Quality and Value in Health Reform

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After months of debate and deliberation, Congress has passed federal health reform legislation, signed into law by President Obama. While the bill is primarily focused on health insurance coverage and changes, a few provisions related to quality and value made their way into the final legislation:

• A charge to the Department of Health and Human Services (HHS) to establish a national strategy to improve health care service quality, the delivery of health care services, health outcomes, and the health of the overall population

• Provisions to improve coordination of care: establishment of Accountable Care Organizations, a bundled payment pilot program, and medical home grants

• Provisions to increase transparency and public reporting: funds for HHS to develop national annual priorities for quality performance improvement, strengthen and improve the federal quality measure development process for new measures, new quality reporting programs for long term care hospitals, inpatient rehabilitative facilities, hospice, and cancer hospitals

• A focus on prevention and wellness, and public and community health

• Establishing the Patient-Centered Outcomes Research Institute to identify national priorities for comparative clinical effectiveness research

At Stratis Health, we look forward to following the legislation as it moves to implementation and rulemaking process. With our partners, we will lead and participate in the quality-focused opportunities that bring our expertise to bear.

In another federal development, Don Berwick has been nominated to serve as administrator for the Centers for Medicare & Medicaid Services (CMS). Dr. Berwick is the President of the Institute for Healthcare Improvement (IHI) and a faculty member at the Harvard University Medical School and School of Public Health. Those who have had the opportunity to hear him deliver an address at the annual IHI conference, or engage with him in health care quality dialogue and debate, know what a dynamic and inspirational champion of health care quality he is. I am confident he will bring energy and leadership for quality and innovation to CMS, the largest health care purchaser in this country. I, for one, am grateful for his willingness to take on the challenge of being a public servant at a time when our country is in the midst of one of the largest health care transformations in our history.

In this issue of Quality Update, you'll see Stratis Health’s work, and our active collaboration with many partners and stakeholders in rural health, palliative care, HIT, health care homes, and more…and how many of these efforts are interrelated and move the bar in dramatic ways to improve our health system. ☺
The long-term care segment of America's health care delivery system is engaged in an ongoing effort to transform itself on many fronts. Nursing facilities are rapidly adding short-stay or post-acute care units focused on transitioning patients from an acute care stay to home. New specialized care settings focusing on dementia and end-of-life care are also emerging throughout the industry. Housing with services options continue to improve and are being more creative to meet the needs of consumers with higher expectations for living settings design and the care and services provided to them.

The Benedictine Health System's (BHS) strategic initiative calls upon us to move in this direction as well. We are also focusing on a new vision for providing care at home, developed using an established care coordination model designed to deliver care and support across a broad spectrum of services aligned with integrated, at risk payment systems.

Although most media attention regarding national health care reform has focused on expanding coverage for the uninsured, recently passed legislation has a great deal of language that will enable new forms of service delivery and greater collaboration and integration of services across the entire health care continuum.

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The Patient Protection and Affordable Care Act (PPACA) of 2010 provides insight into opportunities to create an enhanced use of post-acute settings. The alignment of these settings with acute care providers seems timely.

BHS has partnerships with several hospital systems to design post-acute settings to serve patients who require discharge to transitional or rehabilitative care facilities.

Some of the most interesting provisions of PPACA regarding the development of post-acute settings include:

- **National Pilot Program on Payment Bundling** requires a national, voluntary pilot program to coordinate care for Medicare beneficiaries. Services will include acute care and post-acute services including skilled nursing, inpatient rehabilitation and home health care.
- **Value-based Purchasing** requires a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities be developed.
- **Hospital Readmissions Reduction Program** will reduce payments to hospitals for preventable Medicare readmissions. A strengthened post-acute continuum of care aligned with hospital discharge needs could reduce the risk of negative payment consequences.
- **Medicare Share Savings Program** looks to Accountable Care Organizations (ACOs) to take responsibility to reduce costs and improve quality. ACOs can include a broad definition of providers including post-acute, long-term care professionals, and providers.
- **Community-based Care Transitions Program** provides funding to hospitals and community-based entities that furnish evidence-based transitional care services to Medicare beneficiaries at high risk of readmission.
- **Independence at Home Demonstration Program** creates a new program for chronically ill Medicare beneficiaries that would test payment incentives and service delivery systems that utilize home-based primary care teams aimed at reducing expenditures and improving health outcomes.
- **Medicaid Bundled Payment Project** establishes an eight-state demonstration project, with bundled services including acute care hospital and post-acute.

