2016 Mid-year accomplishments

Quality and Patient Safety

MHA will enable hospitals and health systems to pursue evidence-based methods in order to continuously improve the quality and safety of patient care they provide.

- Help MHA members successfully implement evidence-based practices to reduce patient harm across the board including hospital acquired infections, perinatal and surgical events, and other adverse health events (aligns with HEN goals).
  - MHA members working together through the HEN program have prevented 20,334 adverse events and 12,847 readmissions, which translates to $131.5 million in cost savings and 51,388 nights that patients were able to spend at home rather than in the hospital.
  - The MHA HEN has exceeded the CMS 20 percent reduction goal for readmissions (33 percent) and 40 percent reduction goals for pressure ulcers (60 percent), early elective deliveries (55 percent), sepsis mortality (88 percent) and CAUTI (44 percent).

- Help MHA members improve patient and family engagement (PFE) by increasing the number of hospitals and health systems that have a dedicated patient and family engagement staff person and a patient and family advisory committee (PFAC) (aligns with HEN goals).
  - MHA continues to provide 1:1 PFE consultation and convenes a monthly PFE learning network for members.
  - MHA held a statewide PFE conference in July.
  - Hospitals with dedicated PFE staff increased from 52 percent in January to 70 percent in June.
  - Hospitals with a PFAC or a patient representative on a QPS committee increased from 56 percent in January to 67 percent in June.
• Assist MHA members in addressing and reducing disparities in health care, including but not limited to collecting race, ethnicity and language data (REL), and identifying and sharing best practices (aligns with HEN goals).
  • MHA members currently submit REL information with their administrative claims data. As of July 2016, 118 hospitals are submitting REL information with their administrative claims data, up from 99 at the beginning of the year.
  • An eliminating health disparities webpage was added to the MHA website to provide participating hospitals and health systems with additional resources regarding their work to collect, submit and analyze REL data and develop strategies and action plans.
• Help MHA members utilize available tools and resources to conduct workplace violence prevention planning and training in order to increase the safety of patients, staff and visitors.
  • MHA continued to closely partner with MDH to provide education to prevent workplace violence. 55 hospitals and health systems are completing the violence prevention roadmap in the MHA QPS data portal and reporting increased from 44 to 56 percent best practices in place from first to second quarter 2016.
  • Six health systems were awarded grant support to work on workplace violence prevention initiatives.
• Disseminated reports to MHA members showing potential financial impacts related to Medicare’s value-based purchasing program (VBP), hospital-acquired conditions (HAC) and readmissions.

**Health Care Reform**

*MHA will serve as an expert on the Affordable Care Act and other state and federal health care reform initiatives, and advocate for additional reforms and refinements designed to achieve the Triple Aim.*

