities. With the budget trajectory of health and human services spending threatening to consume an ever-larger share of the state budget (and those of employers and families too), we need to draw on these improvement and collaboration skills at an even higher level. An inclusive collaborative effort called “Silos to Circles” is working to do just that.

An unusually broad group of organizations from across the whole spectrum of health care and social services is attempting to bring our very separate “silos” together. They seek to recognize where our efforts need to be not only better coordinated but even redesigned from a more holistic perspective. And, the people we serve in common are at the center. Over the past 18 months, leaders from long term care, acute care, mental health, public health, and social services organizations have been meeting to share

perspectives and create shared language, new vision, and action plans. We fundamentally believe that the fragmentation, disconnection and misalignment of our services and sectors is part of what creates Triple Aim deficits.

Our goal is to learn how to think and act together as a more connected continuum, bringing greater wholeness to our currently fractured and fragmented parts. Our opportunity is to collectively and more effectively promote health at all life stages with services that are integrated, culturally appropriate, and honor our shared humanity.

“Fragmentation, disconnection and misalignment of our services and sectors is part of what creates Triple Aim deficits.”

Facilitated and supported by the Collective Action Lab, over 30 organizations are working on several tracks:

- ♦ Attempting to quantify the costs of fragmentation and articulate the benefits of integration to build a case for policy and delivery innovation across the continuum
- ♦ Demonstrating through cross-continuum system integration initiatives in the arenas of chronic disease and behavioral health how we can better achieve the Triple Aim
- ♦ Working together to foster community capacity for health and wellbeing as people and families define it

As we do this work, we are trying to build on and leverage the continuum-based change efforts already happening in our communities. Silos to Circles aims to help build critical mass in approaching the ongoing challenge of health system reform in a new paradigm—one that recognizes the value of the whole continuum, and of communities themselves, in producing health. ○



Medicare Focuses on Mental Health

The Centers for Medicare & Medicaid Services (CMS) has launched a new two-part initiative through its Quality Improvement Organization (QIO) Program to improve mental health care for Medicare beneficiaries. The four-year effort aims to:

- Improve identification in primary care clinics of depression and alcohol use disorder among Medicare beneficiaries
- Improve care coordination between care providers for Medicare beneficiaries who have mental health disorders

“CMS is acknowledging that mental illness is a chronic condition that impacts people’s overall wellbeing, their outcomes, their quality of life, their wellness,” noted Jennifer Blanchard, Minnesota Department of Human Services (DHS).

Stratis Health is leading this work in Minnesota through the Lake Superior Quality Innovation Network.

Mental health impacts physical health

Depression and alcohol use disorder are common mental health conditions in the Medicare population. “There’s a myth that depression is part of getting older, that it’s a natural part of aging—that’s not true. Depression should be recognized and treated,” said Dr. Michael Trangle, psychiatrist with HealthPartners.

Older populations have a lot of co-occurring conditions, especially depression and anxiety along with disabling medical conditions. “Heart disease goes along with depression; diabetes goes along with depression,” said Sue Abderholden, NAMI Minnesota executive director. “We know from studies that when you have those co-occurring disorders and you don’t treat the depression, people often don’t get better or ability to function better is delayed.”

These conditions interfere with a person’s ability to achieve their best health possible. Yet, they can be under-identified in primary care settings. Nationwide, CMS aims for 10,000 primary care practices to screen a majority of its Medicare beneficiaries for depression and alcohol abuse with a validated screening instrument by 2019. In Minnesota, the goal is for 200 primary care practices to implement and document screening.

Care coordination

CMS also aims to reduce psychiatric readmission rates in inpatient settings and increase patient follow-up rates with mental health practitioners after discharge.

Challenges in effective care transitions for mental health conditions contribute to high readmission rates and problems in treatment adherence. One focus of the initiative will be to develop referral and consultation relationships with community mental health providers.

Building on Minnesota’s foundation

This initiative will build on the foundation of the DIAMOND program model of collaborative care and the state publicly reported mental health measures.

It ties well with DHS’s new behavioral health home service which begins the summer of 2016. “The goal of the service is to better integrate behavioral health into primary care, primary care into behavioral health. It’s one of many models for better integrated care,” Blanchard said.

Abderholden is pleased Medicare has taken this step. She hopes CMS will take additional steps and bring parity to mental health treatment—so it receives equal health insurance coverage as other chronic conditions. ○



Evidence indicates increased identification of depression or alcohol use disorder in primary care settings can result in better health.

- In the Medicare population, the prevalence of depression has been estimated at 11 percent. It has a higher inpatient readmission rate than all other conditions except for heart failure.
- Most depression treatment is delivered by primary care practitioners, especially for elderly patients. Considerable evidence shows that mental health problems are often under-identified in primary care settings.
- Under-identification and treatment of depression impairs adherence to both medical and mental health treatments. It’s associated with increased mortality and is the leading cause of disability worldwide.
- About six percent of the elderly are considered to be heavy users of alcohol.
- Alcohol use disorder is often associated with depression, and contributes to serious medical conditions, including liver disease and coronary heart disease.