Across the broader long-term care continuum are numerous other provisions of the reform legislation that will impact care and service delivery.

As we enter a significantly new era of health delivery, long-term care providers likely have a great opportunity to enhance the quality and perceived value of their services, as well as work collaboratively with physicians and hospitals, to create the future.
Bringing Health Care Consumers Into Their Own Care

Implementing shared decision making in Minnesota

Empowerment, self determination, personal responsibility, and patient activation are terms used throughout the arenas of politics and social issues when discussing the need to engage Americans in their health and health care.

With statistics like “nearly 63 percent of Minnesota adults are overweight or obese,” everyone working on health reform recognizes that consumers are not effectively engaging in their own health care. Instead, patients expect doctors to take action to fix them. We want technical fixes for our problems, when what’s really needed are adaptive changes—which require people to act differently than they have in the past and adopt new behavior. That’s much harder than taking a pill.

Health care strategies are moving away from a more traditional paternalism in clinical care, to providers and patients as active partners involved in managing health. Many growing and emerging strategies reflect this approach—heath care homes (medical home) and care coordination, palliative care and consultations, and Honoring Choices and advance directive planning, all areas that Stratis Health is actively working in.

Another strategy being adopted that advances this principle is shared decision making (SDM)—an approach that aims for clinicians and patients to partner in making treatment decisions for complex medical decisions when the “best” therapeutic option is unclear. This applies well to conditions like prostate cancer and low back pain, for which the “best” treatment option differs by individual patient.

Communication is central to SDM. Patients need evidence-based information to understand treatment options and likely outcomes, as well as potential benefits and risks to weigh in light of their own values and preferences. Providers need to ask for and be willing to hear what is important to patients and factor that information into care decisions.

“Until we help people think about decisions and what’s important to them, we are not getting at the problems they face,” said Larry Morrissey, medical director of quality improvement for Stillwater Medical Group, which is using SDM with breast and prostate cancer patients.

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According to findings in a 2009 Robert Wood Johnson report, the efficacy of health care strategies is tied to a patient’s level of engagement in health care. Evidence shows that financial incentives and information-only strategies are insufficient to change consumer behavior.

Understanding whether a patient is activated is a communication challenge for clinicians. Patients need a sense of their ability to make health care decisions, along with permission and support to participate in the decision making process. Clinicians can get at this somewhat through health coaching and motivational interviewing.

“Getting patients engaged has been the roadblock,” said Morrissey. “What happens between doctor’s visits is what drives health.”

A University of Western Ontario study indicated a strong correlation between good outcomes—better recovery from discomfort and concern, better emotional health two months later, and reducing diagnostic tests and referrals about 50 percent—and the patient’s perception that the physician and the patient had found common ground in deciding the treatment option.

“If you ask providers if they do shared decision making, most will say ‘yes,’” commented Penny Moran, HealthPartners, which has piloted SDM. “When you explain how shared decision making is different than informed consent, they realize they are not really achieving the desired level of engagement.”

Minnesota moving forward

Several pilots exploring SDM have been conducted in Minnesota. To promote its use in clinical practice throughout the state, a community-wide multi-stakeholder group, the Minnesota Shared Decision Making Collaborative, came together starting in December 2008. Stratis Health is part of this collaborative working to develop standardized approaches to defining, performing, and measuring SDM and decision quality.

Leaders from diverse perspectives are coming together to see how they can change the whole system. In January, the Minnesota Department of Human Services shared its recommendations with the state legislature about how to support SDM in practice.

Morrissey acknowledges that there is uncertainty about how to measure SDM. “We need to keep our minds open about moving forward. We know enough to work on this.”

