Greetings!

Welcome to our July News Update

Good day!
Hope you are having a wonderful summer as it always seems to go so fast!

Summer is also a time when things heat up at the federal level as there is always a flurry of proposed and final facility and provider rules from the Centers for Medicare & Medicaid Services (CMS) on quality and safety, payment, and initiatives going forward. Most of the rules are adjustments to existing CMS programs as with all health programs, they require ‘tweaking’ each year to adjust to changes in the environment. Additionally, any time there is a change in federal executive and agency leadership, there are also new ideas advanced in the form of legislation, and proposed and possibly final rules.

Some of the proposed rules that were recently released include facility and clinician prospective payments and value-based payment programs; increased transparency through proposed release of accreditation program survey results; reductions in home health organization payments; and several more.

As important as it is to monitor the proposed and final rules, it is also important to be mindful of the proposed budgets. Often a new or controversial rule or act maybe approved, but it may not be funded or not fully funded. In some instances, you will find an initiative or program in place for a few years and then it is defunded without any rule to disband it.

As we begin a new federal administrative year and budget, we are monitoring the initiatives that have the greatest effect on persons, patients, and families including, quality and safety programs; public reporting and transparency; healthcare research that includes patients; social factors on health; health equity; increased access to health and health care; costs of care and insurance; and care for the caregivers and organizations that provide preventative and interventional care.

In this newsletter, you will find some timely updates on advancing initiatives by key
Trends in Public Reporting of Healthcare Information: Focus on Transparency

There are environmental pressures that are pushing us toward greater transparency as consumers have electronic access to their test results and interact with their clinicians through patient portals. There are also many web and mobile-based applications that consumers are using to track and manage their health conditions.

Consumers and patients are calling for increased healthcare transparency so they can make meaningful decisions based on quality, cost, outcome, and patient experience. In some states, the All Payer Claims Databases (APCD) have been the foundation of many new and interactive consumer tools to help patients with facility selection based upon quality and cost.

There are several initiatives that were recently released that provide guidance in how best to rapidly advance healthcare information, including:

- **Network for Excellence in Health Innovation (NEHI)** released a new report this past week entitled, “Transparency in Health Care: A Priority Roadmap for Consumer Engagement.”

  The report highlights the information needs of consumers and patients in choosing a plan, choosing a provider, and making treatment decisions. The report also suggests the action steps to be taken to address consumer needs and the engagement and education of consumers, patients, and families throughout the developments and processes.

- **Agency for Healthcare Research and Quality (AHRQ)** recently released a literature review and environmental scan with the objective to map an approach to creating an inventory of measures of quality, cost, and utilization of care across settings for potential use with an APCD. The National Association of Health Data Organizations (NAHDO) through its work with their APCD Council, contributed to the report, “All-Payer Claims Databases Measurement of Care: Systematic Review and Environmental Scan of Current Practices and Evidence.”

  According to the [APCD Council web site](http://www.ahrq.gov/), there are approximately 13 states with...
APCDs and another 4 states that are currently implementing APCDs. States vary in their usage of APCD data pending their state advisory boards or councils --- but all are working to put more information in the consumer hands.

- **Facility Survey Inspection Results** are currently available for nursing homes on Medicare Nursing Home Compare. This past April, the proposed rules for Payment and Quality for facilities, including hospital inpatient services, had a proposed rule for the hospital accrediting organizations share their results with the public in a similar fashion to that of nursing homes. Nursing homes are inspected by state agencies every 12 to 15 months and their inspection results are 'scored' within a state and the scores affect their overall star rating. Hospitals are primarily inspected every 3 years by accrediting organizations and their results are nationally compared with no inspection reports affecting their star rating.

- **Risk Adjusting Hospital Readmissions** - As CMS adds, modifies, and deletes measures for hospitals and nursing homes, the associated star rating systems also change. For example, under the 21st Century Cures Act, CMS is to risk-adjust readmission penalties on the proportion of a hospital's patients identified as dual-eligible beneficiaries, or those that qualify for both Medicare and Medicaid. The risk adjustment is to occur by October 1, 2018. Not only will this affect star ratings, but there will also need to be new training for surveyors on how performance and processes are assessed. The risk adjustment methodology should be publicly available soon.

### HOUSE PASSES BILL ON ACCREDITING ORGANIZATIONS FOR DIALYSIS CENTERS

The House recently passed a bill that is now over in the Senate that allows for accrediting organizations to conduct surveys and inspections of dialysis centers. The bipartisan supported bill, HR 3178, is in response to the delays ranging from a few months to years that dialysis centers are experiencing in having the required inspection before a dialysis center can be certified and receive Medicare funding.

