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QUALITY UPDATE

Health care quality issues for Minnesota's health care leaders

Spring 2017

Collaboration and Innovation in a Changing Landscape

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

How can Minnesota stay a national leader in health care quality? By continuing to collaborate and innovate, especially in today's environment of uncertainty and change.

Minnesota has long been a leader and innovator in health care quality, care delivery, and payment redesign. We were the first state in the nation to pass an adverse health events reporting law in 2003. Our 2008 state health reform legislation established Health Care Homes, state-mandated quality reporting for hospitals and clinics, and baskets of care. Minnesota developed a robust nursing home report card more than a decade ago, and we have long-term care performance improvement projects and incentive payments. Today, Minnesota is implementing Medicaid ACOs, with nearly half of the eligible population now in an Integrated Health Partnership.

Minnesota was an early participant in innovative federal programs—Pioneer ACOs, Medicare Shared Savings Programs, and State Innovation Model testing. We've embraced national payment and care delivery reform opportunities, and been willing to take risk and test new models of reimbursement without full evidence of their viability.

These have inspired new approaches. Today, our Minnesota health care organizations are addressing social and economic

factors beyond the boundaries of health care, designing new care teams, and using new types of health care workers. They are engaging community partners, and better using data and technology. And our purchasers and state agencies are starting to measure, incent, and pay for what we truly value.

Yet, in today's environment of uncertainty and change, health care leaders are feeling a predictable instinct to turn inward, and be less willing to commit time and resources to quality and collaboration. I would argue that, in the coming few years, it is more important than ever to join together to address common barriers, to share and inspire new ideas, and to test and measure innovative approaches.

Stratis Health believes deeply in the power of collaboration. It's the way we approach our work every day. As the environment has shifted, we recognize that the health care quality work we strive to advance competes not only against other priorities, but also with a wait-and-see attitude.

THIS ISSUE

In today's uncertainty, we are pushing ourselves to be ever more clear about the value-add of collaboration. The value is strong. For example, our Duluth-area coordination of care community is reducing hospital readmissions as representatives from 15 acute and post acute care organizations come together to streamline communications and electronic medical record access.

Stratis Health strives to create seamlessness with our partners in serving our community. Recently, we co-convened a number of organizations that are offering education and technical assistance around MACRA/MIPS so we can coordinate and not duplicate. We have been actively involved in ACT on Alzheimer's, and are helping lead the bold Silos to Circles effort to break down the silos of health care to serve our community better.

These innovative collaborative efforts are precisely the way to set the course in uncertain times. We look forward to continuing to support these efforts to achieve our common goals.

Incenting Health Care Transformation

Perspective from
Beth Monsrud, CPA,
Stratis Health Board member

When I began my career 23 years ago in the health insurance industry, the industry was emerging from the period where care was tightly controlled and managed by HMOs through mechanisms like patient panels, primary care capitation funding, and hospital prospective payment. The pendulum then swung to the opposite end of the spectrum with broad, open networks, consumer choice, and fee-for-service payments.

Over this same time period, the cost of health care steadily rose, with per capita spending in the U.S. growing more than one and a half times from $3,788 per person in 1995 to $9,990 per person 20 years later. Many factors contributed to this increase, including the rising cost of pharmaceuticals, new medical treatments, aging populations, and the growing prevalence of obesity and related chronic conditions. Health plans put forth great effort to employ strategies (like disease management or utilization management) to control the rate of spending growth and improve quality of care with some success, but not enough to prevent an ever-increasing cost of care being passed on to employers, government purchasers, and individual consumers. As the cost burden rose and arguably is now hitting an affordability tipping point, these purchasers are increasingly engaged in understanding the value equation.

The passage of the Affordable Care Act (ACA) in 2010 invigorated an emerging trend started among the most innovative payers and providers toward a more patient-centered, value-based approach to health care. The industry now recognizes that financial incentives within the business models of various participants in the health care system—purchasers, payers, and providers—are misaligned. To be sustainable, health care models for the delivery, consumption, and financing of care must change once again.