This fall the collaborative plans to host an educational event to familiarize more providers with SDM and accelerate the adoption of this patient engagement practice.

“Once you experience shared decision making and see the value, you can’t help but get behind it,” said Morrissey.
Kanabec Hospital Prepares for Meaningful Use

Recognized as first Critical Access Hospital in nation to reach stage 6 designation

With an eye on federal incentives and a commitment to embracing technology to support care delivery, Kanabec Hospital knew it needed a complete electronic medical record (EMR).

The hospital has been aggressively adopting health information technology (HIT). Through benchmarking, Kanabec Hospital learned that it is among the leading hospitals in the nation with regard to its EMR use. It was recognized for achieving Stage 6 designation for excellence in EMR adoption, through the Healthcare Information and Management Systems Society (HIMSS) Analytics. It is the first Critical Access Hospital (CAH) in the nation to achieve Stage 6 designation.

Nationally, hospitals scored an average of 2.75 on a scale of 0-7. Similarly, Minnesota hospitals scored 2.72. CAHs only averaged 1.84 nationally. The goal is to reach Stage 7—working in an environment where paper charts are no longer used to deliver and manage patient care, clinical data is used for quality improvement and patient safety, and clinical information can be readily shared through standardized electronic transactions.

HIMSS EMR Scores Quarter 4 2009

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A study conducted by the Flex Monitoring Team, a consortium of the Rural Health Research Centers, found that fewer than 14 percent of CAHs have an EMR with a clinical data repository and clinical decision support capability. Fewer than three percent have an EMR with Computerized Physician Order Entry (CPOE) and an electronic medication administration record (eMAR). Kanabec Hospital has all of these.

Kanabec Hospital CEO Randy Ulseth credits the hospital's success to strong leadership throughout the organization, the strong technical staff and progressive approach of SISU Medical Systems—a consortium of medical centers in greater Minnesota working together to share information technology resources, and the relationships of SISU members.

“Through SISU, we have interrelationships with 16 other hospitals like ours, which creates shared experience and knowledge,” Ulseth said.

“Kanabec Hospital’s staff is dedicated to using technology, from the CEO on down,” noted Mark Schmidt, SISU CIO. “The administration recognizes the value of technology in supporting their job at the hospital—providing patient care and providing efficient systems.”

Gap analysis

Everyone is awaiting the final federal definition of EMR “meaningful use,” to understand how to qualify for incentive money from the 2009 American Recovery and Reinvestment Act and how to avoid reductions in Medicare payments beginning in fiscal year 2015.

“The number one goal is to make sure that our members do not lose money when 2015 comes around,” noted Schmidt.

To help assess where they stood in relation to proposed criteria for meaningful use, the 17 independent rural hospitals that are members of SISU submitted data to the HIMSS Analytics’ Electronic Medical Record Adoption Model (EMRAM) to assess their progress in using EMR.

Rural challenges

SISU worked with HIMSS to modify the EMRAM to work for rural health care providers. Some criteria did not apply to rural hospitals, such as requiring both digital radiography and computer radiography. Few rural hospitals have digital radiography because computer radiography meets the needs. HIMSS changed its scoring so that if a service was provided then the facility was scored on whether or not it had the appropriate technology.

The Flex Monitoring Team report outlines significant challenges that rural hospitals face in getting up to speed to meet the goal of meaningful use. Schmidt said, “It’s hard to imagine how Critical Access Hospitals will get to meaningful use on their own.”

Pulling ahead

Kanabec Hospital has evolved its HIT adoption processes, learning from past mistakes when new implementations failed to account for every process. Now all departments are represented at IT meetings for new modules to make sure all the key people are involved.

The hospital’s leadership volunteers its staff to try out new projects. They acknowledge that it puts a lot of work on people, but staff understand the big picture. The hospital recently implemented a new record locator service to help it exchange health information.

“It wasn’t a difficult decision to make each additional investment in health information technology,” Ulseth said. “We are willing to take the risk of being the first to try new processes.”

