



QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Spring 2016

Leveraging e-Health to Achieve Healthy Communities

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President and CEO, Stratis Health

We have made great progress in e-health in Minnesota and are celebrating numerous successes...yet we have far to go in many areas, and need to proactively and resolutely pursue our goals.

A leading contributor to Minnesota's success of adopting and optimizing electronic health record (EHRs) has been the REACH program (Regional Extension and Assistance Center for HIT), led by Stratis Health in partnership with the National Rural Health Resource Center and the College of St. Scholastica.

While Minnesota was already well on its way to EHR adoption, the 2009 HITECH Act, with its meaningful use requirements and incentives, and the accompanying REACH technical assistance program, rapidly accelerated EHR adoption and supported optimization activities.

In April, we wrapped up this enormous undertaking—a six-year, \$20 million federally effort to bolster the e-health capacity of primary care clinics and hospitals in Minnesota and North Dakota. The program emphasized technical assistance and support for small, rural, and underserved provider organizations.

You'll see highlights and results in this issue of Quality Update. REACH client hospitals and clinics made great strides, which further strengthen Minnesota's position as a national leader in e-health.



While clinics and hospitals have been eligible for meaningful use financial incentives and received technical assistance and support from REACH, similar federally funded incentives and assistance have not been available for health care providers across the rest of the continuum of care. The Minnesota e-Health Advisory Committee has held as a long-standing priority the importance of e-health across the care continuum.

Through the State Innovation Model (SIM), Minnesota has made a bold commitment to support e-health in behavioral health, long-term/post-acute care, public health, and social services.

Stratis Health is excited to be leading the SIM-funded Minnesota e-Health Roadmap initiative, engaging with leaders and health professionals in these four priority settings to provide recommendations and actions to support and accelerate the adoption and use of e-health to improve health outcomes. Input and feedback on the roadmap is being gathered now, with the aim of finalizing the roadmap this summer.

THIS ISSUE

EHRs Needed to Support the Tremendous Change in Health Care 2

Value-based Care Requires Integration Across the Community 4

Regional Extension Center Clients Achieve EHR Meaningful Use 6

Risk in Health Care is Good 7

From Stratis Health's perspective, e-health efforts are not about technology, but rather, about using technology to improve quality, safety, and efficiency. To serve patients well, regardless of where they receive their care and support, we need continued efforts in Minnesota to bolster the e-health capacity across the full continuum of care—including supporting implementation of the soon-to-be-released e-Health Roadmap—and to accelerate information exchange.

Minnesota does not yet have traction in widespread health information exchange adoption, and a concerted effort to advance EHR adoption and optimization across the continuum of care and services also is necessary to help accelerate information exchange.

The 2016 Minnesota e-Health Summit, on June 7, is an important opportunity to focus our collective efforts in maximizing the potential of e-health, as captured in this year's theme, "Leveraging e-Health to Achieve Healthy Communities." I look forward to seeing you there! ○

EHRs Needed to Support the Tremendous Change in Health Care



Perspective from
Stephen Kolar
Stratis Health board member

“I often think that e-health is in the era of the Model T and some day we will have a Maserati.”

Stephen Kolar, MD, FACP, is recently retired as senior vice president and chief medical officer at HealthEast Care System. He practiced internal medicine, served as the physician executive for the HealthEast clinics, and moved into the role of CMO.

THE SUCCESSFUL CONCLUSION of the Stratis Health led, six-year REACH program (Regional Extension Assistance Center for HIT) made me stop and reflect on the vast changes I've seen tied to electronic health records (EHRs).

First reflection: The new world

Tremendous change has occurred in health care. Pay for performance, outcome reporting requirements, and ever increasing economic accountability for care that is delivered (through ACOs and other models) are a reality for us all. None of these are possible, let alone successful, without the assistance of the EHR.

One needs only to think about a chronic disease like diabetes and its complex interactions with the cardiovascular system, the peripheral nervous system, the kidneys and the eyes, and the ever increasing array of drugs and insulins and their actions to begin to get a glimpse of the complexities. Diabetes is just one example of a host of similarly complex chronic illnesses that need to be managed safely, effectively, and efficiently.

Registries, alerts, patient recalls, risk prediction algorithms, and medication lists facilitate successful care of patients in this population.

Not so many years ago, I and many others in practice tried to do all this with paper and pen and clerical help—pouring over paper charts and claims data, calling patients to fill in missing pieces of data, like where and when was their last ophthalmology visit, etc. Well meaning, but we were not very successful and our patients where not well served.