CMS funds the state surveyor programs and has a tiered inspection protocol of which certification of new dialysis centers typically is in the lowest tier while higher priority facilities and facilities that pose immediate risk to patients are on the upper tiers for initial certification and ongoing inspections. Dialysis centers are required to be inspected every three years but many states have slipped in the schedule with some going as long as six years between inspections. Consumer information on dialysis center demographics and quality can be found on Medicare Dialysis Facility Compare or ProPublica. Propublica provides the date of the most current inspection while Medicare Dialysis Facility Compare provides the date the center was originally certified.
Raising the Awareness.

As many providers are increasingly aware of the challenges in managing opioid prescriptions, clinicians are turning to alternative approaches to manage pain and oversee all opioid prescriptions.

While clinicians are working to manage and reduce opioid usage and their prescribing of opioids, consumers, patients, and families need to be aware of the dangers of opioid usage. Any time a physician or other clinician offers or prescribes an opioid for pain relief, patients and families should ask questions, such as:

- Do I really need that opioid drug? Why?
- Are there alternatives to relieve the pain other than the opioid?
- If I take the opioid, what is the timeline for eliminating the opioid?
- Is there a danger in becoming addicted to the prescription opioid?

Study published by CDC suggests that it is a very short period of time in which a patient can become dependent upon opioid prescription. "Awareness among prescribers, pharmacists, and persons managing pharmacy benefits that authorization of a second opioid prescription doubles the risk for opioid use 1 year later might deter overprescribing of opioids. Knowledge that the risks for chronic opioid use increase with each additional day supplied might help clinicians evaluate their initial opioid prescribing decisions and potentially reduce the risk for long-term opioid use. Discussions with patients about the long-term use of opioids to manage pain should occur early in the opioid prescribing process." Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269.

If a clinician cannot provide answers to these questions, seek a second opinion from another clinician. Per the Centers for Disease Control and Prevention “Opioid prescribing continues to fuel the epidemic. Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid. In 2015, more than 15,000 people died from overdoses involving prescription opioids.”

For anyone or family member that needs assistance, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) operates a national helpline, 1-800-662-HELP (4357), is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. For more information on SAMHSA’s support, go to https://findtreatment.samhsa.gov/

Many communities have instituted safeguards and laws to improve protections for consumers in their communities and to respond to the opioid epidemic. For example, in November 2017, the Chicago City Council passed an ordinance that requires all pharmaceutical sales representatives to be relicensed; pay a $750 licensing fee with annual renewal; and undergo training for ethics, marketing regulations, and applicable laws. Chicago marketing representatives will also have to file reports that disclose the names of doctors they visit as part of their work, the number of visits, and any samples,
materials, or gifts provided, along with their value. Many communities and states also have launched innovative interventions to address the opioid epidemic and several have lawsuits against pharmaceutical companies that have promoted the usage of opioid prescriptions.

**AHRQ State Opioid Drill Down Information**
The Agency for Healthcare Research and Quality (AHRQ) has provided state level information for opioid hospitalizations and emergency department visits compared to national data on their [HCUP Fast Stats web site](https://www.hcup-us.ahrq.gov/faststats/index.jsp). One can drill down the data to segment analysis in aggregate by age, sex, community level income, patient geographic location, and payer (Medicare, Medicaid, commercial, and uninsured). Payer information is available by count while all other information is available at a rate per 100,000 population. Trend data is available from 2007 through 2014 and for most states through 2015.

When reviewing the trend lines, it is important to be aware of the vertical axis legend as the rates per 100,000 change to fit the graph as one can see the variations in the graph below.

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**Graphic depicts National and Illinois Opioid-Related Hospital Use by Community Level Income.**

"AHRQ Definition: ‘Community-level income is based on the median household income of the patient’s ZIP Code of residence. Quartiles are defined so that the total U.S. population is evenly distributed. The cut-offs for the quartile designation are determined annually using ZIP Code demographic data obtained from Claritas, a vendor that compiles and adds value to data from the U.S. Census Bureau. Claritas estimates intercensal annual household and demographic statistics for geographic areas. The value ranges for the national income quartiles vary by year. Income quartile is missing if the patient is homeless or foreign. Discharges missing the income quartile are excluded from results reported by community-level income.’"

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**ARE YOU A CLINICIAN EXEMPT FROM QUALITY PAYMENT PROGRAM? EASY WAY TO FIND OUT!**

CMS has added another helpful resource for clinicians to better understand if they are exempt from the Quality Payment Program (QPP). To determine if a clinicians’ participation should be considered as special status and exempt under the Quality
Payment Program, CMS retrieves and analyzes Medicare Part B claims data and runs the data through a series of calculations to determine the status of a clinician. These circumstances are applicable for clinicians in: Health Professional Shortage Area (HPSA), Rural, Non-patient facing, Hospital Based, and Small Practices.

For more information, please visit the Quality Payment Program website. All you need to do is enter your NPI on this site and it will quickly return information on whether you are exempt or not exempt from QPP. If you are not exempt, please utilize the resources on the QPP web site as there is a wealth of info on QPP.