Rewarding value rather than volume is an important step in this transformation, and health plans are uniquely positioned to help facilitate change. Health plans control the flow of funds coming from purchasers seeking care to those responsible for delivering care. Payers are testing several value-based financial models via contractual relationships with providers, including bundled payments, shared savings, or shared risk arrangements. All are intended to incent more efficient care delivery, but still only reward results on the margin. Payers are also incorporating withholds or additional incentives that can be earned if certain quality measures are achieved. While these innovations are a step in the right direction, it is challenging for providers with limited resources and inconsistent access to data to equally balance multiple payer arrangements with varying requirements.

Payers like UCare also look beyond the traditional delivery system and create relationships with community support organizations to address social determinants that impact health. For example, UCare sponsors the Wilder Foundation's Twin Cities Mobile Market, a grocery on wheels that brings affordable, healthy food directly into neighborhood "food deserts."

I believe, to ultimately address the underlying issues driving the high cost of quality care, ALL parties in the health care ecosystem—including empowered consumers—must align around a set of commonly defined goals to deliver high-quality care in an economically efficient manner, and work together to achieve those goals. Traditional boundaries of the payer/provider relationship must evolve to promote greater collaboration, activate consumers, expand data and information sharing and eliminate duplication of effort across the system. Financial models should incent all parties, including the patient/member, to jointly manage the total cost of care within the premium revenue available. UCare's new partnership with Essentia Health, jointly managing a co-branded Medicare Advantage product, was designed with these principles in mind. Most important to its initial success is that both parties came to the partnership with an open mind to new approaches for working together.

Financial models should incent all parties, including the patient/member, to jointly manage the total cost of care within the premium revenue available.

As I look across the health care landscape today, the transformational shift has begun, and it will be important for leaders across the health care continuum to come together to redefine roles to solve for the underlying, fundamental goal of high-quality health care for all at an affordable cost.

Beth Monsrud, CPA, is a member of the Stratis Health Board of Directors. She is senior vice president and chief financial officer of UCare Minnesota, a health plan long known for its work with diverse and underserved populations.

2017 Begins Medicare's New Approach to Quality

Lisa Gall, DNP
Clinical Program Manager, Stratis Health

Amidst all of today's change in health policy, the Quality Payment Program (QPP) will move forward as part of MACRA, legislation that received strong bipartisan congressional support for its aim to modernize Medicare to provide better care and smarter spending for a healthier America.

QPP supports a coordinated approach to care management and payments for Medicare Part B services. CMS is rolling out QPP in 2017 by allowing eligible clinicians to choose their approach to meeting reporting requirements. The flexibility is helpful—and makes for a complex program.

Clinicians can choose the advanced track if they are in certain types of risk payment arrangements. Not a fit? Clinicians can pick their pace, ranging from not participating to reporting for a full year, which impacts their payment adjustments. They can participate individually or as part of a group. Select from hundreds of different quality measures. Multiple data submission methods and scoring techniques are available. Dizzying.

Quality Payment Program

QPP combines three legacy programs, plus a new category into one program:

- Quality - replaces Physician Quality Reporting System (PQRS)
- Advancing Care Information - replaces Medicare EHR Incentive Program (aka Meaningful Use)
- Cost - replaces Value-Based Modifier
- Improvement Activities (new)

Track 1: Advanced APMs

Advanced alternative payment models (APMs) are two-sided risk arrangements, where clinicians share the risks, as well as savings, for their Medicare Part B services. They are reimbursed based on quality performance and cost, resulting from their group's care coordination. The majority of advanced APMs approved in Minnesota are accountable care organizations (ACOs) built around the Medicare Shared Savings Program and Next Generation ACO models.

Track 2: MIPS

The Merit-Based Incentive Payment System (MIPS) is for eligible clinicians not currently in an advanced APM. They are subject to Medicare payment adjustments—up, down, or neutral—depending on their MIPS composite score.

Clinicians can report to MIPS at either the individual level or as a group. To report as a group, all of the clinicians must report the same quality measures, regardless of specialty, and must collectively combine their results. Organization-wide quality measures may not appeal to clinicians in multispecialty, interdisciplinary, or multi-setting organizations.