Innovating Care Delivery Across Minnesota

Communities experiment to improve health

Communities across Minnesota are exploring innovative strategies to enhance care coordination and patient support. Organizations across the care continuum are taking action to build relationships, improve population health, and add value—all key actions to succeed in transforming care and succeed under new payment models. Many of these efforts are being spurred with state and federal support.

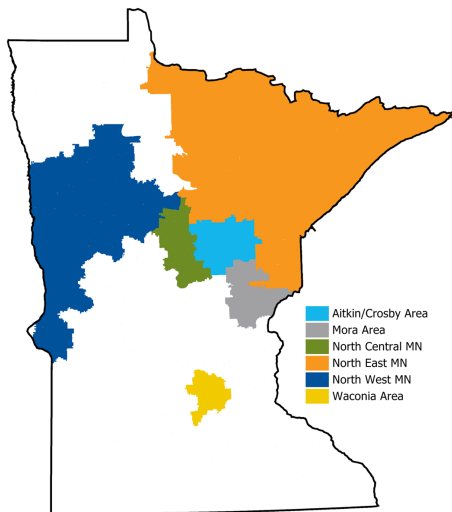
Here are a few exciting efforts currently underway in Minnesota.

Coordination of care communities

Through its Quality Improvement Organization Program, Medicare is fostering nearly 200 new collaborative coalitions across the country to improve transitions of care in their communities. The emphasis is on serving Medicare beneficiaries who may struggle the most with fragmented health care—those with multiple chronic conditions, with health literacy needs or living in rural areas.

In Minnesota, Stratis Health currently is facilitating six of these communities, with nearly 400 participants overall from health care, government, and community organizations. The communities are working on a range of efforts, including advance care planning, discharge processes, medication therapy management (MTM), and social support.

“The world of care coordination is flooded right now with everybody’s intervention and we don’t always know what everyone else is working on,” said Jenny Friday, nurse care coordinator and educator, FirstLight Health System, which participates in the Mora area community coalition. “When we get together at that table we hear what everyone else is doing, so we don’t duplicate work or services, and can build on each other’s efforts.”



This cross-organization sharing has increased patient use of FirstLight’s MTM services. Care partners now better understand the value of MTM and encourage patients to use this service.

“We’re looking at all kinds of ways to better serve our rural community,” Friday said. “And, trying to keep our head above the tide of care coordination.”

Practice facilitation

As part of the Minnesota State Innovation Model (SIM) strategies, the Institute for Clinical Systems Improvement and Stratis Health have combined practice facilitation resources to support eight organizations, with 10 clinics and approximately 140 clinicians, across Minnesota.

The organizations will use a variety of practice enhancement methods to facilitate system-level changes. They will focus on total cost of care, chronic disease management, health care home certification, health IT, behavioral health integration, alternative care models and/or general quality improvement.

Catholic Charities of Saint Paul and Minneapolis, the only non-clinic participating, will work to improve care coordination and leverage health information technology (IT) to support its medical

respite clients staying at its Exodus Residence. Medical respite is short term residential care for individuals experiencing homelessness who are too ill or frail to recover on the streets, but who do not require hospital admission or continued hospitalization.

If someone has a home, health is easier to recover. A person can be surrounded with home care options and might have the support of family and friends. “Individuals experiencing homelessness often lack support networks,” Diana Vance-Bryan, Catholic Charities, senior vice president health services and chief administrative officer, shared. “It can be hard to attend to your physical health care needs, like get plenty of rest, drink lots of fluids, or take medications at the prescribed times. Sometimes medications need to be refrigerated and medical equipment requires a plug in. Seemingly simple needs can become impossible when you are on the streets.”

Its five-bed medical respite pilot in 2012 included 14 individuals. State claims data showed a 67 percent reduction in hospitalizations and over 50 percent reduction in emergency department visits, one year pre-respite to one year post. CMS is looking at medical respite as a potential model to spread.

Having expanded medical respite and health supported housing to 89 beds, Catholic Charities wants to improve internal and external communications to enhance care. Externally, the nonprofit wants to maintain clients’ care continuity with their primary care providers and to foster relationships with more hospitals so patients are directly referred to medical respite, not discharged to the street. Internally, they want to enhance communication between nurses and case managers and ensure completion of patient

assessments and goal setting discussions. They also want to use health literacy tools to better engage distressed patients who may not retain much of their hospital discharge information.

By leveraging health IT, Catholic Charities wants to enhance its ability to gather patient data, as well as capture outcomes and how clients are improving over time.