• Advocate for substantive mental health reforms during the 2016 legislative session, including but not limited to potential reforms to be proposed by the Department of Human Services, as well as preparing for a more ambitious policy and budget advocacy agenda for the 2017 legislative session.
  • MHA successfully advocated for all three of the board’s highest legislative priorities:
  • Legislative appropriation of state matching funding to support the creation of Certified Community Behavioral Health Clinics if Minnesota is selected to participate in a federal demonstration project under the Excellence in Mental Health Act. The Excellence in Mental Health Act was allocated $188,000 in FY17 and $8.4 million in FY18-19. If Minnesota is selected for this national demonstration project, there is potential for up to 90 percent of costs to be paid by CMS.
• Additional state funding of $19.8 million in FY17 and $47 million for FY18-19 for the Community Behavioral Health Hospitals to enable each of them to increase the number of patients they serve from less than 10 per day to their maximum capacity of 16 per day.
• Reform the state’s competency restoration services to free up potential beds for more acute mental health patients at Anoka-Metro Regional Treatment Center and the state security hospital in St. Peter. This was allocated $6.754 million in FY17 and $16.846 million in FY18-19, with the potential to free up approximately 20 beds at AMRTC and 10 beds at the Security Hospital in St. Peter.
• In total, MHA helped secure $48 million of additional state investment in mental and behavioral health services.
• MHA is developing a proposal for a more comprehensive advocacy agenda for the board to consider later this year.
  • The MHA Mental and Behavioral Health Committee initially reviewed approximately 30 state and federal policy initiatives. MHA’s advocacy with the Dayton administration secured two hospital representatives on the state’s Mental Health Task Force, which will develop recommendations for further legislative action in 2017. MHA continues to participate actively in multiple stakeholder groups trying to garner collective support for increasing capacity of mental health services.
  • MHA completed a statewide study quantifying the number of mental health inpatients who would be better served in other settings and the reasons for their delays. This study is expected to be used in MHA’s advocacy to support requests for even more state funding, especially for increasing capacity of services provided by Community Behavioral Health Hospitals and Intensive Residential Treatment Services.
  • MHA compiled a gap analysis of Minnesota’s existing mental and behavioral health system and completed a statistical analysis of the amount of various adult mental health services needed in each region of the state to reach specified benchmarks. MHA is working with DHS to develop financial metrics to allow us to include cost estimates for each of these benchmarks.
  • MHA secured appointment of representatives from our membership to serve on the DHS Substance Abuse Disorder Services Reform Core Work Group and Finance Work Group. The work groups are helping develop legislative proposals to substantially reform chemical dependency and substance abuse services from an isolated and episodic treatment system to a chronic disease medical service that will be eligible to receive federal financial support through Medicaid.
• Promote Critical Access Hospital (CAH) payment reforms developed by MHA’s recent task force and those developed by other states that align with MHA’s interests with other state hospital associations, national interest groups, Minnesota’s congressional delegation and other stakeholders.
  • MHA submitted the association’s CAH reform proposals to AHA’s Vulnerable Rural Communities work group to consider for possible inclusion in recommendations to be presented to the AHA board.
  • MHA presented the association’s CAH reform proposals to a new national group of rural health care leaders from state hospital associations, to individual state hospital associations and at the Minnesota Rural Health Conference. MHA has been invited to present the proposals at a conference for CAHs from states in the southeast.
  • MHA presented the association’s CAH reform proposals to Sen. Franken’s office for possible inclusion in a rural health reform bill he is authoring in his role as co-chair of the Senate’s rural health caucus. In addition, MHA provided recommendations for changes to other potential provisions of his bill to better meet the needs of Minnesota’s CAHs.
• Continue pressing for implementation of new Medical Assistance payment rates for hospitals and begin tracking or measuring their impact on MHA members in anticipation of building a consensus position regarding policy elements of the next rebasing.
  - MHA successfully advocated for and worked with DHS to begin implementation of new Medical Assistance rates for CAHs, which are retroactive to July 1, 2015, in late June and will begin monitoring their impact on members.
  - MHA continues to work with DHS to advance implementation of new Medical Assistance rates for Prospective Payment System (PPS) hospitals, although the state does not anticipate being able to begin paying under the new system until late in the year. Payment rates will be adjusted back to Nov. 2014, which was the implementation date in statute. Because of the potential negative impact caused by budget neutral rebasing, MHA extended the numerous policy payment adjustors, as well as the +5/-5 percent rate bands, through this rebasing process.
  - MHA is working with DHS to explore rebasing of CAH outpatient payment rates, as well as anticipating potential legislation, if needed, to pursue before the next scheduled rebasing in 2017. MHA is planning to convene meetings with our members and key DHS staff to discuss potential issues or concerns in order to develop consensus-based positions for the association and help the state better understand our members’ needs.
  - Hosted a webinar in June targeted at CAHs to share details of both the rebased rates implementation plan and outpatient cost settlements that have been long delayed.

• Engage with the Minnesota Department of Labor and Industry (DLI) and other health care providers with respect to outpatient payment reforms in the state’s workers’ compensation system.
  - Convened the MHA Workers’ Compensation Work Group and met with DLI in an attempt to develop a reformed outpatient reimbursement system. With no clear consensus on a methodology and little data to support the change, MHA pushed for a delay in the process.
  - Provided several examples to DLI outlining problems with the 2016 inpatient reimbursement reforms to show MHA’s concerns about reforming the outpatient reimbursement.
  - MHA successfully worked with DLI to pass clarifying legislation in 2016 correcting a drafting error made by the department in 2015 that inadvertently reduced outpatient payments to non-CAHs with less than 100 beds.

