StratisHealth

QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Spring 2011

40 Years of Quality Improvement

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

During National Patient Safety Awareness Week in March, Stratis Health began a year-long celebration of our 40th anniversary as a leader in health care quality improvement and patient safety. Since 1971, Stratis Health, originally the Foundation for Health Care Evaluation, has been leading and supporting health care quality in Minnesota and nationally—at the provider, community, and population levels, and across the full continuum of health care.

Over the past 40 years, Stratis Health has reached out to nearly every hospital, primary care clinic, nursing home, and home health agency in Minnesota to assist them with improving the care they deliver. We've had the privilege of guiding and working alongside providers to facilitate improvement in health outcomes and the processes and culture that support care delivery.

Stratis Health has continuously held and successfully implemented the Centers for Medicare & Medicaid Services Quality Improvement Organization (QIO) contract in Minnesota since the program's inception in the 1970s—this work has been our hallmark program over the life of the organization. I am pleased and proud to share the news that Stratis Health successfully met the rigorous performance measures for the current 2008-2011 QIO contract; and based on our excellent performance, we will continue to serve as Minnesota's QIO in the next three-year scope of work, which begins on August 1, 2011.

Building on the success and results of its QIO program effort, Stratis Health is a growing organization with more than 60 staff and a diverse funding base. Stratis Health develops and carries out a wide variety of quality and safety improvement initiatives for state and federal agencies, foundations, health plans, and others. And, with our Key Health Alliance partners, we serve as the federally designated Health Information Technology Regional Extension Center, one of 62 such centers across the country.

Stratis Health's strategies and core competencies have evolved as quality improvement and patient safety science have advanced, and include measuring and reporting performance, adopting and effectively using technology, redesigning care processes, and changing organizational cultures. Stratis Health staff members and their work are nationally recognized in rural health, health information technology, cultural competence, and long-term care quality and safety.

In both clinical and non-clinical areas, Stratis Health sits at the intersection of research, policy, and practice. At its core, the organization's work helps providers translate evidence-based research and guidelines into practice to improve quality, advance prevention and wellness, and foster safe and person-centered care. While our work often focuses on system changes, the individual impact on patients and providers is what inspires us to support excellence in care delivery.

With the nation in the midst of groundbreaking efforts to innovate in care delivery and payment design, it's an extraordinary time for Stratis Health to be celebrating 40 years in health care quality. I thank you for your support and shared commitment to quality. We look forward with anticipation and excitement to our future…as the saying goes, life begins at 40, and we are poised and ready to the lead the way.

THIS ISSUE

Fostering Connection—Sustaining Quality in Rural Primary Care

Perspective from
Kathleen Brooks,
Stratis Health Board member

Students become "boundary crossers", health care professionals conversant in medicine and in the needs of the community.

Kathleen Brooks, MD, MBA, is a member of the Stratis Health Board of Directors. At the University of Minnesota, she is the director of the Rural Physician Associate Program at the Medical School and assistant professor in the Department of Family Medicine and Community Health.

Minnesota has been a leader in health care reform efforts for many years and has been known nationally as a state with progressive activities in integration of health care delivery systems, quality improvement, and patient safety programs. This is a state that has historically valued the role and services of its primary care providers.

Minnesota's overall supply of primary care physicians is as good as or better than many other states. Yet, many rural areas of the state are experiencing physician shortages, which are expected to increase because of national trends.[1,2]

Last year, Congress passed the federal Affordable Care Act, which promises to insure more people, likely increasing the need for primary care health care workers. The American Association of Medical Colleges (AAMC) Center for Workforce Studies analyzed physician workforce needs and confirmed likely significant shortages in coming years.[3] Factors impacting this trend include population growth, aging, medical advances increasing demand for services, aging of physicians, and changing work patterns of younger physicians. AAMC concluded that it will be important to use the physician supply wisely, redesigning the health care system to increase the use of interdisciplinary teams, and investing in system-based care that can improve efficiency and effectiveness through such measures as improved use of information technology. These recommendations align well with Stratis Health's work.

Concerns about rural primary care physician workforce shortages were emerging 40 years ago. The University of Minnesota Medical School responded by establishing the Rural Physician Associate Program (RPAP), a nine month, rural longitudinal immersion program designed to nurture interest in rural medicine and primary care at a crucial point in third year medical students' training. It is considered the earliest known such program in the world and has been emulated extensively in the United States, Canada, and Australia.

