2014: A Year of Significant Change in Health Care

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

Since the passage of the Affordable Care Act in 2010, we were anticipating the big changes slated for January 1, 2014. Across the health care system, people have been working hard to support increased access to care with the expansion of Medicaid in many states, including Minnesota. They've pioneered and struggled to develop new systems for health insurance exchanges, with MNSure being established in Minnesota.

These changes are intended to dramatically expand health care coverage and, as a result, access to health care services for millions of people across the country. In Minnesota, add to these coverage efforts the final push in 2014 to meet the January 1, 2015 mandate for interoperable health records.

Yet the impact of these changes won't be obvious in the health care system all at once. While many people nationally and in Minnesota were newly covered by health care insurance as of the end of March, how and when they access and use services remains to be seen.

Stratis Health is looking at these changes with an eye to how the health care system can ensure quality, safety, and value. Just as many businesses have found ways to simultaneously deliver on price, quality, and speed, health care needs to find how to design care delivery to improve popula-

tion health and experience of care while making care affordable.

The efforts underway in recent years to redesign the care delivery system and test new payment models that incent and reward quality and value are increasingly essential in anticipation of the influx of new patients. Minnesota has been a leader in embracing changes driven by federal and state reforms, and by commercial and private payers. This leadership has been demonstrated by the State in the:

+ Minnesota Health Care Homes program
+ Community Transformation Grants
+ State Innovation Model and "Accountable Communities for Health" approach
+ Integrated Health Partnerships Program in Minnesota Medicaid
+ State Quality Measurement and Reporting System

Stratis Health has been leading collaboration and implementation of innovations in support of health care's golden triangle

THIS ISSUE

of the Triple Aim. We are working with providers to increase access to "upstream" care such as prevention and screening, and to use their electronic health records to understand and support their patient populations. We are leading the RARE Campaign to reduce avoidable readmissions in partnership with the Minnesota Hospital Association and the Institute for Clinical Systems Improvement, paving the way for nursing homes to embrace QAPI (Quality Assurance Performance Improvement), and guiding rural communities and provider organizations to be actively participating in new care delivery and payment models through our national rural health value project with the University of Iowa.

When we look back on 2014 a few years down the road, my hope is that these significant changes will have resulted in a genuine and positive impact on health and health outcomes. ○

Health care delivery is ever changing – with more changes to come

Perspective from
William Jacott, MD
Stratis Health board member

Insights on changes in health care and quality improvement: past, present and future

William Jacott, MD is a former trustee of the American Medical Association, past chair of the Joint Commission, and associate professor emeritus of family medicine at the University of Minnesota Medical School.

I STARTED PRACTICE IN 1965. There were three of us GPs in a small community office in Duluth. We were general practitioners since family practice was not approved as a recognized specialty until 1969. In 1980 we joined a large multi-specialty clinic in Duluth. Our overhead dropped 19 percent and we were better able to initiate quality systems and quality measurement. This trend of independent practices consolidating or joining health systems has continued. I believe in the future we will see that most solo or small group practices will join larger groups or systems, except for a few non-primary care specialists.

That year, 1965, was also the year that Congress adopted Medicare and Medicaid. When it was implemented one year later, we found that our payments for an office call had doubled. In our case, it went from $3.00 to $6.00 per visit. Now, 50 years later, we have another huge health care law before us—The Affordable Care Act (ACA). Yes, there are some controversial components like the mandate for coverage and birth control issues. I suspect those who are calling for total repeal have not read the complete bill. It does contain support for quality initiatives and already the number of uninsured has dropped significantly as a result of its provisions. However, let's leave the debate for the politicians and professional organizations. It will be argued for many years to come.

> " That future will brighten if those of us in health care break down some barriers and work together."

Patient care and quality

Let's look at some other issues that will affect patient care and quality:

Health care professional education. Big changes are already in place but will expand greatly in the coming years. There will be more use of technology which will facilitate more independent study. The old lectures are out—sorry, professors. There will be more use of simulation and actors who serve as standardized patients. The curriculum will include more emphasis on quality measurement and patient safety.

Outpatient or ambulatory care. More and more procedures will be performed away from the hospital, which will become one large intensive care unit. (When I first started practice, cataract patients spent seven days in the hospital with sand bags on both sides of their head.) Systems for quality measurement will finally apply to outpatient or ambulatory care settings.

Geriatrics. More support for education and care within this specialty will occur. Assisted living facilities will finally be monitored and evaluated.

Patient safety. Better programs, realistic solutions, and buy-in by all health care professionals has to occur.

Transparency. What we do in health care must be more visible and understandable. The detailed cost of care delivery should be part of this area.

