Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Preparing Now for What's to Come: Concepts for Improving Quality and Patient/Provider Satisfaction

May 3, 2017

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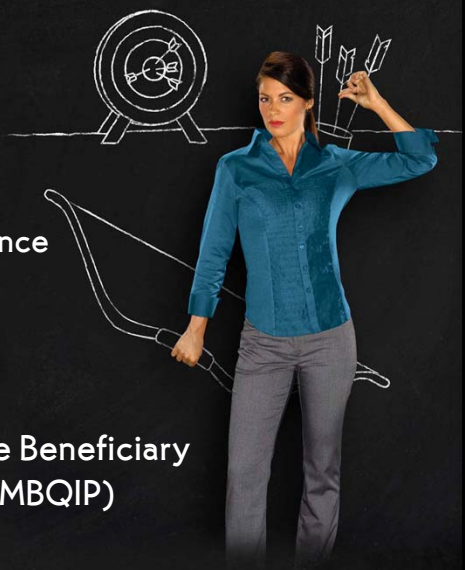
CPAs and Consultants
HEALTH CARE PRACTICE

AGENDA



- The National Health Care Market
- Blueprint for Performance Excellence
- Population Health Management and Impact on Quality
- Complex Care Management
- Quality Measures from Medicare Beneficiary Quality Improvement Program (MBQIP)
- Provider Satisfaction
- Redesigning a System of Care to Promote Quality

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Learning Objectives

- Discuss market changes that are driving rural hospitals to focus on population health strategies.
- Prepare for the transition to value and population-based payment systems by focusing on population health.
- Review the Blueprint for Performance Excellence.
- Discuss physician satisfaction and its impact on patients and processes; define improvement strategies.
- Consider redesigning your system of care to improve quality.

It's all about payment reform and accountable care.

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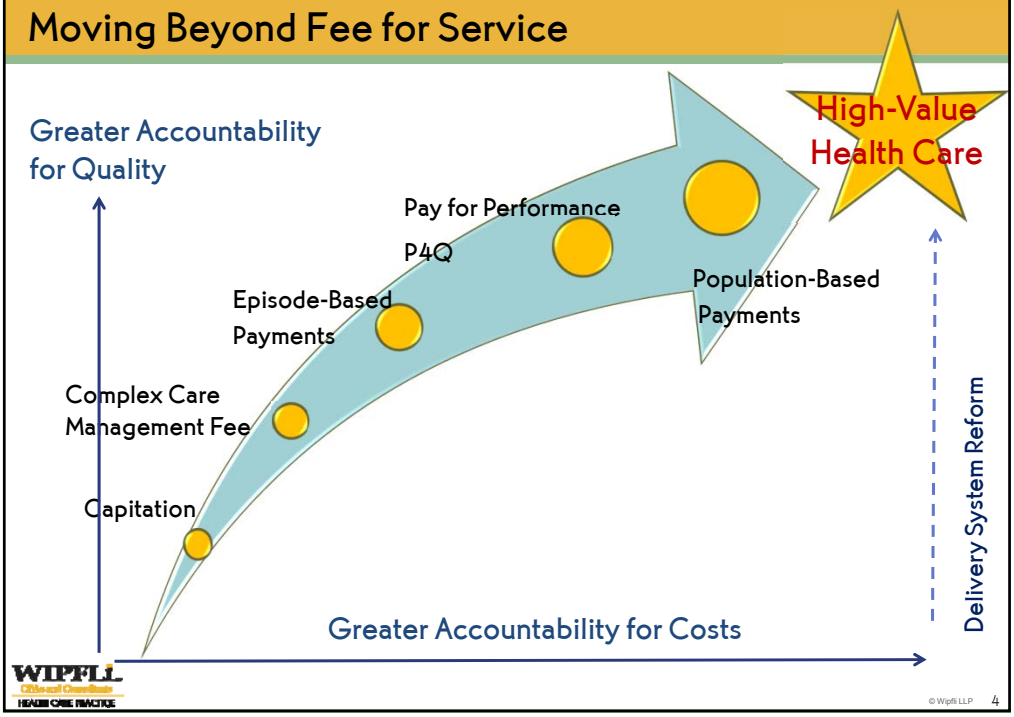
National Health Care Payment Reform: Moving Beyond Fee for Service



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Challenges With Transitioning to a Value-Based System

Market-Driving Forces	Transition Challenges
SIM Grants, CMMI Models	Leadership Awareness, Education
ACOs, Alternative Payment Models	Reimbursement Reductions
MACRA, MIPS, Quality Incentives	Data Access and Management
State Medicaid Payments, CCOs	Bifurcated Payment Models
Network Initiatives	Confusion due to Transition Process
Awareness of Population Health	Patient Engagement and Compliance
Reductions in FFS Payments	Current Financial Reporting Rules

Complex change, if not managed properly,
takes a toll on providers, staff, and patients.