Approximately 40 RPAP students a year live and train in rural communities, completing their core clinical clerkship requirements. They experience continuity with patients, their families, the health care team, and the community, getting to know them and becoming known and trusted. Students become "boundary crossers", health care professionals conversant in medicine and in the needs of the community. They participate in online discussions with their classmates across Minnesota about quality and patient safety approaches in their systems.

Students complete a community health project engaging with local stakeholders to address an identified local health care need. For six RPAP students last year that meant participating in their community's palliative care learning project, through Stratis Health's Minnesota Rural Palliative Care Initiative—an innovative community-based effort to build palliative care capacity in rural communities. Students participated in a variety of ways, from delivering community presentations to working on order sets, and gained experience as part of interdisciplinary teams.

The opportunity to have an authentic role in a rural health care delivery system allows the RPAP students to significantly advance in their identity formation as future physicians. Of the more than 1,200 students who have participated in RPAP since 1971, 75 percent practice primary care, 67 percent are family physicians, and more than half practice in rural settings.

Through RPAP, the medical school collaborates with health care systems across the state and with organizations such as Stratis Health to create curricula that help educate future physicians for their roles on health care teams caring for patients and communities. In this way, Minnesota can continue its long tradition of working to proactively address future primary care workforce needs.

1. Brooks KD. Cieslak JE. Radcliffe PM. Sjogren K. Primary Care in Minnesota: An Academic Health Center Perspective. University of Minnesota Academic Health Center. January 2008.
2. Minnesota Physician Workforce Geography 2009. Minnesota Department of Health Office of Rural Health and Primary. July 2009.
3. Dill MJ, Salsberg ES. The Complexities of Physician Supply and Demand: Projections Through 2025. AAMC Center for Workforce Studies. November 2008.

Rural Palliative Care

Evidence is mounting for this community-based approach

Palliative care has been gaining momentum as a care delivery method. This approach to managing chronic disease and other serious and advanced illness—centering on relieving suffering and improving quality of life for patients and their families—has slowly proven itself as an effective means to improve quality of life, enhance care delivery, and conserve limited health care dollars.

Nationwide systematic changes in care delivery take time. Hospice was first introduced in the 1960s. Two decades passed before it became a provisional Medicare benefit, finally becoming a guaranteed benefit in 1993. Clinical and fiscal evidence is mounting in favor of broadly implementing palliative care.

A study published in 2010 by the *New England Journal of Medicine* showed that lung cancer patients who received palliative care early lived longer and chose less aggressive care than patients receiving standard care.[1]

A recent study of palliative care team consultations for Medicaid patients at four New York State hospitals, showed that, on average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than patients who received standard care. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals than similar patients.[2]

"We now have the scientific evidence for what we knew in our hearts all these years," said Julie Pahlen, director of the LifeCare Home Medical Center, and participant in Stratis Health's Minnesota Rural Palliative Care Initiative.

The models for palliative care programs come from urban settings focused on hospital-based programs, with higher patient volumes that allow for offering specialized care. In resource-strapped rural communities, these models don't apply. Recognizing the need to support palliative care, Stratis Health leads learning collaboratives aimed to develop or strengthen palliative care services in rural areas. Without models for palliative care in rural communities, Stratis Health used community capacity development theory to help the communities create programs that meet their needs.

Building community capacity

Developed within the public health realm, community capacity development theory focuses on transferable knowledge, skills, systems, and resources that affect change on the community and individual levels.

Consistent with the community capacity approach, each team in Stratis Health's collaboratives identifies its current gaps in service, needs of its community, and available resources. The teams then develop a program matched to the needs and resources in their community.

Because palliative care is about caring for the whole person, it requires the support of a multidisciplinary team. The communities that have participated in the initiatives have built and strengthened relationships across departments and across organizations in order to develop and support palliative care services.

"Our palliative care efforts have strengthened our health care community. It's pulled us together and had us look at the team approach to better serve patients," said Pahlen. "We now have put faces to agencies, and we've shared concerns back and forth."

This connectivity will serve them well in supporting other cross-setting initiatives, such as health care homes and reducing hospital readmissions, which are gaining national prominence. Numerous tools exist to address barriers in care coordination

and reducing hospital readmissions—the primary challenge is bringing together community teams to implement the tools, processes, and services.