Also, I reflect on the rapidity of future developments of evidence-based guidelines and recommendations. An often quoted study in the *New England Journal of Medicine* over 10 years ago now, maintained that it took 17 years for evidence-based care to reach the mainstream of practice. I am not sure I ever agreed with that figure, but there is little doubt, the EHR can

We were not very successful and our patients were not well served when we tried to manage complex chronic diseases by paper and pen and clerical help.

incorporate those recommendations for use immediately.

Second reflection: Patients and their families

Providers of care will be the first to tell you that electronic health records do not make practicing medicine any easier, quite the contrary. Some say it is the same work but done in a different way with many more steps, which I personally believe. What providers will say, and patients and families will echo, is communication between them can be easier and more efficient.

With patient portals, electronic patient record access, and messaging to patients about results, our next steps after providing direct patient care no longer depend on a clumsy telephone call, or worse yet a posted letter.

The ability to schedule appointments 24/7 and the growth and potential of e-visits are a next huge leap forward in progress today.

We are just scratching the surface to explore how to effectively use community home visits by nurse practitioners (NPs), physician assistants (PAs), or specially trained paramedics. Utilizing access to patient records and communicating with the patient's regular provider, allow these professionals to employ early interventions, that then prevent a patient from deteriorating and ending up in an ER.

Third reflection: The future

We have just begun to design the future. I often think that e-health is in the era of the Model T and some day we will have a Maserati.

E-health functionalities will continue to evolve to improve care delivery, safety, quality, evidence-based delivery, and efficiency for those delivering care to the patient either face to face or virtual.

Several guiding principles need to be kept in mind, however:

- Create e-health developments in partnership with providers and with patients. Developers need to be in contact with providers and patients, striving for efficiency that allows ever more focus on the patient and eliminate unnecessary steps.
- Incorporate practicing chief medical and chief nursing informatics officers, often “at the elbow” during development. I believe this is very important and builds confidence in the new systems as well.
- Be judicious with EHR alerts. Although alerts are a vital tool, creation of too many leads to alert fatigue and defeats the purpose.
- Offer support to providers so that they are practicing with an EHR at the top of their license—it’s critical. The use of scribes for scribe appropriate tasks is one example.
- Continue to strive for economy of scope. Currently, including the most important elements of the patient encounter in the EHR so that they are easily found and digested is one area that needs work.
- Continue to elevate security and have it foremost on the mind of all users and developers. Perhaps, more system and developer-wide collaboration is called for in this area.

I have asked many providers and patients, “Would you go back to the old world if possible?”

Many comment on changes they would like to see and most are hopeful for the future.

Few, however, would go back.

Certainly not me. ○

Building Healthier Communities Awards

Promoting a culture of health care quality and patient safety in Minnesota

Stratis Health provided grant support for five projects through its Building Healthier Communities award, announced in March. This Stratis Health annual award supports projects and programs that promote a culture of health care quality and patient safety in Minnesota. The 2016 projects reflect how critical cross organization engagement, education, and electronic tools are to fostering quality care:

- ACT on Alzheimer’s will use its award to sponsor one additional rural Minnesota community to become dementia friendly. The community will use the Dementia Friendly Communities Toolkit, undertake a community engagement process, and implement at least one priority goal.
- Face-to-Face Adolescent Health Clinic will develop and implement an evaluation tool to measure patients’ satisfaction, their understanding of the health information provided to them, and their level of activation to engage in and manage their own health care.
- Minnesota Rural Health Association will use its funds to establish a student chapter at the University of Minnesota Duluth, with a goal of exposing future health care professionals to rural practice opportunities. It also intends to develop infrastructure for expansion of student chapters at health care training programs across Minnesota.
- The Paramedic Foundation’s funds will support creation of continuing education modules in an internationally standardized curriculum for community paramedics, who fill local gaps in access to health care. The curriculum is available free to any accredited college or university. The first of the new modules will be geriatric specific.
- Senior Community Services will optimize its client information system to better support care coordination, using insights from a Stratis Health community-based organization health IT training. The organization will build capacity to create population level reports to share with other organizations to build collaborations that support the health of seniors in their communities.