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Critical Access Hospital (CAH) Blueprint for Performance Excellence

Rural Hospital Toolkit for Transitioning to Value-Based Systems (SRHT) 2015

Blueprint for Performance Excellence

Rural Hospital Toolkit for Transitioning to Value-Based Systems

- Strategic Planning
- Leadership: Board, Employee, and Community Engagement
- Physician and Provider Engagement and Alignment
- Population Health Management
- Financial and Operational Strategies
- Revenue Cycle Management and Business Office Processes
- Quality Improvement
- Community Care Coordination and Chronic Disease Management

Source: https://www.ruralcenter.org/srht/rural-hospital-toolkit

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An Assessment Tool Evaluates Current Capacity

Using the assessment tool, assess an organization's current capacity in the following domains:

- Leadership
- Strategic Planning
- Patients, Partners, and Communities
- Measurement, Feedback, and Knowledge Management
- Workforce and Culture
- Operations and Processes
- Impact and Outcomes

Respond from 1 - Strongly Disagree to 4 - Strongly Agree

National Rural Health Resource Center
Critical Access Hospital Blueprint for Performance Excellence; 2013

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Assessment, Gap Analysis, and Planning

- Implement the assessment tool as a multidisciplinary team. A variety of perspectives will bring out the truth about an organization's current state.
- Thoughtful and meaningful engagement of providers and community stakeholders during the assessment will lead to relationships and partnerships vital to success.
- Use the assessment tool to identify opportunities and prioritize action steps.
- Review the assessment tool frequently. Planning at regular intervals keeps the plan fresh and current.

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Considerations in Executing Your Blueprint

- **Population Health Management:** Focus on a defined population of patients for whom a health care provider might be responsible under value-based payment models; normally cohorts of patients with chronic conditions.
- **Complex Care Management:** Adopt an approach to complex care management that facilitates coordinated care and team-based care. This will ensure that you can meet your patients' needs and preferences, and will result in improved health outcomes.
- **Adopt Quality Measures From MBQIP:** Engage in the Medicare Rural Hospital Flexibility (Flex) Grant Program to strengthen your approach to quality improvement.
- **Public Reporting of Data:** Transparency in reporting is the catalyst to performance improvement. If you are already reporting, expand your efforts. If you are not reporting, learn now and begin the journey.

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Population Health Management and Impact on Quality

- Definitions
- Assessment and Risk Stratification

Integration of Care With Population Health.

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What is Population Health?

Population Health has been **defined** as "the **health** outcomes of a group of individuals, including the distribution of such outcomes within the group." This approach to **health** aims to improve the **health** of an entire human **population.**

Population Health Management is the aggregation of patient data across multiple **health** information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.

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Implementing Population Health Management

Population Health Management is the core of payment reform.

Implementation requires the following:

- Empanelment of patients to providers
- Adoption of evidence-based guidelines
- Ability to prepare "exception reports" from electronic health records (EHRs)
- Evolution to team-based care
- Intentional care coordination
- Systematic outreach to patients to close gaps in care
- Transparent reporting across the practice and regionally

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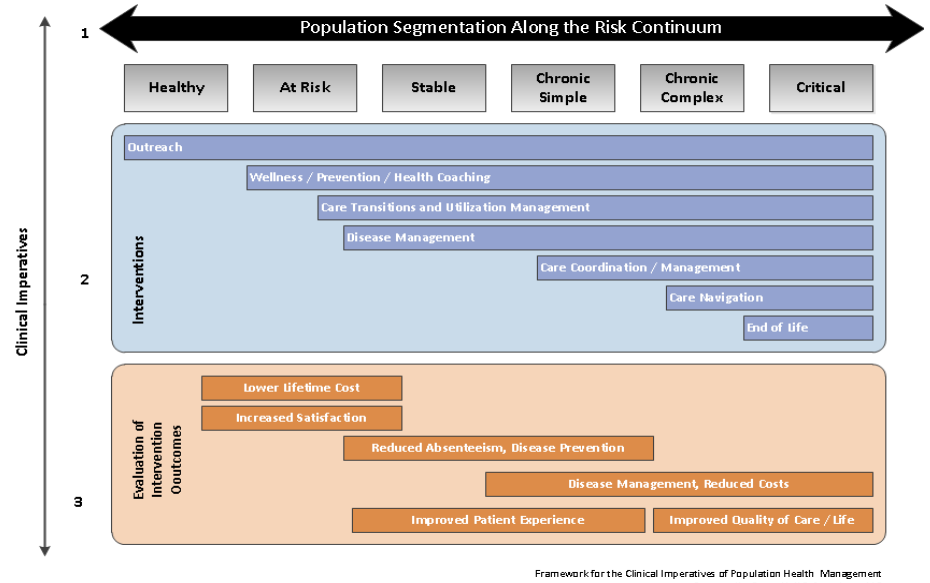
Population Health: Risk Stratification and Interventions