"We need to find creative ways of bringing together interdisciplinary teams," said Rhonda Wiering, regional director of quality initiatives, Avera Health System, and member of Stratis Health's rural palliative care advisory committee.

Emerging models

Palliative care programs are emerging from various settings in rural communities—home health agencies and nursing homes, as well as hospitals.

"A key finding from our first collaborative was that rural communities can find a way to provide palliative care services," said Karla Weng, Stratis Health program manager. "Programs can develop wherever the skill sets and champions are found."

Stratis Health has helped foster programs that have grown from a passion of health care providers who have seen patients suffering in the care gap between treatment and hospice care. With time, these programs may serve as models for implementing palliative care in rural areas throughout the country.

"If we do not have palliative care in our rural sites, we are going to fail people," said Wiering.

More on palliative care at www.stratishealth.org/palcare.

1. Temel et al. Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer. New England Journal of Medicine. August 2010; 363:733-42.
2. Morrison et al. Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries. Health Affairs, 30(3), 454-463.

Making Significant Improvements through Minnesota's Medicare QIO Projects

Advancing patient safety and quality improvement for Medicare consumers

By participating in Medicare Quality Improvement Organization (QIO) projects over the past three years, health care providers and organizations in Minnesota made significant improvements in health care processes and patient care, as assessed by more than 40 measures. As Minnesota's Medicare QIO, Stratis Health developed and led evidence-based clinical initiatives and provided objective expertise to meet national health care priorities, which focused on the greatest needs and opportunities for improvement identified by the Centers for Medicare & Medicaid Services (CMS).

Adult primary care clinics

Stratis Health is working with 10 clinics to leverage electronic health record (EHR) systems to support evidence-based practice that will improve preventive health care for Medicare consumers. The clinics modify clinical workflows to achieve greater efficiency with EHRs, fully utilize EHRs to coordinate patient care, and extract and report data from their EHR system to support quality improvement. The clinics achieved two-year target goals within the first year of the project. Rates improved dramatically for the four preventive screening measures:

- Influenza immunization—from 44.24% to 47.29%
- Pneumoccocal immunization—from 25.33% to 49.95%
- Colorectal cancer screening—from 28.30% to 38.96%
- Mammography—from 35.79% to 45.36%

Hospitals

Stratis Health has been providing tailored technical assistance for patient safety to hospitals on clinical quality, teamwork, organizational culture, and leadership. Nine Minnesota hospitals are participating in a

project to improve surgical care by reducing surgical complications and improving heart failure treatment. The project focuses on preventing complications in four areas that comprise 40 percent of the most common complications after major inpatient surgery: infection, blood clots, and adverse cardiac and respiratory events.

- Collectively, the hospitals are improving on 7 of 8 measures, exceeding 5 benchmarks

We are working with two Minnesota hospitals to maintain low methicillin-resistant Staphylococcus aureus (MRSA) infection rates. Only one hospital-acquired MRSA infection has occurred during the project.

Stratis Health supported transparency in health care quality and patient safety by working with all Minnesota hospitals to collect and submit quality data to Hospital Compare, and by offering educational and technical assistance on the use of CMS reporting specifications, systems, and tools.

- 100% reporting by critical access and prospective payment system hospitals

We collaborate with the Minnesota Hospital Association to calculate and publish measures of Minnesota hospital performance, including clinical quality and patient experiences of care, on Minnesota Hospital Quality Reports.

Grand Itasca Clinic and Hospital, Grand Rapids, worked with Stratis Health on improving surgical care. Through root cause analysis, the hospital identified how to approach improvements. Its multidisciplinary team developed a "hard-stop" process for discontinuing antibiotics within 24 hours after surgery— resulting in 100 percent consistency.

After Stratis Health trained Chippewa County Montevideo Hospital staff to use an evidence-based teamwork system designed to improve patient safety through better communication and teamwork skills, the hospital implemented a handoff communication tool to ensure pertinent information accompanies patients as their care providers change.

Evansville Care Campus has watched its use of physical restraints diminish over the past few years. Now, nursing home staff uses restraints as a last resort.

Villa Health Care Center, Mora, reduced the incidence of pressure ulcers for its residents over two years. The facility reduced its rate from 15 to 2 percent—well below the state and national average.

Nursing homes

Working with 43 nursing homes to reduce the incidence of pressure ulcers and the use of physical restraints, Stratis Health provided assistance with implementing evidence-based practices, organizational leadership assessment, and support for culture change toward person-centered care.