“We need to do a better job of data collection around care coordination and case management,” said Vance-Bryan. “Data gives a clearer picture of the work we are doing and how staff are helping the population they serve.”

Community wellness

Based on priorities identified through a multi-organizational community needs

assessment, the Todd-Wadena Healthy Connections collaboration made a commitment to develop a prediabetes referral process to community-based services. As part of that effort, Tri-County Health Care and Lakewood Health System, two central Minnesota independent health systems, are collaborating in offering prediabetes education in the region.

Among the classes, they have partnered with the University of Minnesota Extension to deliver its 12-week evidence-based course I CAN Prevent Diabetes. Tri-County Health Care’s first group of participants lost an average of 10 percent of their body weight.

Stratis Health is supporting both health systems in assessing how they can use their electronic health record systems to

track patient participation in prediabetes classes and to create a feedback loop so primary care providers know their patients have taken action for their health. Much of this work is supported through a Minnesota Department of Health Community Wellness Grant.

“With accountable care and all of the changes that are happening, we need to be focusing on well and healthy—really promoting more wellness with community outreach and education,” said Sara Stone, medical social services and health promotion manager, Tri-County Health Care.

As payment methods move toward providing limited money to treat conditions, health care organizations need to prioritize a culture of wellness and be creative to foster healthier communities. ○

The Role of Community-Based Organizations in Population Health

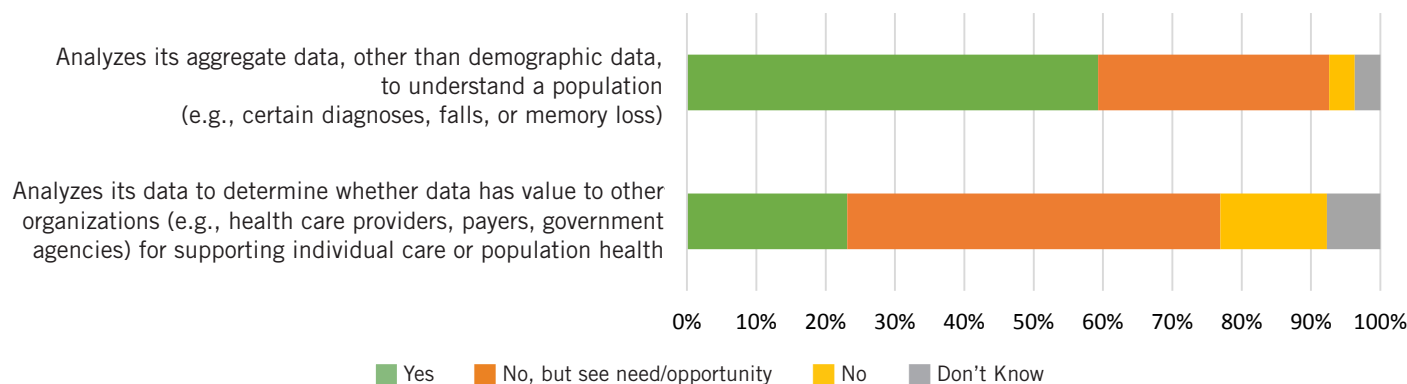
Community-based organizations/home and community-based services (CBOs/HCBSs) support population health through care coordination, daily living support, caregiver support, and delivery of evidence-based self-management programs. Their services can be essential in supporting the poor and underserved in maintaining their health and housing. CBOs/HCBSs want to be able to position their services as tools that advance the health care delivery goals of better care for individuals, better health for the population, and lower cost through improvement.

The Metropolitan Area Agency on Aging sponsored a three-part training series led by Stratis Health on health IT to help CBOs/

HCBSs understand the terminology, rules, tools, and processes of health IT so the organizations can remain vital and vibrant within the framework of value driven health care. Findings from a Stratis Health survey of 27 participants include:

- Nearly 60 percent are using data to understand the populations they serve. But, fewer than 25 percent use that data to coordinate with others serving the same population (chart below).
- CBOs/HCBSs recognize the need to reframe their services to be viewed as part of the net of care that supports individuals in achieving their own level of optimal health and wellness.

Community-Based Organizations Use of Data to Support Individual and Population Health in a Community



[Full survey summary](#) available online.



Challenge to Rural Communities: Find Your Role in Delivery System Reform

Karla Weng, MPH
Sr Program Manager, Stratis Health

Significant efforts are underway to fundamentally change the way health care is provided and paid for in the United States. To increase the pace of these changes, in early 2015 the U.S. Department of Health and Human Services (HHS) launched a delivery system reform initiative to accelerate improvements to our health care delivery system. The overarching objective of the initiative is to improve care while spending dollars more wisely across the U.S. health care system.