Team care. This has already improved but we will see more progress. The patient will finally be involved as part of the health care team.

This is only a brief sketch of where we are today and where we hope to be in the future. That future will brighten if those of us in health care break down some barriers and work together for the achievement of better health for the people of our country. ◯

Medicare Redesigns and Expands Quality Improvement Program

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services (CMS) has laid out the direction for the nation's largest health care quality improvement program, the Medicare Quality Improvement Organization (QIO) program, for August 2014 through July 2019. The program is based on the U.S. Department of Health and Human Services' National Quality Strategy's three broad aims: better health care, better health for people and communities, and affordable care through lowering costs. This work will be carried out through two separate QIO structures:

- Quality Innovation Network QIOs (QIN-QIO): quality improvement through education, technical assistance, and collaboration
- Beneficiary Family Centered Care QIO (BFCC-QIO): quality improvement through individual case review

Quality Innovation Network QIOs

CMS has three high-level quality improvement aims. And, much of the QIN-QIO work builds on the strong foundation health care providers have been laying in conjunction with QIO support over the past three years.

1. Aim: Healthy People, Healthy Communities: Improving the Health Status of Communities

- Improving cardiac health and reducing cardiac health care disparities: expanding to engage home health and others, in addition to ambulatory clinics
- Reducing disparities in diabetes care: spreading the work started in a three-state pilot, the Everyone with Diabetes Counts project
- Improving prevention coordination through meaningful use of health information technology and collaborating with Regional Extension Centers: continuing and expanding to other providers

2. Aim: Better Health Care for Communities: Beneficiary-Centered, Reliable, Accessible, and Safe Care

- Reducing healthcare-associated infections in hospitals: continue to address central line-associated bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI), and C. Difficile (CDI), and add ventilator-associated events (VAE)
- Reducing healthcare-acquired conditions in nursing homes: continue strong progress in reducing antipsychotic medication use, falls, pain, pressure ulcers, physical restraints, and urinary tract infections

- Coordination of care: continue to support hospitals and deepen engagement with community partners, especially nursing homes, home health agencies, social service providers, and community health providers to further reduce avoidable readmissions

3. Aim: Better Care at Lower Cost

- Quality improvement through Hospital Value-Based Payment, Physician Value-Based Modifier, and the Physician Feedback Reporting Program: using data to identify opportunities for improvement in quality, efficiency, and care coordination

Also, QIN-QIOs will support quality improvement plans that stem from the BFCC-QIO reviews.

Beneficiary Family Centered Care QIOs

BFCC-QIOs will protect beneficiaries and improve health care services for Medicare beneficiaries through quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and Emergency Medical Treatment and Active Labor Act (EMTALA) reviews.

Reshaping the QIO Program

The redesigned QIN-QIO and BFCC-QIO contracts cannot be held by the same organization. Stratis Health chose to pursue the quality improvement work as a QIN-QIO. We will continue to perform clinical review work, including the Medicare appeal reviews, until July 31, 2014. Once the new BFCC-QIO serving Minnesota has been selected by CMS, Stratis Health will work to support a smooth transition to the new service provider.

The new QIN-QIO structure requires a regional approach, with multiple states coordinating as a network. Stratis Health is teaming with the QIOs in Michigan (MPRO) and Wisconsin (MetaStar) to serve the three states which have many traits in common: large integrated delivery networks, sizable metropolitan areas, more than 25 percent of their populations in rural areas, and reputations for innovation and having some of the best health care delivery organizations in the nation and around the world.

Like today, much of the QIN-QIO work will be performed at the state level with each of the QIOs offering tailored education, tools, and resources to health care providers in their states. The three will share opportunities and successes throughout their region to facilitate rapid improvement. ❍

Improving Quality of Care for Medicare Beneficiaries

Looking at the numbers: impact sampling

31,900 more nights that patients slept in their own beds instead of in the hospital due to avoidable readmissions

7,975 fewer readmissions among 86 Minnesota hospitals

900 fewer hospital admissions in three geographic communities

328 fewer nursing home residents were on antipsychotic medications

32% relative improvement for 12 hospitals working to reduce CAUTI infections

7,260 patient visits at 31 clinics met optimal clinical care goals for cardiac health

56 electronic health information exchanges between skilled nursing facilities, hospitals, and pharmacies

100% of participating providers received Physician Quality Reporting System incentive payments for their use of EHRs

HEALTH CARE PROVIDERS ACROSS MINNESOTA HAVE BEEN WORKING TO IMPROVE THE QUALITY, effectiveness, and efficiency of services delivered to Medicare beneficiaries. Stratis Health has been leading this work through statewide learning and action networks and through direct technical support as the Quality Improvement Organization (QIO) for Minnesota, on behalf of the Centers for Medicare & Medicaid Services (CMS).