Framework for the Clinical Imperatives of Population Health Management
Source: Kaufman, Hall & Associates, LLC

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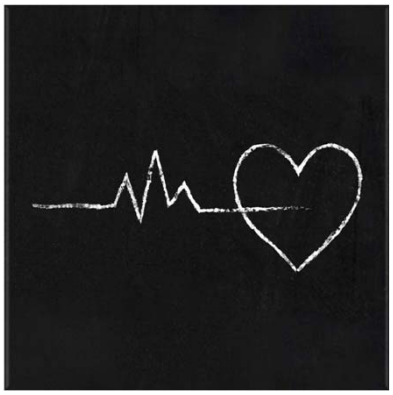
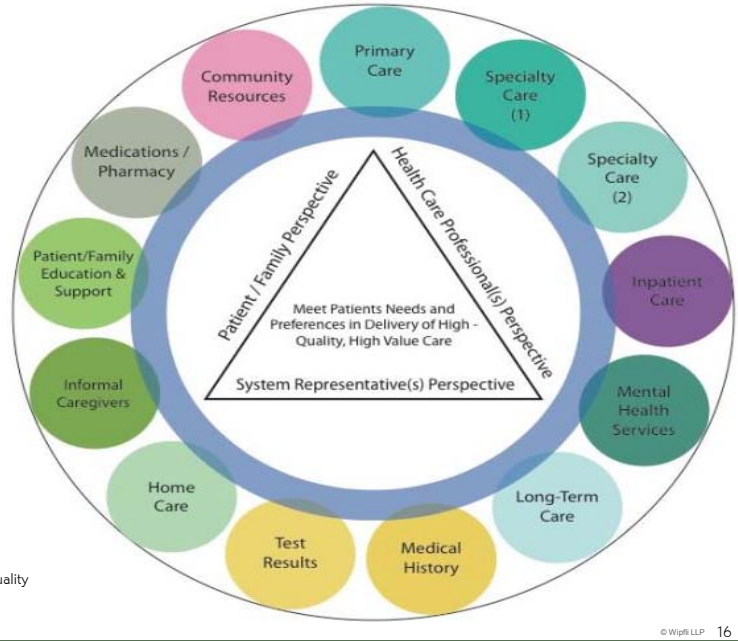