- Pressure ulcers rates decreased from 11.27% to 9.08%
- Use of physical restraints decreased from 4.65% to 1.69%

Stratis Health provided quality improvement technical assistance to three nursing homes identified by CMS as having a history of serious quality issues. All of the homes have taken steps to improve and have successfully graduated from the CMS special focus facility list.

Health plans

Stratis Health worked with one Minnesota health plan to improve drug safety by identifying top medications associated with drug-drug interactions (DDIs) and potentially inappropriate medications (PIMs) in the elderly, then developing educational and system strategies with providers, pharmacies, and care coordinators to address these medications. The health plan far exceeded improvement goals. Its DDI and PIM rates improved faster than the rates of other Minnesota health plans.

Medicare beneficiaries

In addition to our assistance to health care organizations, Stratis Health works in protecting beneficiaries and promoting health care value by addressing quality of care complaints and reviewing discharge appeals. In our 2008-2011 QIO work to date, we responded to nearly 3,500 Medicare medical record review cases and fielded 4,450 helpline calls.

New Direction for Medicare QIO Work

The Centers for Medicare & Medicaid Services (CMS) has laid out a new direction for its national health care quality improvement program, implemented through the Medicare Quality Improvement Organizations (QIOs) nationwide. It is based on the U.S. Department of Health and Human Services' National Quality Strategy, called for under the Affordable Care Act, which is the first effort to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care in the United States.

From August 2011 through July 2014, Stratis Health's work as the QIO for Minnesota will be based on the National Quality Strategy's three broad aims: better health care, better health for people and communities, and affordable care through lowering costs by improvement.

The key themes for the upcoming quality improvement work include:

Beneficiary and family centered care

- Implementing a case review program to respond to quality of care concerns, appeals, utilizations reviews, and Emergency Medical Treatment and Labor Act (EMTALA)
- Patient and family engagement

Improving individual patient care

Make care safer and more affordable by:

- Reducing health care acquired conditions, including infections and pressure ulcers
- Reducing physical restraint use in nursing homes
- Reducing adverse drug events
- Enhancing hospital quality reporting

Integrating care for populations and communities

Improve quality of care for beneficiaries who transition between care settings by:

- Reducing readmissions following hospitalizations

Improving health for populations and communities

Work with providers to use their electronic health record systems for:

- Improving prevention through screening and immunizations
- Improving prevention in cardiovascular disease and early diagnosis through improved use of technology
- Facilitating physician participation in national quality reporting

Stratis Health will support care reinvention through the spread of innovations by providing training and technical assistance on clinical quality, teamwork, organizational culture, and leadership; leading local learning and collaborations by facilitating strategic partnerships; and supporting and convening learning and action networks.

Some aspects of this work continue or build upon past QIO work. This work is framed to have great impact and a broad reach. It will tap into Stratis Health's experience and expertise in leading learning collaboratives through several learning and action networks, focused technical assistance based on evidence based best practices, and strategies to spread innovation.

Stratis Health has served as Minnesota's Medicare Quality Improvement Organization since the program's inception in the 1970s. Through the next Medicare QIO body of work, we will collaborate with many health care organizations and providers, and engage consumers, to accelerate and broaden the impact of quality improvement, and continue to lead measurable improvements in care for Minnesota's 780,000 Medicare consumers.

Stratis Health Helps Minnesota Achieve 100% of Hospitals Reporting

As part of a larger Minnesota health reform initiative passed in 2008, all hospitals, including critical access hospitals (CAHs), are required to report quality data collected on measures found in the Minnesota Statewide Quality Reporting and Measurement System.

By the reporting deadline in late 2010, all of Minnesota's 79 CAHs and 53 prospective payment system (PPS) hospitals were submitting data.

The goal of this initiative is greater transparency and, ultimately, improved health care for Minnesota health care consumers. Public reporting provides a transparent view of provider performance based on quality information on selected measures.

Larger hospitals were already reporting these measures and had little, if any, change in abstraction and reporting requirements. CAHs not already abstracting and reporting the Centers for Medicare & Medicaid Services core measures needed to understand the proposed rule and plan for implementation. Stratis Health provided training to CAHs on what the measures are and how to accurately abstract and enter data into the reporting system—in addition to having an active role in determining the quality measures for hospitals.