While clinicians work toward goals that make the most sense for their practices, they need to be aware of the quality and cost targets of QPP and the rationale behind them. Using practice-specific goals not only engages clinicians, it also promotes care coordination, as well as individual and population health.

QPP quality category

Quality measures make up at least 60 percent of the MIPS Composite score in 2017, making the category very important in setting a MIPS goal.

The quality category is complicated due to multiple data submission methods, as well as differences in scoring and category weight calculations. Not all of the 271 measures are available in all reporting methods, and different quality measure benchmarks may apply to the different data submission methods.

Estimating your MIPS score

To support clinician success in QPP, Stratis Health developed a MIPS Estimator. It helps individuals and organizations calculate an estimated MIPS score, and compare results across data submission methods and over time as they implement performance improvement strategies.

Using the results of the MIPS Estimator, one rural setting with 18 clinicians discovered their quality score using claims data was notably lower than electronic health record (EHR) or registry data submission methods, and they performed better as a group overall. Adding the points for their Advancing Care Information and Improvement Activities categories to their combined quality scores placed the group well over the 70 points needed to qualify for an exceptional care bonus—and provided new internal benchmark goals for targeted quality measures.

Success in QPP

A key strategy for long-term success in QPP is to align organizational goals with cost goals, population needs, quality measures, technological capabilities, and preferred data submission method.

Involve all members of the care team to inspire innovative approaches to care and optimize technology to improve patient and population health.

Stratis Health MIPS Estimator: www.stratishealth.org/MIPS-Estimator

Framing Value in Cancer Care

Leveraging the Quality Payment Program to achieve Minnesota's cancer plan goals

Cancer Plan Minnesota 2025 was released in January 2017 by the Minnesota Cancer Alliance. The plan is a framework for action—with 19 measurable objectives and 92 strategies—that invites everyone to get involved in reducing the burden of cancer and promoting health equity. It challenges organizations and individuals in every sector and every region of the state to step up, work together and make a difference for all Minnesotans. As an active member of the Minnesota Cancer Alliance, Stratis Health looks for ways to support implementation of the cancer plan.

One way was to develop a crosswalk of the cancer plan's goals to the quality measures in the Medicare Quality Payment Program (QPP). Stratis Health is actively supporting Minnesota clinicians and health care organizations to understand QPP and achieve exceptional performance in their Merit-based Incentive Payment System (MIPS) Composite Performance Scores.

Clinicians eligible for QPP must start collecting performance data in 2017. Those in the MIPS track—the majority of eligible clinicians participating in QPP—need to identify which of the 271 quality measures they plan to report on.

Quality Payment Program - quality measures

The alignment between the cancer plan and the QPP quality measures is strong. QPP MIPS has 46 cancer-related quality measures.

Minnesota Cancer Plan 2025 Goals Alignment with the Quality Payment Program Quality Measures

MN Cancer Plan Goals	QPP Quality Measures
Prevention	3
Detection	18
Treatment	22
Survivorship/Quality of Life	4
Health Equity	--

QPP Care Plan measure falls under both treatment and quality of life.

Of these, 36 are categorized as process measures. They primarily fall under two National Quality Strategy (NQS) domains, with 21 under Effective Clinical Care, such as percentage of women 50-74 years of age who had a mammogram to screen for breast cancer, and 11 under Communication and Care Coordination, such as percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram.

"When a guidance document like the Minnesota Cancer Plan comes up, we'll typically review it to see if it aligns well with our current strategic direction and the asks from payers, CMS, and the state," said Timothy Hernandez, family physician and medical director for quality and clinical practice at Entira Family Clinics.

Entira has partnered for four years with Health East in a Medicare Shared Savings Program (MSSP) accountable care organization (ACO). Because the ACO does not yet take on downside risk, Entira eligible clinicians fall under the MIPS track. When looking at how to approach the menu of options for the QPP measures, Hernandez said, "The key is to hone in on those you are currently doing and maybe need some minor adjustments. We are hopeful that we can ride our wave of high quality long enough until we can figure it out."