Complex Care Management

- Coordination of Care - Model
- The Care Model

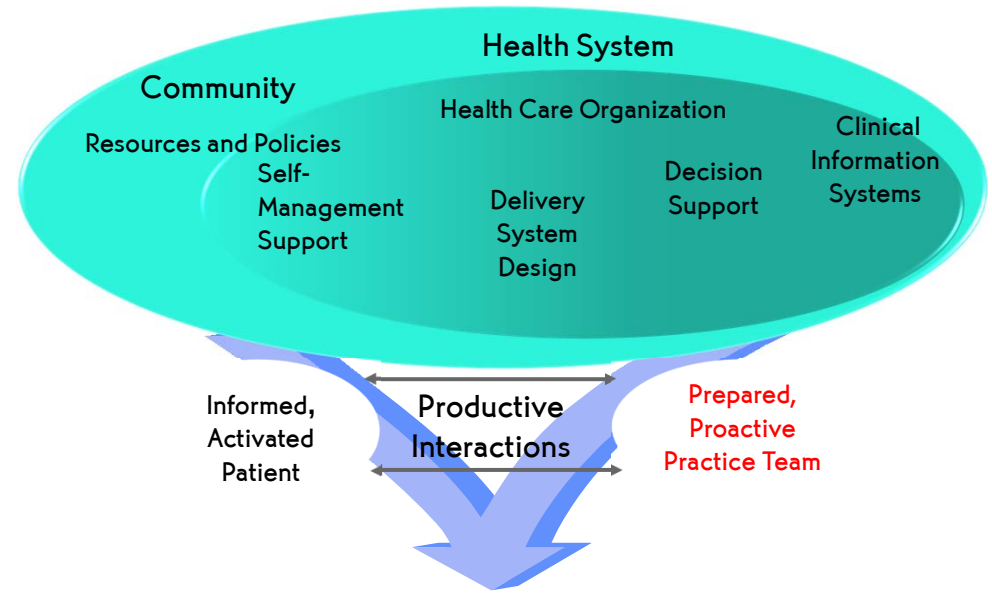
Understand Your Population

Understanding your population allows you to coordinate care and manage care transitions across a continuum.



Agency for Healthcare Research & Quality

The Care Model



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Why the Evolution to Team-Based Care?

Change is necessary - The evidence is clear:

- Delivering all evidence-based guidelines for preventive and chronic disease care has been estimated to take 18 hours per day for an average-sized patient panel.

  (Yarnall et al 2009; Alexander et al 2005)

- Most physicians deliver only 55% of recommended care; 42% report not having enough time with their patients.

  (Center for Studying Health System Change 2008; Bodenheimer and Laing 2007)

- Providers spend 13% of their day in care coordination and only use their medical knowledge 50% of the time.

  (Gottschalk 2005; Margolis and Bodenheimer 2010)

- Patient care is fragmented, and patients are dissatisfied with the level of attention they receive in primary care.

  (Bodenheimer 2008)

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What is Team-Based Care?

A model of health care delivery that utilizes individual staff members in various roles, each ***functioning at their highest level according to credentials and competencies.***

Shared accountability for overall patient health outcomes within a framework of clearly defined roles and responsibilities under the leadership of the primary care provider.

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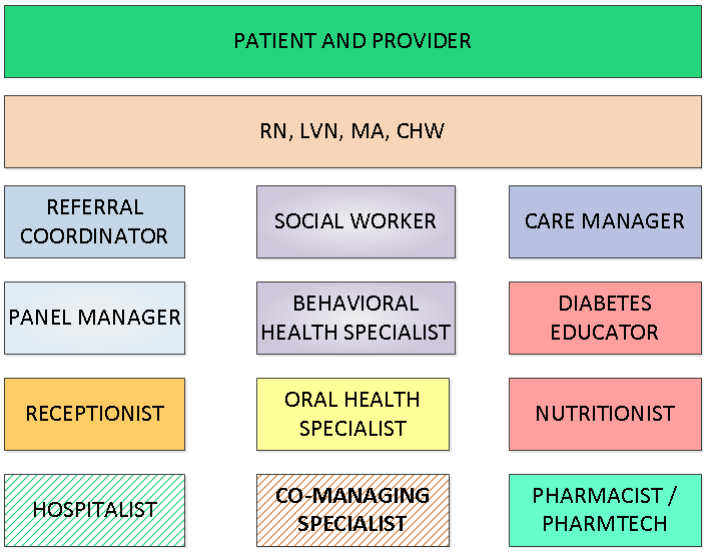
What Does a Care Team Look Like?



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The Enhanced Medical Assistant Role

Team Partner, Care Coordinator, Health Coach

- Allows team members to function at their highest level.
- Provides job satisfaction, potential for upward mobility, and retention of excellent staff.
- Provides enhanced, trusting relationships with patients and practical advice on self-management when cultural background is shared.

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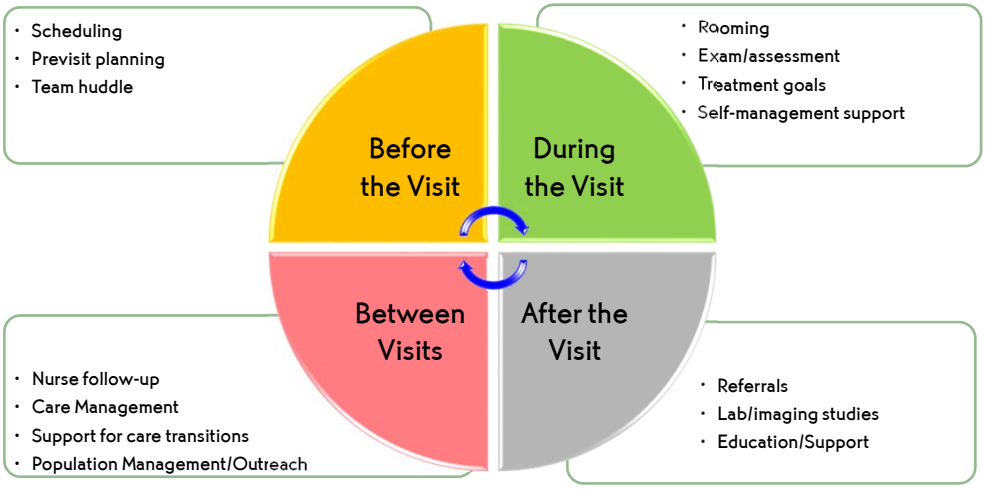
Use Stages of the Care Cycle to Define Team Member Roles and Responsibilities