• Invite and seek to collaborate with interested law enforcement groups to develop best practices or agreed upon standards for security when a person in custody, under arrest or guarded while receiving care in a hospital.
  - MHA is partnering with MDH to convene a multi-stakeholder coalition aiming to improve the safety of Minnesotans in law enforcement custody needing hospital-level care. The initial coalition meeting of MHA members, MDH, law enforcement, counties, EMS agencies and other key stakeholders is scheduled for Aug. 2016. The goal is to co-create a set of best practices or protocols to improve communication between health care entities and law enforcement agencies, ensure consistent implementation of state and federal regulations, and improve patient and staff safety when patients are in law enforcement custody.
Common Ground Across the Care Continuum

MHA will convene stakeholders, including physicians, long-term care providers and other health care organizations, as well as businesses and community groups with interests in health care policy issues, find areas of common ground, and leverage the power of coalitions to advance the Triple Aim.

- Collaborate with LeadingAge Minnesota to explore post-acute care cost and/or quality measures that will help MHA and LeadingAge members advance the Triple Aim.
  - A joint task force was created between MHA and LeadingAge Minnesota members in 2016 consisting of health system ACOs and post-acute providers to create recommendations regarding standards on how to integrate post-acute, home-based and community-based services into ACO models.
  - MHA partnered with LeadingAge Minnesota to engage 18 of their members to reduce CAUTI in post-acute care settings. This “On the CUSP CAUTI” learning network has resulted in a 38 percent reduction in CAUTI per 10,000 patient/resident days.

- Build and strengthen MHA’s collaborative relationships with other mental health stakeholder groups through work on common policy, advocacy and care delivery improvement efforts.
  - MHA worked closely and successfully with other mental health stakeholder groups, especially the Minnesota Association of Community Mental Health Programs (MACMHP), to advocate for state funding of the Excellence in Mental Health Act demonstration project. MACMHP’s executive director discussed the legislation with MHA’s Mental and Behavioral Health Committee and Policy and Advocacy Committee; worked jointly with MHA to host a well-timed press conference on the bill; and coordinated efforts with MHA to align NAMI Minnesota, Minnesota Mental Health, DHS and other stakeholders behind this high-priority initiative.
  - MHA worked with NAMI Minnesota and organized a grant program to subsidize MHA members who want to host mental health first aid training in their communities. Seven MHA members have expressed interest in receiving a grant and one training session has been held under this grant program so far.

- Work with the Minnesota Medical Association and support the Twin Cities Medical Society’s initiative to promote the Honoring Choices campaign to encourage more residents to complete advance care planning.

- Disseminated reports showing total cost of care data associated with Medicare’s Comprehensive Care for Joint Replacement (CJR) bundled payments program. These reports show post-acute care’s contribution to total cost of care, especially for those involved in bundled payments and accountable care organization programs.
Population and Community Health

MHA will lead collaborative initiatives with MHA members and community stakeholders to advance population or community health efforts, including assessing community health needs, designing and implementing community benefit programs, and impacting measures of population health.

- Provide public health and community needs assessment resources, education and tools to help MHA members complete their community health needs assessments and implementation strategies.
  - MHA continues a positive working relationship with the Local Public Health Association (LPHA). MHA and LPHA jointly applied for and received a grant from the Robert Wood Johnson Foundation to allow MHA and LPHA members to meet across Minnesota to facilitate collaboration in the community health needs assessment input and implementation process.

- Advocate for state and federal policies that protect or expand the levels of meaningful coverage for residents, whether through state public programs or other subsidies that ensure affordability.
  - Throughout the legislative process, MHA has been a consistent voice for maintaining the MinnesotaCare program and for coverage for low-income Minnesotans.