Being integrated with the Minnesota health care community positions Stratis Health to effectively meet the goals of the QIO Program in the state. Besides care providers, like health systems, hospitals, nursing homes and physicians, our partners include trade associations, state agencies, disease advocacy groups, and consumer groups—with patients always at the heart of what we do.

Here's a look at what we have accomplished together to make lives better for Medicare beneficiaries in Minnesota through the QIO Program work since August 2011.

Medicare beneficiaries

To bolster the Minnesota health care community's efforts to reduce medical errors, Stratis Health conducted 3,734 Medicare medical record reviews between August 2011 and March 2014, including beneficiary complaints, coverage and discharge appeals, hospital admission appeals, and quality of care concerns. During that same time, the Stratis Health helpline responded to 4,498 calls with questions about care received and Medicare rights and responsibilities.

With Stratis Health assistance, the communities of Alexandria, Mora, and Waconia began supporting patients and physicians in discussing end of life care issues to enhance timely use of hospice services. Minnesota ranks below the national average for hospice utilization, even though hospice is shown

to have high patient and family satisfaction and to decrease Medicare expenditures during the last year of life by an average of $2,309 per patient.

More than 75 individuals in 12 diverse groups, from areas across Minnesota identified as being at risk for poor cardiac health, participated in self-directed conversations about heart health. This innovation project aims to empower people to take a more active role in their health.

Across the care continuum

Stratis Health used a community-based approach to support the Brainerd, Duluth, and Twin Cities north metro areas to improve transitions between care facilities and reduce hospital readmissions among the 71,000 beneficiaries collectively served. What began as six hospitals, 18 nursing homes, and eight home health agencies talking about obstacles became implementation of changes that contributed to 900 fewer hospital admissions and 200 fewer readmissions.

Cross-setting health information exchange advanced in Minnesota, with 56 successful electronic information exchanges between skilled nursing facilities, hospitals, and pharmacies (details on page 6).

Stratis Health is making lives better as the Quality Improvement Organization for Minnesota

Adult primary care clinics

All of the 23 providers who worked with Stratis Health to facilitate reporting of clinical measures through the Physician Quality Reporting System (PQRS) and to track improvement received the incentive payments for using their electronic health record (EHR) systems to report PQRS measures.

For the 31 medical clinics that Stratis Health worked with to track quality improvements in cardiac care, 7,260 of their patient visits met clinical care goals for use of aspirin, blood pressure control, cholesterol management, and smoking cessation.

Stratis Health is collaborating with the Minnesota Department of Health (MDH) to improve blood pressure control in four northeastern Minnesota communities as part of the Million Hearts Initiative.

Partnering with the Regional Extension Assistance Center for Health Information Technology, which serves Minnesota and North Dakota, Stratis Health is promoting the use of health information technology to improve population health. In addition to improvements in cardiovascular health, this work assists primary care clinics in optimizing EHR as a tool to increase preventive services like mammography screenings, colorectal cancer screenings, and flu and pneumococcal immunizations.

Hospitals

Stratis Health assists hospitals with quality reporting and improvement initiatives by creating a bridge between state and national efforts, including understanding value-based purchasing, a rewards system with incentive payments for quality of care.

To enhance patient safety, Stratis Health is providing direct technical assistance to 12 hospitals working to reduce hospital-acquired infections. Within their 22 patient care units, Stratis Health documented a 32 percent relative improvement rate for catheter-associated urinary tract infections, a decrease from 175 to 119 infections between 2012 and 2013. Statewide, Stratis Health is co-leading infection reduction efforts as part of the Collaborative Healthcare Associated Infection Network (CHAIN) with the Association for Professionals in Infection Control and Epidemiology (Minnesota chapter), MDH, and the Minnesota Hospital Association (MHA).

Through the RARE Campaign, led by Stratis Health, MHA, and the Institute for Clinical Systems Improvement, 86 hospitals have prevented 7,975 avoidable hospital readmissions since 2011—equating to 31,900 more nights sleep for patients in their own beds.

From 2010 through the fourth quarter of 2013, hospitals reduced potentially preventable readmissions using evidence-based strategies like comprehensive discharge planning, medication management, and transitions support.

Stratis Health is working with six hospitals to advance the use of medication therapy management to reduce adverse drug events.