As a nonprofit organization, Stratis Health is committed to being a responsible and engaged community member. Awards align with Stratis Health’s mission and vision, advance Stratis Health’s work and relationships, focus on Minnesota, and benefit the community by making lives better. ○

Value-based Care Requires Integration Across the Community

Long-term care and support providers need to prepare

Each state or federal push toward value and quality in health care nudges the system in the direction of better integrating care and extending care coordination into the community. The latest proposed Medicare policy change, the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is another example, with clinician reimbursement based on measures that include coordination of care and health information exchange.

These incentive programs have helped drive hospitals and clinics to build their foundations to support new models of care. Today, those on the same electronic health record (EHR) platform often can share data. But, they have almost no true electronic data exchange with long term and support service (LTSS) organizations.

What's needed to integrate LTSS with these medical care providers?

Technical foundation

Leaders in LTSS acknowledge they lag behind hospitals and clinics in having the technology needed to seamlessly share health data across organizations.

"We are not at the point of really exchanging information the way we need to," said Kathy Messerli, executive director, Minnesota HomeCare Association. "Part of that we need to own. Homecare does not have the technology we need to have."

Lacking incentive drivers similar to those for hospitals and clinics, most LTSS providers have not been able to garner the resources necessary to establish technology platforms which enable information exchange. Unless LTSS providers are part of a large system, the vast majority do not have financial resources or IT professionals in their organizations to engineer integration to make exchange possible.

Those LTSS providers who are looking at the future are asking how can they get the support they need to begin adopting and using information technology that supports their integration with acute and primary care—before the technology divide between these settings of care grows greater.

Exchanging health data

While technology is an essential tool to allow real-time health information exchange, organizations have to understand and plan with each other how to shape data exchanges to effectively and efficiently support care.

From her experience in southwest Minnesota, Mary Fischer, executive director, Southern Prairie Community Care, believes "Prior to electronic connection, you need to become familiar with the strengths and limitations of the system and how organizations work together to meet the needs of individuals—and you need to cut through the silos and the bureaucracies."

To best support individuals as they move between service providers, we have to ask, "How does a typical patient move through the system and what are the important pieces of information that each of the providers need? How will the data be exchanged and what transactions are needed?" explained Peter Schuna, president and CEO, Pathway Health. "The work Stratis Health has done with the long-term and post-acute care roadmap (see sidebar) is helpful. The types of stakeholder dialogues they've facilitated is what we need."

The market-based approach to health information exchange (HIE) in Minnesota still struggles to enable comprehensive and viable exchange. Many hospitals and clinics who can already share data directly with each other through their EHRs look at participating in HIEs with a limited view.

"They see only what they have to put into the system and have no understanding of whether they are going to get anything back," according to Schuna. They need to have a business case that shows what's in it for them.

Although conceptually the care community understands the need to work together so communication about health and services can happen automatically, it hasn't made financial sense for organizations to spend resources to come together across the community to support an exchange system. Some LTSS leaders note the lack of economic incentives is a barrier to participating in a market-based HIE.

Intentional collaborations

Collaborations across communities will be essential as the requirements for value and quality in health care grow. LTSS organizations have client data, that when combined with other providers' data, creates a whole picture of an individual that allows for better support of health and wellbeing. With the onset of the Medicare Quality Payment Program, almost all of a patient's medical care costs will be attributed for value scoring to the one clinician they see most often. This interdependency is intended to spur greater care management, and makes having the whole patient picture more important.

LTSS providers need to prepare themselves to partner with hospitals and clinics. Today, most LTSS providers lack the skills for how to analyze and present their data in a way that's meaningful to potential community partners. They need support to learn how to structure and package their data so they can frame their value as partners in care.

"As an association, we encourage home care providers to develop relationships with hospitals. As they do that, they need to be prepared to show their outcomes and they need to continue to increase their quality ratings," said Messerli.