Some organizations are finding that their electronic health record (EHR) systems are not configured to capture data for their preferred cancer-related QPP measures. Because of the advanced age of its population, one Minnesota primary care practice shared that it was considering selecting the Age Appropriate Screening Colonoscopy measure (percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31), for which lower numbers are better as an indication of efficient use of resources based on evidence-based care practices. Unfortunately, its EHR vendor was not able to build the measure into its system for use this year as one of its QPP quality measures.

"Each time CMS changes the measures in any significant way, there's a tremendous amount of work to be done in recalibrating your systems to support them," noted Hernandez.

Because QPP builds on previous quality programs, measures from the former Physician Quality Reporting System and Medicare EHR Incentive Program may already be built into an EHR system. Clinicians may be able to leverage existing workflows, decision-support tools, templates, and standardized reports to ease the transition into MIPS. One vendor clearly laid out the 24 QPP measures its system will support in 2017. Three of those measures are for cancer screenings and two are for preventive care.

> " I think person-directed care is now what quality means—viewing the whole person, listening to what people have to say, what's important to them."

MN Community Measurement has submitted an application to become a Qualified Clinical Data Registry (QCDR). Once approved, clinicians can use MNCM as a registry submission method to report on approximately 10 measures, one of which is Q113 Colorectal Cancer Screening.

"In working with clinicians to understand QPP, 2017 really is a transitional year for most of them," said Candy Hanson, Stratis Health program manager supporting clinician participation in QPP. "For many, the program is making them take a bigger step toward using their population data and to understand the future of payment based on quality and cost effectiveness."

Consumer view on value in cancer care

Many patients expect health care organizations to already be meeting quality standards. When asked what value in cancer care means to them, members of the Stratis Health Community Outreach Committee said:

- Whole person, person-centered/directed care
- Prevention
- Early detection
- Education
- Quality of life
- Ability to connect with your doctor or oncologist
- Support from the whole care team
- Advocacy of treatments
- Meaningful research

Many of these answers align with the QPP Advancing Care Information or Improvement Activities categories, like "Patient-Specific Education" and "Engagement of patients, family, and caregivers in developing a plan of care."

We invite you to review Minnesota's new cancer plan to see how it aligns with your strategies and ability to succeed in the Quality Payment Program.

Cancer Plan Minnesota 2025: mncanceralliance.org/cancer-plan-minnesota-2025

IN BRIEF

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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Medicare QIN-QIO Program Early Impact

Stratis Health leads Lake Superior Quality Innovation Network (QIN), which serves as a local change agent—in Michigan, Minnesota, and Wisconsin—to help the Centers for Medicare & Medicaid Services (CMS) achieve national health care quality goals and improve care for the 3,857,863 Medicare beneficiaries in our region.

Across the Lake Superior QIN region, early data for the current large-scale, 5-year program (August 2014 through July 2019), shows that the QIO Program is making a difference and care is improving for Medicare beneficiaries.*

1,653 Patients avoided a hospital readmission

825 organizations across 26 communities are reducing hospital readmissions by improving coordination of care. Medicare beneficiaries in these communities have had 1,653 fewer 30-day hospital readmissions, compared to the previous year.

6,991 Fewer nursing home residents took antipsychotic medications

Medicare beneficiaries have a better quality of life, as 6,991 fewer long stay nursing home residents are taking antipsychotic medication. Use of antipsychotics has declined to 13.4 percent, below the national average of 16.3 percent.

33% Percent of patients screened annually for depression

33.4 percent of Medicare beneficiaries are being screened annually for depression, higher than the national average of 14.7 percent.

* Data is only available for Medicare fee-for-service beneficiaries.

Looking at the numbers:

Minnesota Hospice Goal Aims to Increase Quality of Care for Cancer Patients

Increase the utilization of hospice services is one of 19 objectives in Cancer Plan Minnesota 2025, released this January. The measurable target is for the median length of stay (LOS) in hospice for cancer patients in Minnesota to increase from the 2014 baseline of 22 days to 25 days by 2025.

The latest available Medicare fee-for-service (FFS) claims data shows a 17-day median LOS—well below the cancer plan's goal of 25 days.