Kanabec Hospital intends to use the acknowledgement of its achievement to continue to be a leader, including helping other SISU members reach Stage 6, then Stage 7. Ulseth noted, “Being the first Critical Access Hospital in the country to reach Stage 6 has allowed us to interact with other systems on a different level to talk about better interoperability.”

The proposed federal stages of meaningful use do not align with the HIMSS EMR stages.
Leveraging REACH Services to Achieve Meaningful Use

Minnesota has been a leader in health information technology (HIT) adoption in physician offices. Its providers are savvy about leveraging resources to improve care, and they work collaboratively, benefitting the whole as well as themselves.

The Regional Extension Assistance Center for HIT (REACH) is the latest resource available to providers working to achieve meaningful use of their electronic health records (EHR) and earn incentive payments.

Starting in May, providers will be able to register for REACH technical assistance services. Information from registration will be used to calculate eligibility for discounted services, based on federal formulas for type of organization and number of providers per organization. Qualifying organizations can receive services at up to a 90 percent discount. REACH funding cannot be used to purchase technology.

REACH is a the federally funded HIT Regional Extension Center providing technical assistance in preparing for, selecting, implementing, and optimizing adoption of EHR. As a companion to the Medicare and Medicaid incentives, the HIT REC program assists primary care providers in achieving meaningful use of their EHR, enabling eligible providers to earn Medicare/Medicaid incentive payments.

Key Health Alliance (KHA) and its North Dakota team—North Dakota Health Care Review and University of North Dakota, School of Medicine and Health Sciences, Center for Rural Health—are developing the program’s infrastructure. Two state-specific councils also have provided input on program design and will continue to guide the REACH program.

REACH approach

REACH technical assistance is a mix of individualized on-site assistance with direct hands-on support, consultations, and group learning collaboratives.

Milestones

The Office of the National Coordinator (ONC) will release funding to KHA incrementally as participating primary care providers reach the following milestones toward meaningful use.

1. Provider agreement between a healthcare practice and a Regional Extension Center is signed.

2. A practice and its associated providers are actively utilizing e-prescribing and quality reporting measures, such as disease registries.

3. A practice and its associated providers have met meaningful use, based on the CMS standard. The meaningful use definition is currently being promulgated.

To be successful, REACH staff will be working side by side with providers and practices.

Key Health Alliance is a partnership of Stratis Health, Rural Health Resource Center, and The College of St. Scholastica. REACH is a project federally funded through ONC.
Looking at the numbers: health care homes readiness in Minnesota

To be certified as a Health Care Home (HCH) in Minnesota, the Minnesota Department of Health (MDH) requires clinics to meet criteria related to the five following standards.

- **Access/communication.** Facilitates consistent communication among the HCH and the patient and family, and provides the patient with continuous access to the HCH
- **Patient tracking and registry function.** Uses an electronic, searchable registry that enables the HCH to identify gaps in patient care and manage health care services
- **Care coordination.** Focuses on patient and family-centered care
- **Care plans.** For selected patients with a chronic or complex condition, that involves the patient and the patient’s family in care planning
- **Performance reporting and quality improvement.** To improve the quality of the patient’s experience, health outcomes, and the cost-effectiveness of services

Health Care Homes is a model for primary care in which primary care providers, families, and patients work in partnership to improve the health and quality of life for individuals, especially those with chronic and complex conditions.

MDH commissioned a survey to understand how ready providers were for this new model of primary care. The survey was sent to 707 Minnesota primary care clinics—covering family medicine, pediatrics, and internal medicine. The response rate was 53 percent.

The majority (73%) of primary care clinics self-reported having some of the components of health care homes already implemented in their clinics. Of those clinics, 76 percent were urban and 24 percent were rural.

Minnesota has put a lot of effort into public reporting and quality improvement, so it’s no surprise that the majority of clinics (71%) reported having most of these criteria in place. By contrast, meeting the standards for care plans and care coordination will require the greatest amount of work.

As of April 2010, 354 clinicians at 43 clinics are moving forward with the certification process to become health care homes.


Stratis Health developed and analyzed this survey under contract with the Minnesota Academy of Pediatrics Foundation and MDH. Stratis Health conducts analytical work in support of assessing and improving health care quality and patient safety.