Progress in southwest Minnesota

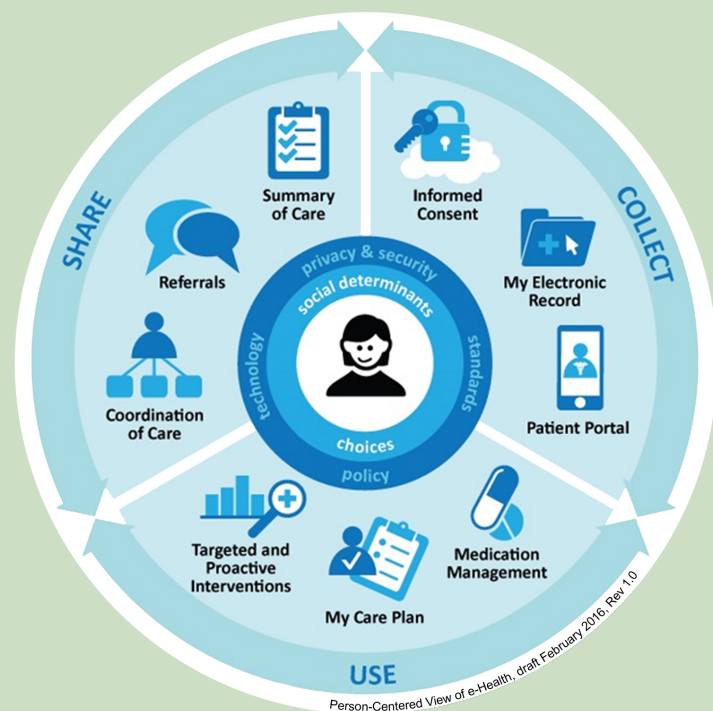
Southern Prairie Community Care is a 27-member rural Integrated Health Partnership (IHP), Minnesota's Medicaid Accountable Care Organization model, across 12 counties in southwest Minnesota. It provides a service delivery network which coordinates health and human services for Medicaid high risk patients, with support from two state programs aimed at new ways of delivering and paying for health care. Southern Prairie is building an integrated electronic record so both medical and community-based service providers have access to real-time information at the point of service—an idea sparked a decade ago.

A lot of time was spent enhancing relationships and creating a common vision for individual care and data sharing, before moving ahead with technology. Southern Prairie plans to have its HIE live by year's end. It is working provider-by-provider to get health information loaded into the exchange it built. The IHP also is in the process of engaging its tertiary centers—the hospitals and clinics it most often refers patients to in the Twin Cities area, South Dakota, and Iowa—in the project and in participating in the exchange.

The IHP is in the midst of developing a sustainability plan to address funding support on a long-range basis. "We need to plan for when grants are not available and shared savings opportunities shift—when we hit a floor or a ceiling in term of how much it costs to take care of high risk populations," said Fischer. "It's difficult to answer this financing question from a market-based perspective. We're in this window where these projects need to be supported across a shaky bridge."

Fischer notes, "It's an investment if you want change to be meaningful, long lasting, and sustainable. It has to be real, transformative change." ○

Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services



The Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services will be available late summer. It will provide recommendations and actions to support and accelerate the adoption and use of e-health. The Roadmap will emphasize the future state of using e-health in these four priority settings, highlighting how these four settings integrate with acute and primary to improve health outcomes.

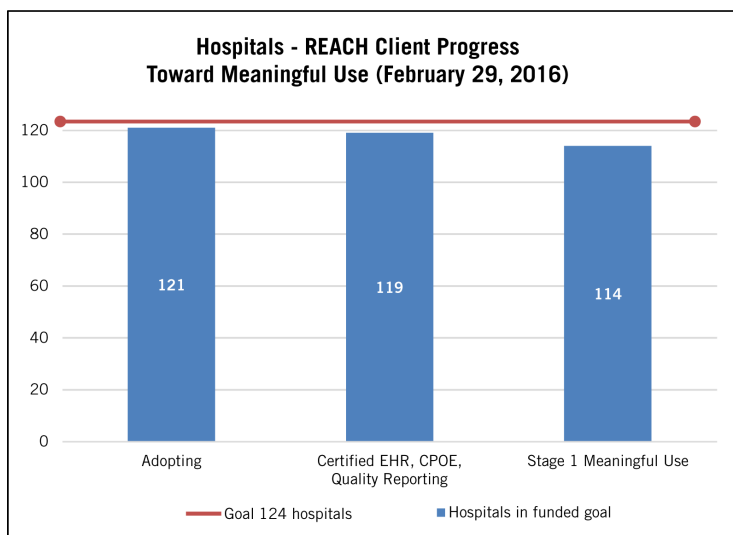
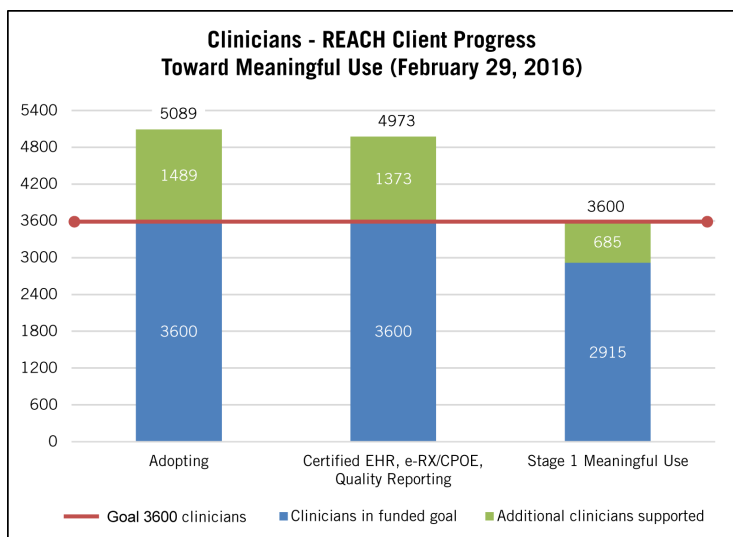
The Roadmap project is a collaborative effort led by the Minnesota Department of Health's Office of Health Information Technology and Stratis Health. Stakeholder engagement and a consensus-based approach were used to create the roadmap.