A critical component of delivery system reform is to accelerate adoption of reimbursement models that reward value and care coordination. Alternative payment models, such as accountable care organizations and bundled service payments, are one key component, with HHS setting targets of 50 percent of Medicare Fee-For-Service payments through these new models by 2018. Incentives linked to quality of care metrics also are growing exponentially, with an HHS goal of 90 percent of Medicare FFS payments linked to quality by 2018.

Several barriers and challenges stand in the way for rural providers to participate in these reimbursement models:

- ♦ Paid under cost-based reimbursement models aimed at stabilizing financing for safety net care, providers designated by Medicare as critical access hospitals (CAHs) and rural health clinics are excluded from many quality incentive programs and care coordination payments linked to current fee-for-service structures.
- ♦ Rural hospitals frequently don't have enough patients with specific conditions to meet the minimum population sizes for public reporting of quality measures, and many current quality metrics focus on services they may

not provide, such as specific types of surgery or ICU care.

- ♦ Most small rural providers do not have a sufficient patient panel of any single payer type to meet participation requirements for alternative payment models. For example, Medicare ACOs require a minimum of 5,000 Medicare FFS beneficiaries—more than entire populations of many rural towns.
- ♦ Rural hospitals generally have limited capital and financial resources, and face acute provider shortages, making the infrastructure investments needed for successful participation in alternative payment models even more challenging.

“ Holding on to the status quo leaves rural communities at risk of being left behind.”

Although some rural health care leaders may breathe a sigh of relief that they are excluded from many of these changes, they are not immune to the impacts. Value-based reimbursement models nearly all include incentives related to reducing overall costs by improving care coordination and reducing hospitalizations and emergency department utilization. Providing evidence of high quality care delivery necessitates participation in quality reporting programs, as partners, payers, and consumers will, and should, demand evidence that the quality of care provided in a small rural hospital is equivalent, if not better than those same services in an urban setting.

Despite the challenges, many rural communities are stepping up to the opportunities of delivery system reform.

- ♦ Although considered voluntary by CMS, nearly 90 percent of CAHs nationwide participate in public reporting of at least some quality metrics. Nearly all of the 79 CAHs in Minnesota publicly report quality data.
- ♦ Many rural health care organizations are embracing redesign of care delivery focusing on the full spectrum of population health needs. We're seeing rural communities develop school-based services to reach families and children; focus on care coordination and community supports for those with chronic illnesses; and address end-of-life care needs such as advance care planning and developing palliative care services.
- ♦ Rural health care organizations are integrating emerging health professions, such as community health workers and community paramedics, to help effectively meet community needs.
- ♦ New governance approaches which pool patient panels across communities and/or align across a wide spectrum of health and human services are being developed to allow participation in alternative payment models and incentive redesign of service delivery.
- ♦ In Minnesota, State Innovation Model supported efforts have accelerated involvement of rural providers in delivery system reform, more so than in many other parts of the country.

For continued viability in a delivery system reformed world, rural health care leaders need to be thinking broadly about health and health care in their communities—what is their organization's role in ensuring not only access to health care services, but to improving health and wellbeing of the population they serve. Holding on to the status quo leaves rural communities at risk of being left behind. ○

STRATIS HEALTH NEWS

Quality Measures for Community-Based, Rural Palliative Care Programs in Minnesota: A Pilot Study. This Journal of Palliative Medicine article reviews a Stratis Health study to identify and field test a standard set of quality measures for rural, community-based palliative care programs.

Jennifer P. Lundblad, Stratis Health president and CEO, presented on the impact of delivery system reform on rural health at the National Advisory Committee on Rural Health and Human Services on behalf of Rural Policy Research Institute (RUPRI) Health Panel.

Kim McCoy, Stratis Health Minnesota state director QIN-QIO program and senior program manager, was certified as an official site visitor for the national Public Health Accreditation Board. Public health accreditation provides a framework for a health department to identify performance improvement opportunities, improve management, develop leadership, and improve relationships with the community.

One component of accreditation focuses on integration of performance management and quality improvement practices and processes for the continuous improvement of the public health department's practices, programs, and interventions.

Dr. Paul Kleeberg will be leaving Stratis Health in November 2015 after five years as chief medical informatics officer and REACH clinical director.



"I really believe in what Stratis Health does," Dr. Paul Kleeberg. "I am proud of what we have accomplished together to help others leverage health IT to make lives better."

"Paul's commitment and leadership has deeply contributed to Stratis Health's robust health IT program and health reform role," said Jennifer Lundblad, Stratis Health president and CEO. "We are poised to continue strengthening the capacity of health care organizations and their partners to use technology to improve health."

Upon leaving Stratis Health, Dr. Kleeberg joins Aledade as medical director.



Gary Wingrove, chair elect, recognizes outgoing board member Huda Farah for her six years of service on the Stratis Health board of directors.



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, convener 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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