Four strategies were called out for action:

- Conduct a large-scale community awareness and education campaign that uses consistent messaging about palliative care and hospice.
- Educate health professionals, including those in training, about tools and resources that can help them to have meaningful, culturally sensitive conversations with patients and families about hospice and palliative care services.
- Increase the number of primary care providers receiving continuing medical education about hospice care.
- Increase the number of nurses completing palliative care training courses.

Having led community-based efforts to increase appropriate referrals to hospice care and help eligible patients receive hospice care sooner, Stratis Health strongly supports these hospice strategies.

Cancer-related hospice measures in the Quality Payment Program

The Quality Payment Program has two hospice-specific quality reporting measure options for Medicare patients who die from cancer:

- Proportion admitted to hospice for less than 3 days
- Proportion not admitted to hospice

Other measures, such as proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life, also would be positively impacted by increased hospice enrollment.

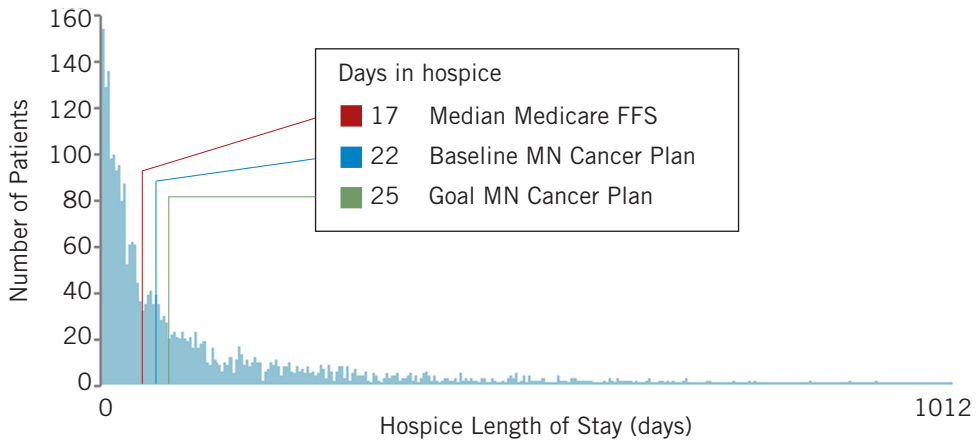
Medicare FFS claims data shows that 88 percent (2,476 of 2,813) of Minnesota beneficiaries in hospice, who had a cancer diagnosis and died between October 2015 and September 2016, received care that met the hospice-specific QPP measures.

Minnesota's cancer plan sets a higher bar for quality of life than the QPP hospice measures. Let's strive for that.

Stratis Health hospice toolkit:
www.stratishealth.org/providers/hospice.html

Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety.

Lengths of Stay in Hospice - Comparison of Minnesota Cancer Plan to Minnesota Medicare FFS Data (4Q2015 - 3Q2016)



Patients who died while enrolled in hospice with a cancer diagnosis

Minnesota FFS Beneficiaries Enrolled in Hospice Who Died (4Q2015 - 3Q2016)

	Cancer (any diagnosis)	Other (any diagnosis)	Total
Had length of stay less than 3 days	337	744	1,081
Had length of stay 3 days or more	2,476	3,798	6,274
Total	2,813	4,542	7,355

Length of Stay for Minnesota FFS Beneficiaries Enrolled in Hospice Who Died (4Q2015 - 3Q2016)

Length of Stay (LOS) in days	Cancer (any diagnosis)	Other (any diagnosis)	Overall
Median LOS	17	15	16

Building Healthier Communities Awards

10 years of promoting a culture of health care quality and patient safety in Minnesota

Stratis Health celebrates 10 years of impact through our community benefit program Building Healthier Communities. Stratis Health has had the privilege to serve as a catalyst for collaboration and innovation by providing small grants for 37 projects over the past decade. These projects have helped build a culture of health care quality and patient safety in Minnesota.

Board members Tom Blum and Stephen Kopecky, along with Jennifer Lundblad, presented three Building Healthier Communities awards in 2008.

As a nonprofit organization, Stratis Health is committed to being a responsible and engaged community member. The Stratis Health Board of Directors dedicates a portion of company reserves to fund the community benefit program. Award nominations are made by Stratis Health Board or staff members. 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.