**Technology in a Health Care Home**

With the 2015 mandate for interoperable electronic health records (EHRs), clinics seeking to become health care homes should be sure that their EHRs and processes support them as they put the patient and family at the center of their care, develop proactive approaches through care plans, and offer more continuity of care through increased care coordination.

Through MDH funding, Stratis Health is developing actionable resources on how health information technology can be used to support health care homes. Available online in June.

Resources will include information about patient tracking and registry functions, identified as a need through the readiness survey.
Rural Palliative Care Emerging as a Health Care Priority

The national Priority Partnership recently identified palliative and end of life care as one of six priorities for the American health care system—ways to eliminate harm, waste, and disparities. The 32 key health care stakeholders in the Partnership represent the public and private sectors, from the Agency for Healthcare Research and Quality to AARP.

To listen to the 10 communities present at the Minnesota Rural Palliative Care Outcomes Congress in April is to know that palliative care is taking root in rural Minnesota. Each community’s program is as unique as the community itself. Yet, the challenges are similar.

Palliative care services are being offered through hospitals, nursing homes, hospice programs, and home health agencies. Lack of medical professionals training in palliative care, collaboration between health care silos, confusion about how palliative care and hospice differ, and financing were presented as common challenges.

Rural communities have advantages over urban areas for supporting palliative care services, David Weissman, consultant for the Center to Advance Palliative Care noted. They have smaller bureaucracies, closer inter-personal relationships, a greater primary care emphasis, and greater opportunities for collaborative practice across care settings.

Rural Palliative Care Community Development

Stratis Health continues its partnership with UCare to build palliative care capacity in rural Minnesota communities through two new projects.

Through a Rural Palliative Care Community Development Project, six rural communities from around Minnesota will be selected to participate in a 10-month project to start or strengthen palliative care services in their communities. To be eligible for the project, a community must be served by a hospital with 100 or fewer licensed beds. Application deadline is May 28, 2010. Information online at www.stratishealth.org/palcare.

Funding will also support the development of a publicly available online resource center aimed at fostering palliative care in rural communities. Many resources are available on palliative care, but this is the first Web site to focus on palliative care to meet the unique needs of rural communities. The site will build on the evidence-based, actionable resources gathered for the communities in Stratis Health’s Minnesota Rural Palliative Care Initiative.
Board of Directors. Stratis Health has elected new officers to its board of directors. Dale Thompson, was elected Board Chair. Thompson is President and CEO of Benedictine Health System, one of the nation’s most extensive systems, providing acute and long-term care in nine states. Stephen Kopecky, MD, remains on the board as immediate past chair. He is a cardiologist at the Mayo Clinic, based in Rochester. He also teaches at the Mayo Medical School. William E. Jacott, MD, is chair elect. Most recently, he was special advisor for professional relations for the Illinois- and DC-based Joint Commission on the Accreditation of Healthcare Organizations and an emeritus professor at the University of Minnesota Medical School. Dee Kemnitz remains as treasurer. Ms. Kemnitz serves as a beneficiary representative on the Board and spent more than 45 years at Carlson Companies. Clinton MacKinney, MD, MS, remains secretary. He is an emergency and family physician at Emergency Practice Associates in Little Falls, and also a nationally recognized consultant in rural health quality and physician leadership.

Staff changes at Stratis Health. Susan Hann is joining Stratis Health as business development director, to lead and support Stratis Health’s business growth and expansion. She brings experience in strategic business development, enhanced by her clinical expertise as an RN. Hann has worked as a consultant and principal for Kurt Salmon Associates, senior director of Care Delivery Strategy Development at HealthPartners, and program director of Fairview Health Services’ Palliative Care Leadership Center, as well as System Manager for Planning and Analysis at Fairview.

Sue Severson, Stratis Health Director of Health Information Technology Services, is serving as director of the new Regional Extension Assistance Center for Health Information Technology (REACH), a program of Key Health Alliance. Stratis Health program manager, Jane McGrath, will serve as program manager for REACH.