National Themes, Issues and Aims

Understanding national priorities and issues related to quality and safety can help health care organizations when it comes to defining their own strategic goals. National-level priorities and issues can serve as guide posts or may be imperative, driving strategic direction. In addition to the National Quality Strategy aims and the key themes for the Medicare Quality Improvement Organization, quality and disparity themes from Agency for Healthcare Research and Quality (AHRQ) and issues for Medicare provide insights into the concerns driving national health reform.

AHRQ themes from 2010 analysis

AHRQ called out four themes in its 2010 National Healthcare Quality Report and 2010 National Healthcare Disparities Report.

1. Health care quality and access are suboptimal, especially for minority and low-income groups.
2. Quality is improving; access and disparities are not improving.
3. Urgent attention is warranted to ensure improvements in quality and progress on reducing disparities with respect to certain services, geographic areas, and populations, including:
   - Cancer screening and management of diabetes
   - States in the central part of the country
   - Residents of inner-city and rural areas
   - Disparities in preventive services and access to care
4. Progress is uneven with respect to eight national priority areas:
   - Two are improving in quality: palliative and end-of-life care, and patient and family engagement
   - Three are lagging: population health, safety, and access
   - Three require more data to assess: care coordination, overuse, and health system infrastructure
   - All eight priority areas showed disparities related to race, ethnicity, and socioeconomic status

Top 10 Medicare issues in 2011

The Bureau of National Affairs Medicare Report listed the following items as the top 10 Medicare issues for this year.

1. Regulations to determine shape and scope of accountable care organizations
2. Testing different payment methods by the Centers for Medicare and Medicaid Innovation
3. Potential cuts in Medicare payments
4. Changes in Medicare Advantage enrollment periods and a payment freeze
5. Reducing Part D plan enrollees' share of drug costs in the coverage gap until eliminated in 2020
6. Physician quality reporting system and electronic prescribing incentive programs
7. Provider penalties for failing to participate successfully in program
8. Beneficiaries required to obtain their competitively bid items only from CMS-contracted suppliers with successful bids in 2010
9. Continued litigation of whether general assistance days should be included among Medicaid-eligible days
10. Litigation over use of collection agencies and concurrent write-offs for bad debts

1. National Healthcare Quality Report, Agency for Healthcare Research and Quality, March 2011.
2. Bureau of National Affairs, Medicare Report, January 7, 2011.

Looking at the numbers: preventive screenings in Minnesota clinics

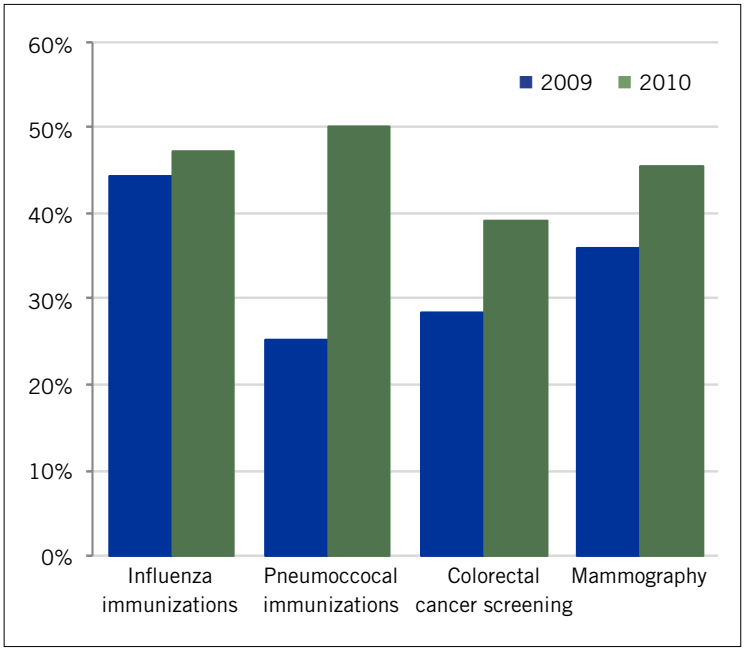
Since 2009, Stratis Health has been working with 10 Minnesota clinics to leverage electronic health record (EHR) systems to increase rates for influenza and pneumococcal vaccination, colorectal cancer screening, and mammography for Medicare consumers. Stratis Health works with primary care practices that have implemented an EHR system to:

- Track preventive care, tests, and immunizations
- Generate clinical reminders at the point of care
- Identify patients who have not received preventive services
- Measure preventive service rates at the practice level
- Report performance on preventive care and quality of care indicators

The 10 Minnesota clinics increased their EHR-reported rates and achieved the two-year target goals set by the Centers for Medicare & Medicaid Services (CMS) within the first year of the project.