The final version of the roadmap will be available at www.health.state.mn.us/e-health/roadmaps.html.

Looking at the numbers: Regional Extension Center Clients Achieve EHR Meaningful Use

“The EHR will provide a safe and secure way for us to serve our patients, across the treatment team, enhancing care coordination.”

- Charlie Mandile, executive director, HealthFinders Collaborative



Nearly 5,100 clinicians at 662 clinic locations, and 121 critical access and rural hospitals in Minnesota and North Dakota, advanced their use of electronic health records (EHRs) to improve patient care, over the past six years, with support from the Regional Extension Assistance Center for HIT (REACH).

The national regional extension center (REC) program and REACH concluded on April 7. Stratis Health co-led REACH, with partner organizations in both states. The program aimed to improve care by implementing and using EHR systems, to achieve Stage 1 meaningful use through the federal incentive payment program for health care providers. Stage 1 meaningful use focused on using the EHR to capture and share data.

REACH worked across the two states, primarily with small health care organizations and those providing care to the underserved, such as community health centers and rural care providers. These providers generally lagged behind in EHR adoption because of their size and resource limitations.

REACH far exceeded its goal to serve 3,600 clinicians:

- + 3,600 clinicians achieved Stage 1 meaningful use
- + An additional 1,489 clinicians were supported in adopting and optimizing EHRs
- + Nearly all (98%) 5,089 clinicians implemented certified EHRs, e-prescribing (e-RX), and quality reporting—stepping stones to using EHRs to improve care delivery through meaningful use
- + Of the 62 RECs, REACH ranked seventh in the nation for the number of priority primary care providers assisted to achieve Stage 1 meaningful use.

Of the 121 critical access and rural hospitals REACH assisted:

- + 114 (94%) achieved Stage 1 meaningful use
- + Nearly all (98%) implemented certified EHRs, computerized physician order entry (CPOE), and quality reporting
- + Nationally, REACH had the greatest number of hospitals achieve Stage 1 meaningful use.

In the final month of the REC program, REACH met with 39 client groups, representing 58 hospitals and 370 clinic sites to understand ongoing e-health needs, identify opportunities to further improve care, and assess work still needed to meet Stage 3 requirements. Based on these insights and its experience with clients, REACH offered recommendations in eight key areas:

- + Data security
- + Patient safety
- + Patient experience and engagement
- + Population health
- + Health information exchange
- + Incentive programs
- + Change management skills
- + Clinician experience

These recommendations suggest next steps that support using e-health to transform care and help clinicians and health care organizations succeed in alternative payment models. ○

“We’re now using our EHR to focus on what really matters—improving the care we offer our patients.” - Kirk Stensrud, CEO Glacial Ridge Health System



Risk in Health Care is Good

**Greg Linden, Vice President, Information Services/Chief Information Officer,
Stratis Health**

RISK IS GOOD. You don't hear those words much in health care, do you? We usually strive to wring risk out of the system, to ensure that we're delivering the safest care we can. While health care must always set a very clear risk limit that we don't take risks with safety, taking risk in health care is vital. Risk is inherent in innovating new ideas and approaches.

Here at Stratis Health, we understand and embrace quality standards like evidence-based medicine. We seek out and master established best practices around quality and safety, and we share them with the health care providers we work with. This is an important part of our mission. However, we also recognize that we need to innovate in areas that lack established guidance, such as when we developed a model for rural communities to create capacity and deliver palliative care services locally.