Data Aggregation and Analysis

MHA will provide members with analysis of and access to a collection or aggregation of useful data for solutions-based initiatives to improve the quality of care, better manage the total cost of care, and increase the health status of MHA members' patients and communities.

- Collaborate with MHA members’ chief medical officers and other clinical experts to measure over- or avoidable utilization of inpatient psychiatric beds.
  - Potentially Avoidable Days (PAD) data analysis was performed in partnership with Wilder Research in March and April 2016 which included 20 hospitals statewide showing that of 32,520 possible bed days, 6052 days – or 19 percent – were potentially avoidable due to non-availability of community resources such as Community Behavioral Health Hospitals, Intensive Residential Treatment Services and chemical dependency treatment options.
  - MHA engaged members’ financial leads to support the PAD study to develop estimated reimbursement and cost impacts.

- Develop mental and behavioral health assessment protocols or other best practices to improve care delivery and outcomes.

- Develop and propose options for increasing the scope of MHA’s data used for helping members understand and improve their clinical, financial and organizational performance.
  - MHA used workforce data reported by many MHA members over the past several
years to create a new online analytics tool that allows participating members to better understand the trends in hiring, demographics, turnover and other statistical measures for 38 direct-patient care jobs. MHA created a statewide summary available to members on the MHA Member Center.

- Synthesize national- and state-level health care trend data for members’ use in board and community education.
  - Provided financial impact analysis of Medicare’s FY2017 proposed inpatient rule in addition to quarterly value-based purchasing impact reports.

- MHA reconfigured the Minnesota Hospital Quality Report website to better display consumer-friendly quality data. This helps consumers gain more information on quality of care and patient experience to help make more informed decisions about future hospital care.

Education and Public Relations

MHA will deliver accessible and tailored education, information and resources for MHA members’ trustees, physicians, executives and community leaders, as well as for communicating the Association’s messages and priorities to the public, media, policymakers and other audiences.

- Offer quarterly education programs related to advancing The Triple Aim.
  - MHA provided education to members through conferences, seminars, regional meetings, webinars and newsletters.

- Provide up to eight new on-demand video education events.
  - On-demand videos were created on the topics of legislative issues, workforce, quality and patient safety, employee resiliency and reimbursement changes. These videos are available to all members and the public on the MHA website.

- Disseminate monthly opinion leader emails on patient safety, quality of care and hospitals’ and health systems’ community contributions.
  - Continued opinion leader outreach campaign with eight email blasts to 4,000 members and external stakeholders.

- Expanded the MHA Member Center to include details on MHA committees and the board of directors. Information includes committee rosters, meeting minutes and policy resources.

- Disseminated social media messages related to quality and patient safety, the 2016
Minnesota Hospital Association’s 2016 mid-year accomplishments

• Provided members’ communicators with press materials and briefings on the annual MDH adverse health events report.

• Provided members’ communicators with press materials and messaging on the annual community benefit report.

• Provided members with key messages on media inquiries and issues in the news on a timely basis.

• Distributed MHA’s legislative report and election toolkit to members along with resources posted on the MHA Member Center.

Strengthening Healthy Communities Campaign

• Launch and maintain a mental health mini-campaign that positions MHA as a leader and collaborator in addressing this complex challenge.
  - With collaboration with MHA’s Mental and Behavioral Health Committee and the Policy and Advocacy Committee, the Strengthening Healthy Communities Campaign Steering Committee developed a value statement with five unique principles for a mental health awareness campaign.
  - The campaign launched at the end of February with new written and video content featuring community partnerships and innovative solutions MHA members are using to improve mental health access and care.
  - Subsequently, the mental health mini-campaign has released additional video and written content with accompanying ads, with new content scheduled for production and release this summer and fall.

• Create local media opportunities for members that spreads the campaign stories in traditional media, as well as develop and launch an annual statewide editorial board media tour in partnership with members to highlight issues critical to Minnesota’s hospitals and health systems in local media markets statewide.
  - In partnership with members, MHA conducted a statewide editorial board tour with six daily newspapers, resulting in editorials and earned media coverage in four publications.