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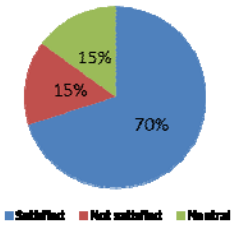
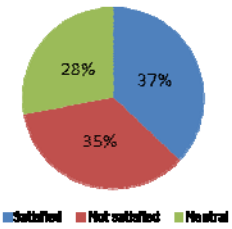
Clinician Satisfaction With Teams

N=135



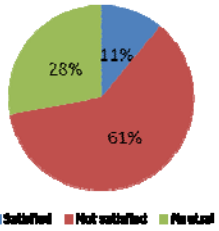
TEAMLET
(work with same MA)

N = 27



TEAM
(work with group of MAs)

N = 90



NO TEAMS
(work with different MAs)

N = 18

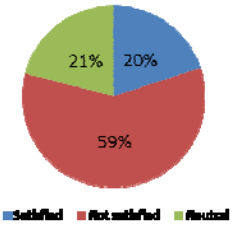
Source: Tom Bodenheimer MD, UCSF 2012

Provider Confidence in Panel Management for Cancer Screenings Using Teams

N=129

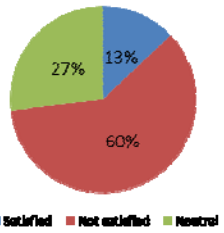
TEAMLET
(work with same MA)

N = 26



TEAM
(work with group of MAs)

N = 88

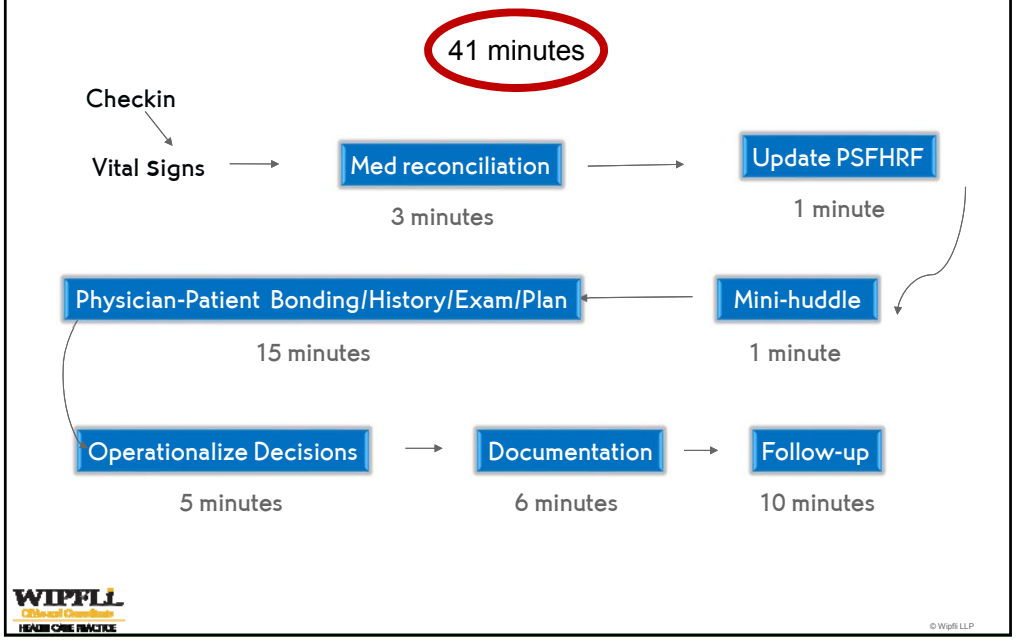


NO TEAMS
(work with different MAs)