Nursing homes

Stratis Health's statewide work with 171 nursing homes includes enhancing systems of care that lead to better outcomes, addressing systemic issues, and improving overall care. Resident care improved as 328 fewer beneficiaries were on antipsychotic medications.

From December 2010 to August 2013, our collaborative of 27 nursing homes decreased pressure ulcer rates from 12.5 to 6.44 percent and reduced use of physical restraints from 7.46 to 1.2 percent. ⭕

Paynesville Area Health Care System, a small rural critical access hospital, used medication therapy management to achieve a much lower readmission rate than the national average for its for high-risk Medicare patients—8.8 percent compared with the national average of about 18 percent.

Avera Marshall Morningside Heights has reduced resident falls to 4.8 percent, with one of its resident neighborhoods going without a fall for 67 days.

Minnesota hospitals improved their average Value-Based Purchasing total performance score, moving above the national average.

The communities of Alexandria, Mora, and Waconia began supporting patients and providers in discussing serious illness and end of life care issues to enhance timely use of hospice.

Apple Valley Medical Center used its EHR to identify patients at risk for cardiac conditions and improve their clinical care. The clinic had an 83 percent success rate in meeting quality goals for these patient encounters.

Progress in Cross-Setting Health Information Exchange in Minnesota

Medicare innovation project advances HIE for post-acute care, identifies issues

A common misconception among consumers is that their medical information already is being shared between health care providers to support their care, said Coral Lindahl, RN-BC PointClickCare coordinator at Ebenezer Ridges Care Center, Burnsville. Recently, two communities moved Minnesota a little closer to that reality, as they tested how to exchange health information by transferring data between electronic health records (EHR), not merely sharing view-only files.

Live exchanges of patient health data in March between two skilled nursing facilities (SNF)—Ecumen North Branch and Ecumen Parmly LifePointes—and Thrifty White Pharmacy were among the first Minnesota exchanges of health information across care settings and across different EHR platforms, to focus on improving transitions of care and medication management.

"It felt like I participated in making a small step to safer health care and better decisions for everybody," said Lindahl.

This work was part of an 18-month special innovation project, developed and implemented by Stratis Health on behalf of the Centers for Medicare & Medicaid Services (CMS), to improve transitions of care and medication management through health information exchange (HIE).

The two communities—one rural and one urban—with three hospitals and 10 SNFs successfully exchanged health information in test exchanges between care settings: 42 SNF to hospital, 12 hospital to SNF, and two hospital to pharmacy. The project advanced knowledge about what's needed to support cross-setting HIE.

EHR system design to support care transitions

Every care setting gathers and organizes patient information in EHR systems designed to best support care for their patients in that care setting. These systems have not been designed to support patients as individuals who move across multiple settings in their need for care.

Independent EHR systems can be inefficient and may result in less than optimal care. For example, skilled nursing facilities often share 40 to 65 pages of paper with hospital emergency departments in an effort to provide information believed to be needed in a transition of care. Conversely, skilled nursing facilities and others must print out forms and re-enter information shared by fax or view-only access to a hospital EHR, creating potential transcribing errors.

> " It felt like I participated in making a small step to safer health care and better decisions for everybody."

"EHR systems and workflows were built to support individual organizations and lost track of the patient's needs," said Paul Kleeberg, Stratis Health chief medical informatics officer. "Now, the challenge is getting the right people to the table and figuring out workflows across care settings."

To design systems that work for all care settings, we need to understand what information is needed by all settings, how information will be received on the other end, and how to add information within an EHR so it can be shared effectively. We need to be aware how individual systems interact across settings.

Improving Medication Management

CMS special innovation project findings

Medication management and medication reconciliation are most effective when viewed as a shared responsibility across all care transitions.

Stratis Health made the following recommendations to CMS for hospitals and long term post-acute care organizations based on the findings of a CMS health information technology special innovation project:

- Require indication/diagnosis for all prescribed medications to be documented in the EHR
- Increase pharmacy's role in medication reconciliation
- Implement prospective medication review (PMR) prior to exchanging health information

"Actions often cause unintended consequences," said Joe Litsey, PharmD, director of consulting services, Thrifty White Pharmacy. "Changes on the pharmacy end might require a change in workflow for the nursing home or hospital."

True interoperability not understood

Health care organizations mistakenly believe that EHRs are interoperable if they are sharing information electronically—which is not so if the information can only be viewed. True interoperability is sharing information seamlessly, moving discrete data that can be inserted into another system's database and pulled into its EHR fields.

While faxing, sharing PDF files, and other view-only access allows providers to meet the Transfer of Care Summary criteria and attest to Stage 1 meaningful use to receive financial incentives, it treats transitions of care as handoffs of patients and their information from one setting to the next.