ARE WE TRENDING TOWARD A FUTURE OF COLLABORATIVE HEALTH?

Project Patient Care (PPC) board member Michael Millenson recently wrote a provocative article in The BMJ (formerly the British Medical Journal) entitled “When ‘patient centered’ is no longer enough: The challenge of collaborative health.” In addition to serving on the PPC board, Michael is president of Health Quality Advisors and is adjunct faculty at Northwestern University’s Feinberg School of Medicine. He’s also an author and a former Chicago Tribune reporter nominated three times for a Pulitzer Prize.

In his BMJ article, Millenson advances the notion of “collaborative health” as a “shifting constellation of collaborations for sickness care and for maintaining well-being that is shaped by people based on their circumstances. The result is not reform, but a transfer of power in which the traditional system loses some of its control.”

Pat Merryweather, Executive Director at PPC, talked with Michael to explore that trend. (His article was recently made available for access outside the BMJ pay firewall, here.)

According to Millenson, “The paradigm change is occurring within and outside of healthcare. It is happening to people because of social and economic factors that clinicians cannot control.” One indicator is the increasing number of web and mobile applications allowing a person to better manage their health and diseases.

The current “patient-centered care” approach was highlighted in the Institute of Medicine’s (IOM) 2001 “Crossing the Quality Chasm” report. It was defined as, “Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”

Millenson posits that we are seeing a shift in which patient-centered care is subsumed into the larger collaborative health phenomenon. In collaborative health, other, non-medical actors such as health plans or tech companies may be involved in the effort to preserve and maintain health. The traditional care system at times may not be involved at all. What the collaborative health concept provides, he writes, “is a framework for understanding how the traditional and untraditional will co-exist and interact in a health care ecosystem with new players and relationships.” For physicians to maintain patient trust in this new environment, Millenson says they must adopt three core principles: shared information, shared engagement and shared accountability.

We thought we would share this evolving concept and paper with our readers because the word “collaborative” is increasingly being used to refer to an evolving health system.
that is multidirectional and multidimensional. One of the most recent uses is in the Healthcare Payment Learning and Action Network’s “Alternative Payment Model (APM) Framework White Paper Refreshed 2017.” The Healthcare Payment LAN paper references that person-centered care rests upon three pillars, one of which is Collaborative Patient Engagement and the other two pillars being Quality and Efficiency.

Millenson concludes his forward-looking article this way: “Though the role of the doctor is in flux, there remains great value in professional expertise rooted in ethical and legal traditions. As economic, technological, and social changes give rise to new networks of collaborations, we the citizenry (your sometime patients) need you at our side, both for our sake and to counteract others’ economic or political agendas. Accepting a less central role may feel at first as if collaborative health is shrinking the profession’s importance. In reality, accepting true partnership will profoundly expand the profession’s influence in the days to come.”

Millenson's Three Core Principles for Collaborative Health

Shared information
Opening the complete electronic health record for patients to read, comment on, and share improves their ability to manage their health. Moreover, by making the sharing of information the default, the profession sweeps away a critical information asymmetry and gives itself the moral standing to demand that corporations and governments practice similar transparency with the “big data” they collect. That’s imperative at a time when half of consumers are willing to share their health data with Apple, Samsung, Microsoft, or Google. At the same time, the profession will have to become much better at communicating information clearly.

Shared engagement
Collaborative health is multidirectional and multidimensional. For example, a pediatrician related how parents of a baby with a rare condition referred him to a Facebook group where families exchanged stories. What he learnt there shaped the eventual clinical decision.

Collaboration also means accommodating varying engagement preferences. Elsewhere, I’ve suggested that clinicians adopt Quill and Brody’s enhanced autonomy approach, which encourages active exchange of ideas and the explicit negotiation of differences “in an intense collaboration between patient and physician.” This flexibility fits those who may want or need the doctor to guide prevention or care, those in the do-it-yourself health movement, those who prefer shared decision making, and those whose preferences may shift because of illness or a new life situation. It’s also a model that sometimes allows one partner to say, “I want you to decide.”

Shared accountability
Shared accountability may pose the greatest challenge. Hierarchies have clear lines; shared power is more complex, particularly among diverse individuals and organizations. For example, a device company offers consumers a diabetes management app developed with an artificial intelligence company. Who is accountable for that individual’s health, and what role does the doctor play?

Important questions related to ethical and legal responsibilities for care continuity, communication, privacy, and security remain. However, adopting an explicit collaborative health framework that acknowledges the presence and power of traditional and non-traditional actors—not just “providers” and “patients”—allows and encourages the raising
What connects these strategies is the physician and ethicist Jay Katz’s radical alternative to the traditional “caring custody.” Offered nearly 35 years ago, it still resonates: surrender “the idea of physicians’ Aesculapian authority over patients” and replace it with mutual trust.

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