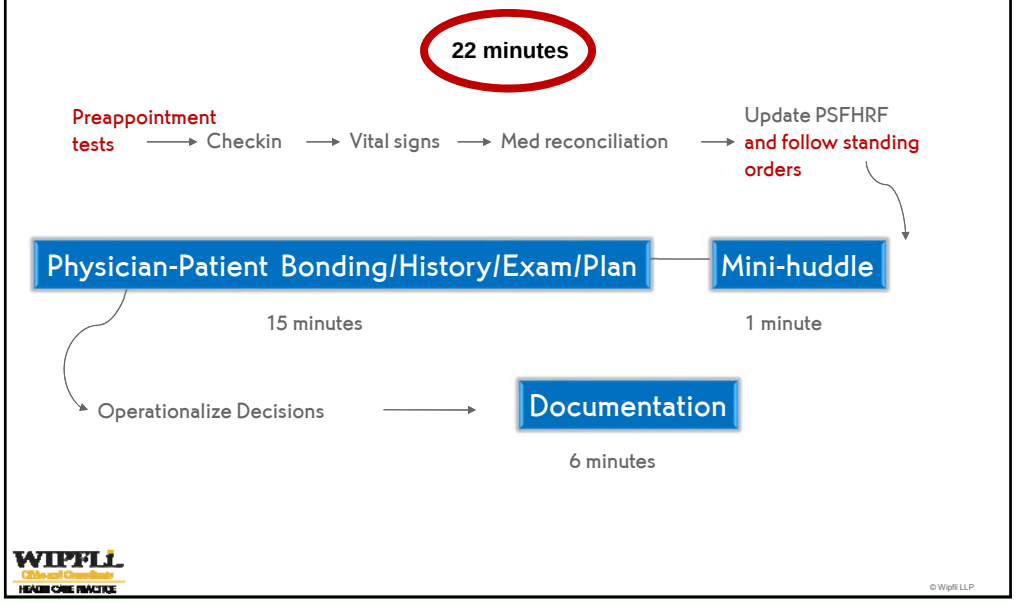
N = 15

Source: Tom Bodenheimer MD, UCSF 2012

Sample Provider Time Study



Impact of a Strong Patient Care Team



Team-Based Care Influence on Panel Size

If portions of care delivery are delegated to nonphysician team members, larger practice panels are possible.

	Level of Delegation of Preventive/Chronic Care Management Responsibilities			
	NONE	LOW	MED	HIGH
Panel Size	983	1,387	1,523	1,947
% Increase from Base		41%	55%	98%

Source: Altschuler, et.al., Estimating a Reasonable Panel Size for Primary Care Physicians with Team-based Task Delegation. Annals of Family Medicine, Vol 10, No. 5; September/October 2012

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Measures of Team Effectiveness

- Employee satisfaction surveys
- Employee turnover rates
- Tools to measure "team cohesiveness"
- Continuity and empanelment reports
- Operational reports (i.e., office wait time, visit cycle times, no-show rates, call abandonment rates
- Population health reports
- Direct audit of items in standardized workflows
- Patient experience/satisfaction surveys

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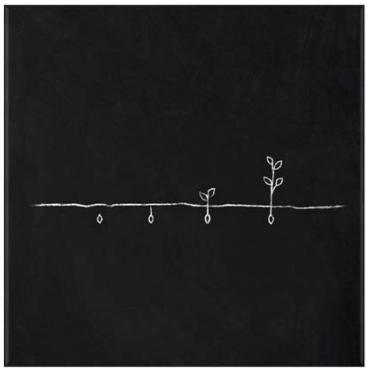

Medicare Beneficiary Quality Improvement Program (MBQIP)

- Goal: Improve Quality of Care in CAHs
- Review Core and Optional Initiatives
- Track and Trend Data/Publicly Report

Medicare Rural Hospital Flexibility (Flex) Grant Program

What is the Medicare Rural Flex Grant Program?

Under HRSA's Federal Office of Rural Health Policy (FORHP)

Objective: Improve access to preventive and emergency health care services for rural populations.

- Flex funding encourages the development of cooperative systems of care in rural areas, joining together CAHs, emergency medical service providers, clinics, and health practitioners to increase efficiencies and quality of care.

The Flex Grant Program includes support for the following Program Areas:

- Support the quality improvement efforts of CAHs
- Improve the financial and operational performance of CAHs
- Support for health system development and community engagement

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Medicare Beneficiary Quality Improvement Program (MBQIP)

Goal: Improve the quality of care provided in CAHs by increasing quality data reporting, then driving QI activities based on the data.