As all of us work on innovative approaches, we take on risk. Mitigating this risk as much as possible is important. But "mitigating" isn't the same as "eliminating." Mitigating means we identify the risks, and do our best to minimize them, or prepare for what might occur.

Innovation is imperative. We all have to realize that we need to press forward, challenge convention, and try out new methods and approaches if we're to achieve our shared mission.

Stratis Health has the opportunity to work with numerous Minnesota communities as they strive to innovate collaboratively in the area of health information exchange (HIE).

All of these HIE projects are examples of innovation... and risk taking. Health care organizations and other service providers haven't shared data with each other

in this way before. And, many issues need addressed, such as the technology, legal issues, governance, and workflow. Each of the issues carry some risk, which communities figure out how to mitigate and move forward, to the benefit of those they serve.

Stratis Health is currently engaged on one such project: the Minnesota Personal Health Record (PHR) for Long Term Services and Supports (LTSS) Demonstration. Visionary leaders at the Minnesota Department of Human Services (DHS) were awarded a grant from CMS to try a number of innovative approaches to better support Medicaid beneficiaries, including linking information about an individual's community-based long-term services and supports along with their health care and medical information.

One of the project's goals is to offer a PHR to beneficiaries. DHS believes this fits as part of the person-centered mission guiding its work. When the PHR becomes available to beneficiaries in a pilot project in Otter Tail County this fall, we will learn how they value such a service, how they use it, and how it could make a difference in their care.

It will require all the participants in our collaborative to think about how they approach their beneficiaries, and bring about change in both process and culture. No small feat and many opportunities for setbacks.

This DHS project is part of a national effort to develop a new standard for sharing LTSS data between providers. It is benefiting from the risk that the Office of the National Coordinator (ONC) has taken in reaching out and trying to form this

standard collaboratively across the nation. And, this effort has hit walls. With each of these small "failures," we've had to back up, assess, and modify our approach in order to continue moving forward. We've taken

"Taking risk in health care is vital, because it's inherent in innovating new ideas and approaches."

those lessons, the positive outcomes of taking risks, and have applied them in new ways in our communities.

Will our LTSS PHR pilot be successful? We're sure working hard to achieve that. But, we're out in front of settled science and trying approaches that are new, because we think they could be valuable. Medicaid beneficiaries will certainly benefit from what we learn, whether it's through complete success or building knowledge for the next iteration in care innovation.

We all stand on the shoulders of the giants of innovation, as well as build from the incremental progress of smaller innovators. Without their thoughtful risk-taking (and failures) as they innovated new ideas and approaches, we wouldn't have the health system we have today.

We seek to emulate them as we attempt to transform care delivery to provide better care and create better health, at lower cost. If all of us in the health care arena don't take the opportunity to innovate, and accept the associated risk, we won't be delivering the best care we can.

Lincoln's words inspire us: "The best way to predict the future is to create it." Let's do that. Together. It's our duty to innovate for the people we serve. ○

STRATIS HEALTH NEWS

Rural Quality Improvement Technical Assistance. With funding from the Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy, Stratis Health is providing quality reporting and improvement technical assistance and support to the 45 State Flex Programs and more than 1,300 critical access hospitals nationwide for the next three years.

Minnesota Action Plan to Improve Health Literacy. Stratis Health was one of 42 cosponsors supporting the Minnesota Action Plan to Improve Health Literacy, released by a broad coalition of Minnesota health organizations. The plan identifies six priorities to improve health literacy throughout the state.

Art Berman, MBA, elected to Stratis Health board. Art is an accomplished nonprofit



CEO and business executive financial and organizational strategy leader, Mr. Berman currently leads a consulting practice, Berman Consulting Partners, LLC. He also is a board member of Appetite for Change, Better Futures Minnesota, and Marnita's Table, Inc.

Cathy Weik, Stratis Health senior vice president of administration, and chair of the National Association of Workforce Boards, presided over NAWB's annual forum in Washington, DC, and moderated an industry panel on workforce strategies in health care.

Stratis Health welcomes new quality improvement staff.

Sarah Brinkman, program manager, leads Stratis Health's Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) work to reduce healthcare-associated infections in Minnesota hospitals.



Jane Gendron, program manager, will lead Minnesota's Medicare QIN-QIO work in cardiac and behavioral health. She will provide expertise in clinic operations, the full care spectrum of behavioral services, and Physician Quality Reporting System (PQRS).



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, 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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