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety. This work was completed as the Medicare Quality Improvement Organization for Minnesota, under contract with CMS.

Preventive Screening Rates at Participating Minnesota Clinics

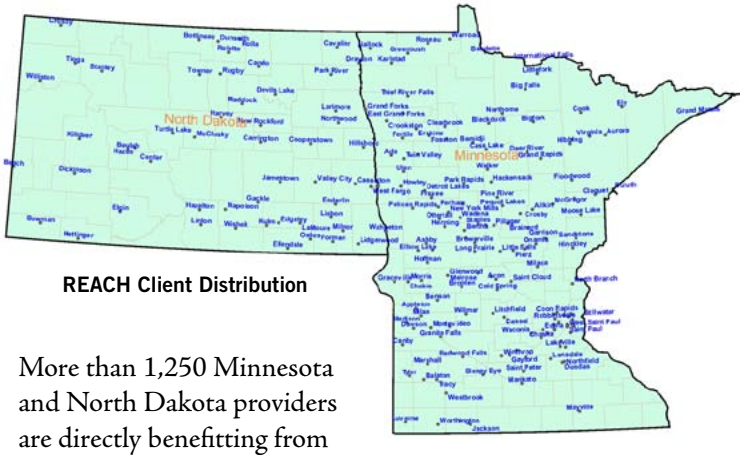


Progress toward EHR meaningful use - more than 1,000 providers served

The Office of the National Coordinator has made some major changes to the federal Health Information Technology (HIT) Regional Extension Center program. These changes impact how the Regional Extension Assistance Center for HIT (REACH) works with providers in Minnesota and North Dakota, to achieve meaningful use. The changes:

- Expand provider eligibility
- Extend recruiting through January 2012
- Continue REACH work with providers on achieving meaningful use of their EHRs through 2013. Clients must have a signed contract by January 2012
- Increase funding for critical access and rural hospitals with fewer than 50 beds from $12,000 to $18,000 per hospital

REACH ranks 13th among all 62 regional HIT extension centers across the nation for recruitment achievement regarding the number of priority primary care providers engaged in the program. It ranks second regarding the number of critical access hospitals engaged.



REACH Client Distribution

More than 1,250 Minnesota and North Dakota providers are directly benefitting from REACH services, including 295 primary clinic locations and 62 critical access hospitals; 35% and 51% respectively of its client recruitment goals. Nationally, 60,000 providers are working with regional extension centers.

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

STRATIS HEALTH NEWS

MHA-Stratis Health Regional Meetings. Throughout April, Stratis Health and the Minnesota Hospital Association held six regional Patient Safety and Quality Meetings as forums for quality and patient safety professionals to discuss current issues, common barriers, and success stories, as well as the opportunity to network and problem-solve with peers.

Health Plan Performance Improvement Projects For the Minnesota health plans that offer publicly subsidized health care programs, Stratis Health provides facilitation and consultation in developing, implementing, and evaluating performance improvement projects. Information about the performance improvement projects is available at www.stratishealth.org/providers/healthplanpips.html.

Stratis Health welcomes new staff members. Joining our quality improvement staff, **Kristi Wergin, RN, program manager,** supports quality improvement in nursing homes. She has 30 years experience as a registered nurse with background in elder care, quality improvement, leadership, and management. She applies her interests in person-centered care, staff education and training, and measuring and improving customer and employee satisfaction.

Leslee Frisch, RN, case review manager, provides expertise in the areas of medical record review and data abstraction and serves as a key contact for beneficiaries, physicians, and providers throughout the medical record review process. She also assists in the administration of the Medicare Helpline and immediate appeal telephone lines.

National presentations. Karla Weng, MPH, program manager, presented "Community-Based Care Transitions: Rural Considerations" to the National Advisory Group on Rural Health and Human Services in February.

Paul Kleeberg, MD, REACH clinical director, gave federal testimony in January before the Health Information Technology Standards Committee, Implementation Workgroup, on electronic health record implementation experiences as a regional extension center for health information technology.

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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