- This project provides an opportunity for individual hospitals to:
  - Look at their own data
  - Measure their outcomes against other CAHs
  - Partner with other hospitals in the state around QI initiatives to improve outcomes and
  - Provide the highest quality care to their patients.
- Core Improvement Initiatives include:
  - Patient safety
  - Care transitions
  - Patient engagement
  - Outpatient/ED

See Handout

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MBQIP Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Core Improvement Initiatives	**OP-27:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(Facilities report a single rate for inpatient and outpatient settings)* **IMM-2:** Influenza Immunization	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *7 sub-measures; 27 data elements; 1 composite* • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • **All-EDTC:** Composite of All 27 data elements	**OP-1:** Median Time to Fibrinolysis **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **OP-4:** Aspirin at Arrival **OP-5:** Median Time to ECG **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients **OP-20:** Door to Diagnostic Evaluation by a Qualified Medical Professional **OP-21:** Median Time to Pain Management for Long Bone Fracture **OP-22:** Patient Left Without Being Seen

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MBQIP Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Additional Improvement Initiatives	**Healthcare Acquired Infections (HAI)** • **CLABSI:** Central Line-Associated Bloodstream Infection • **CAUTI:** Catheter-Associated Urinary Tract Infection • **C. diff:** *Clostridium difficile* Infection • **MRSA:** Methicillin-resistant *Staphlococcus aureus* **Perinatal Care** • **PC-01:** Elective Delivery **Pneumonia** Proportion of patients hospitalized with Pneumonia – potentially avoidable complications **Falls** Potential measurement around: • Falls with Injury • Patient Fall Rate • Screening for Future Fall Risk **Adverse Drug Events (ADE)** Potential measurement around: • Opioids • Glycemic Control • Anticoagulant Therapy **Patient Safety Culture Survey**		**Discharge Planning** *Potential measurement TBD with FORHP* **Medication Reconciliation** *Potential measurement TBD with FORHP*	**ED Throughput** • **ED-1:** Median Time from ED Arrival to ED Departure for Admitted ED Patients • **ED-2:** Admit Decision Time to ED Departure Time for Admitted Patients **Stroke** • **OP-23:** ED – Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival **Surgery/Surgical Care** • **OP-25:** Safe Surgery Checklist Use

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MBQIP Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Additional Improvement Initiatives	Reducing Readmissions *(These measures are automatically calculated for hospitals using Medicare Administrative Claims Data)* Stroke • STK-1, STK-8 All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016 • Proportion of patients hospitalized with Stroke – potentially avoidable complications Venous Thromboembolism (VTE) • VTE-1, VTE-2, VTE-3 All retired by the Centers for Medicare & Medicaid Services (CMS) as of 1/1/2016			

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MBQIP Data Aggregation Made Easy

- More than 90% CAHs throughout the United States are participating in MBQIP and learning to use an internal quality-monitoring tool called the CMS Abstraction and Reporting Tool (CART).
- If you use CART, you can generate reports to track progress and benchmark your performance against your goals. The February 2017 MBQIP Newsletter details the process of use and provides best practices and data guidance.

Quarterly Measure Summary Trends						
Quarterly Encounters for Quarters Starting:	Numerator	Denominator	Percentage	Your Goal	Notes or Comments	Date Data Entered
July 1, 2016	3	5	60%	100%		2/1/2017
October 1, 2016			N/A	100%		

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Provider Satisfaction
Addressing the Fourth Aim

Care of the Patient Requires Care of the Provider

Impact of Physician Satisfaction on Patients

- Patients whose physicians report greater practice satisfaction report significantly greater satisfaction with their care.

  Haas JS, Cook, EF et al. Is the professional satisfaction of general internists associated with patient satisfaction? J Gen Intern Med, 2000 Feb;15(2):122-8.

- The Rand Medical Outcomes Study demonstrated a significant positive correlation between physician satisfaction and patient adherence to care recommendations among patients with major chronic conditions.

  DiMatteo MR, et al. Physicians' characteristics influence patients' adherence to medical treatment: results from the Medical Outcomes Study. Health Psychol 993 Mar;12(2):93-102.

- The Community Tracking Study survey of over 16,000 practicing U.S physicians found that dissatisfied physicians were two to three times more likely to leave medical practice than their more-satisfied colleagues.

  Landon BE et al. Leaving medicine: the consequences of physician dissatisfaction. 2006 Mar;44(3):234-42.