Providers need to move to using a continuity of a care document (CCD) that offers all of the information needed to support continuation of care. The CCD specifications outline the encoding, structure, and semantics of a patient summary clinical document in a concise, standard format for exchange between care settings.

EHR software for long term care settings has only recently added the ability to produce and use the CCD. Early use of CCD is being seen both in hospitals and some skilled nursing facilities, although its use to facilitate transitions of care is still rare.

Technology hurdles

According to CMS, over 35 percent of Medicare transfers of care are to post-acute care settings. Until their EHRs are seamlessly connected with other care settings, care transitions will be less than ideal.

Although 2011 data from the Minnesota Department of Health shows EHR adoption rates for nursing homes (69%) slightly lagging clinics (72%), the majority of nursing homes are using their EHRs primarily for Minimum Data Set (MDS) submission, demographics, and billing—not for resident care. Incentive programs, similar to those made available to hospitals and clinics to adopt and optimize EHRs, could significantly advance EHR progress and interoperability in long term post-acute care to successfully support care transitions.

Top 10 Medicare Issues in 2014

The Medicare Report listed the following items as the top 10 Medicare issues for this year.

1. Reform of sustainable growth rate
2. Impact of readmission rates on hospital payments
3. Shift from fee-for-service to accountable care organizations
4. Changing payment structures for managed care plans
5. Payment reform delivery demonstration programs
6. Value-based purchasing programs
7. Part B quality improvement programs
8. Dual eligible demonstration programs
9. Implementation of Stage 2 of meaningful use initiative
10. Implementation of the International Classification of Diseases, 10th Revision (ICD-10)

Source: Bureau of National Affairs, *Medicare Report*, January 10, 2014.

A health data intermediary/health information service provider (HISP) which provides the technical mechanism to perform the actual secure HIE, such using the Direct encryption standard, must be available in a geographic area. And, providers need to understand whether their HISPs are connected together to allow for information transfer.

Changing how we communicate in health care

While hospitals, nursing homes, and pharmacies have made great strides in testing and successfully transferring patient data in support of care transitions, much work is needed to achieve the exchange of information that consumers already assume is happening.

Litsey noted, "Health information exchange will change the health care industry by changing the way health care professionals communicate with each other."

We need bold and courageous leaders within health care to step outside of current models and practices to encourage and support true health information exchange. ❍

Stratis Health serves as the Medicare Quality Improvement Organization for Minnesota. www.stratishealth.org

STRATIS HEALTH NEWS

RARE Campaign received the Eisenberg Award. Pictured: Mrs. John Eisenberg; Christine Cassel, National Quality Forum; Kathy Cummings, ICSI; Tania Daniels, MHA; Vicki Olson, Stratis Health; and Margaret VanAmringe, The Joint Commission.

The RARE Campaign earned the 2013 John M. Eisenberg Patient Safety and Quality Award. This prestigious award from the National Quality Forum and The Joint Commission recognizes innovation in patient safety and quality.

Quality Assurance Performance Improvement (QAPI) resources. CMS has made available resources, developed by Stratis Health and the University of Minnesota, to support roll-out of its national framework for nursing homes to implement a systematic, data-driven approach to quality of life, care, and services.

RuralHealthValue.org. This new website is one of the resources developed through a cooperative agreement of the Health Resources and Services Administration (HRSA) Office of Rural Health Policy with the University of Iowa's RUPRI Center for Health Policy Analysis and Stratis Health. The project analyzes rural implications of changes in the organization, finance, and delivery of health care services. It assists rural communities and providers transition to a high-performance rural health system.

Shared Decision-making Roadmap. The Minnesota Shared Decision-Making Collaborative has developed a seven-step shared decision-making implementation roadmap, www.msdmc.org.

Jennifer Lundblad, Stratis Health president and CEO, was honored by Women's Health Leadership TRUST. The trust recognized 35 women leaders from across the state who exemplify leadership excellence in the health care industry. Honorees were selected based on achievements, evidence of leadership, impact on community, special talent or expertise, unique endeavors, and the challenges they have experienced.

Marilyn Reierson, MS, Stratis Health program manager, was elected vice chair of the Advancing Excellence in Long-Term Care Collaborative Board of Directors for the 2014-2015 term. She currently works with Medicare Quality Improvement Organizations and nursing homes throughout the country in support of the National Nursing Home Quality Care Collaborative and QAPI implementation.

Paul Kleeberg, MD, Stratis Health chief medical informatics officer, was named to the Certification Commission for Health Information Technology (CCHIT) board of trustees.

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

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