Grants have ranged from $5,000 to $44,500. The types of projects funded have included clinician outreach and training, consumer outreach, and program assessment. Half of all projects had statewide impact, including the 2008 matching grant which helped the Minnesota Diabetes Collaborative develop and disseminate the award-winning "Control Your Diabetes for Life," low literacy patient education materials.

One third of the geographic-specific projects supported rural communities, such as helping the Rural Health Association establish a student chapter at University of Minnesota Duluth, in 2016, with a goal of exposing future health care professionals to rural practice opportunities.

2017 award recipients

In 2017, board and staff members proposed 13 projects for funding. Stratis Health provided grant support for the following seven projects:

- **Appetite for Change** will expand evaluation of its Community Cooks program in North Minneapolis to show the value of food as a health building tool and how people cooking, eating and sharing knowledge with one another builds the overall culture of health in a community.
- **Aitkin/Crosby Communities,** led by Riverwood Healthcare Center and Cuyuna Regional Medical Center, will encourage patients to complete a health care directive and to pursue advance care planning with their family members and health care providers.
- **Center for Community Health** identified mental health and wellness as a shared public health priority area for the seven-county Minneapolis/St. Paul metropolitan area. Its award funds will increase geographic reach and broaden the populations served by CCH-supported mental health programs.
- **Circle in the Field** will use its funds to help produce a short hospice stories documentary. It will feature diverse individuals and families relating the lived experience of hospice. The video will be promoted to health professionals for use at the time of terminal diagnosis to help laypeople understand the benefits of hospice.
- **Mankato ACT on Alzheimer's** will develop the first Giving Voice Chorus in Greater Minnesota for people affected by Alzheimer's disease and their caregivers. The chorus will provide a meaningful and consistent engagement experience to improve health outcomes and to reduce the social isolation and public stigma of dementias.
- **Minnesota Association of Geriatrics Inspired Clinicians** will conduct strategic planning as the foundation to refocus a professional association that supports clinicians in Minnesota who advocate for and serve those with medically complex needs in the community.
- **Minnesota Veterans Home – Minneapolis** will launch the first Cycling Without Age chapter in the Twin Cities. This program improves mental wellness and increases social connectedness between seniors, family members, and community members.

STRATIS HEALTH NEWS

Support for small practices in CMS Quality Payment Program. Stratis Health provides technical assistance to small practices in Minnesota, to help them prepare for and participate in the new Quality Payment Program. Merit-based Incentive Payment System (MIPS) eligible clinicians in small practices with 15 or fewer clinicians in rural locations, health professional shortage areas, and medically underserved areas can participate. This work is part of a seven-state project, lead by Altarum Institute and funded by the Centers for Medicare & Medicaid Services.

Nationwide initiative to optimize use of antibiotics across health care settings. Stratis Health is a partner with NORC, supporting researchers at Johns Hopkins Armstrong Institute for Patient Safety and Quality who aim to identify which approaches are most helpful and operationalize efforts to optimize antibiotic prescribing. In year one of this Agency for Healthcare Research and Quality (AHRQ) funded project, Stratis Health is offering input on use of the Comprehensive Unit-based Safety Program (CUSP) and tool development for use in hospitals, nursing homes, and ambulatory clinics.

Jane Pederson, Stratis Health chief medical quality officer, presented at the national conference for AMDA—The Society for Post-Acute and Long-Term Care Medicine—on working with Quality Innovation Network - Quality Improvement Organizations.

David Satin, MD, joins Stratis Health board. Dr. Satin is assistant professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School. He leads the quality improvement and patient safety curriculum and is director of courses on ethics, law, policy, finance and structure for the Medical School. He practices as a family physician at Smiley's Clinic in Minneapolis and rounds with the family medicine inpatient service at the University of Minnesota Medical Center.

Stratis Health welcomes our new quality improvement program managers: **Heather Keyes** leads work in infection control, medication safety, and antimicrobial stewardship. **Carrie Zimmerman** leads our Indian Health Service (IHS) Hospital Project, partnering with IHS hospitals to help them continuously improve quality of care for their Medicare consumers.

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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