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Major Physician Dissatisfiers

- Schedule is too busy to allow for adequate patient care
- Inadequate or inefficient staff and technology support
- Administrative "paperwork" and other nonpatient care activities interfere with physician-patient contact
- Lack of input into key decisions involving the practice

Solution: Team-Based Care

Source: Crosson FJ, Casalino L Physician Practice Satisfaction: Why We Should Care. Health Affairs May 9, 2013

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Improving Physician Satisfaction

- Reduce work through previsit planning and preappointment lab tests
- Share clinical care among team members
- Use nonphysician order entry and streamlined prescription management
- Have a nurse or medical assistant filter electronic and paper information for fewer inbox messages
- Use team meetings, colocation, and workflow mapping to improve team function

Source: In Search of Joy in Practice: A Report of23 High-Functioning Primary Care Practices." Annals of Family Medicine.

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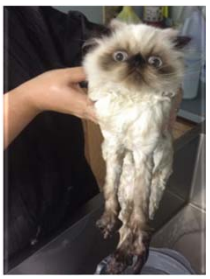
Before and After Implementation of Teams in Practice



Working at Starbucks would be better.

Benjamin Crocker, MD, October 3, 2007

I look forward to going to work each day. I'm loving it!

Benjamin Crocker, MD, July 13, 2011

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Redesigning a System of Care to Promote Quality

Preparing for the Future

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Redesigning a System of Care

Many health care organizations have made important advancements in the design and performance of their current *systems of care.* Despite these improvements:

- Many improvements remain unused, partially implemented, fragmented, and isolated.
- Clinicians often feel overworked and unable to take on new work.
- Patient satisfaction levels are not optimal.
- Wait time for patients continues to increase.

It is a leadership imperative to assess your delivery system—people, processes, and quality outcomes—against your peers and benchmarks.

- Determine your strengths and opportunities for improvement.
- Use the "Blueprint for Performance Excellence" to assess your current state and develop an action plan.

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https://www.hrsa.gov/quality/toolbox/508pdfs/redesignsystemofcaretopromoteqi.pdf

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Integration of Care With Population Health - The Accountable Care Organization

Providers who will successfully deliver cost-effective, coordinated care through population health management must consider four well-planned steps.

1. **Optimize network management.** Because success in value-based care hinges on providing the right care in the right setting, network management could yield savings. Select care partners carefully—those who are focused on patient-centered care and quality outcomes.
2. **Manage care transitions.** Through improved discharge planning and post-acute outreach, practices can provide patients with better coordinated care, foster confidence in self-care, and prevent costly hospital readmissions.
3. **Consider in-home intervention/expansion into the community.** Providing in-home care, coaches, or use of technology to "see into the home" for high-acuity patients can keep them on the road to recovery.
4. **Expand chronic disease management.** Directing chronic care coordination and complex case management to specific patient populations can improve clinical outcomes and reduce health care costs.

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The Synergy...

There is a synergistic relationship in these concepts. When focusing on patient outcomes of care concurrent with redesigning systems, satisfaction is positively impacted.

- Quality is inherent in organizations that redesign systems and processes and effectively train staff to achieve the best outcomes for patients.
- Provider satisfaction is enhanced when systems work for them and the patient. Team-based care, with enhanced oral and electronic communication modalities, care coordination processes, and complex care management, improves provider and staff satisfaction and improves outcomes.
- Patient satisfaction is an indicator of quality care (physical, psychosocial, communication that ensures understanding and a focus on the patient's goals).

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  http://www.annfammed.org/content/12/6/573.full#sec-8
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  https://www.qualityforum.org/Projects/n-r/Rural_Health/Final_Report.aspx
- Population Health Strategies of Critical Access Hospitals, Flex Monitoring Team. August 2016.
  http://www.flexmonitoring.org/wp
- Primary Care Integrated, Complex Care Management: Clemens Hong.
  https://www.ghdonline.org/ccm/discussion/primary-care-integrated-complex-care-management/?ref=expertpanels
- Redesigning a System of Care to Promote QI: HRSA.
  https://www.hrsa.gov/quality/toolbox/
- Rural Hospital Toolkit for Transitioning from Volume to Value: 2015
  https://www.ruralcenter.org/srht/rural-hospital-toolkit
- Stratis Health, QIO Minnesota. QI Toolkit for the Emergency Department.
  http://www.stratishealth.org/documents/ED_Transfer_QI_Toolkit_Principles_of_Care.pdf

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Questions?

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Thank you!

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