• Continue to develop and disseminate hospital stories, especially those that highlight the scope of different members of the care team,
in strategic areas of mental health, improving community health and emergency preparedness in ways that make it easy for members to share them with their own communities.

- The campaign created and published two videos on mental health initiatives by members, as well as six written stories published to the campaign’s microsite.

- Continue efforts to create public and political support for hospitals and health systems, contributing to MHA’s ability to defeat legislative proposals to impose government-mandated Minnesota.

  - MHA shepherded a press conference in partnership with mental health stakeholders announcing the introduction of Excellence in Mental Health Act legislation.
  
  - MHA launched an advocacy website and advertising promotion to support the Excellence in Mental Health Act legislation passage near the end of the session.
  
  - MHA developed a cost of care infographic video and handout explaining the rising cost of health insurance and deployed ad to reposition hospitals during public conversations regarding higher health insurance premiums. The video and handout are available on the MHA website and handout was used extensively with legislators.
  
  - MHA was prepared to work against any nurse staffing legislation that might have been given a legislative hearing. Nurse staffing legislation was not introduced in the Senate and the House bill mandating nurse staffing quotas was not given a House hearing in 2016.
  
  - MHA was anticipating that the Minnesota Nurses Association/National Nurses United in 2016 might pursue follow-up legislation to the 2015 workplace violence prevention legislation, calling for mandated reporting to the Minnesota Department of Health of any incidences of violence. MHA members have been actively implementing the 2015 legislation by involving direct care workers in the formation of their workplace violence prevention plans, providing violence prevention training for direct care staff and reviewing incidences of violence. MHA voiced that hospital resources should focus on prevention and not implementation of a burdensome reporting system. MHA is pleased to report that the diligent work of our members on the issue of workplace violence prevention helped thwart the advancement of burdensome reporting.

- Assist members with election campaign-related and candidate visits to their hospitals, engaging employees who identified themselves as willing to be involved in public policy through the PropoNET employee engagement tool.

  - MHA and Tunheim developed and rolled out a campaign for Minnesota Hospital Week. The campaign included a proclamation from Governor Dayton and images of elected officials, local sports figures, member
employees and patients holding signs saying thanks to Minnesota’s hospitals. The images were shared on social media throughout the week. MHA also provided members with a media toolkit to roll out their own #ThanksMNHospitals activities on social media. Seven members participated during the week and Lieutenant Governor Tina Smith mentioned MHA in a Tweet using the campaign hashtag.

- At the spring region meetings, hospital-specific candidate lists were provided for members.
- MHA developed and distributed its 2016 election toolkit, which provides resources to help members participate in their local campaigns.
- MHA's government relations staff is actively meeting with both incumbents and candidates for the upcoming election.
- MHA's government relations staff is continuing outreach to encourage members to host candidate visits this coming fall.

### Increase MHA Value

MHA will define and articulate the Association’s value, services and roles for its members.

- Conduct a dynamic and engaging process resulting in a new, multi-year strategic plan for the Association.
  - MHA engaged MedTrends to interview MHA senior staff, select MHA board members and health care policy leaders in Minnesota to develop divergent scenarios of how Minnesota’s health care system will evolve in the years ahead. These scenarios will be used during the strategic planning process to better identify common strategic priorities, areas of concern or opportunity and different perspectives of the challenges MHA and its members will face in the next three to five years.
  - MHA used The Walker Company to survey board members and MHA’s membership at large to assess MHA’s effectiveness, members’ most significant concerns and priorities and the areas for focus in the upcoming strategic plan.
  - MHA invited leaders from the Minnesota Medical Association to participate in a portion of the strategic planning retreat discussions for the first time.

- Engage each of the following key stakeholder groups in a joint or collaborative initiative: Leading Age, Minnesota; Minnesota Medical Association; Minnesota Council of Health Plans; Minnesota Department of Health; National Alliance on Mental Illness (NAMI) – Minnesota.
  - MHA staff and the MHA Registry Advisory Committee worked closely with MDH in late 2015 and 2016 to significantly improve the adverse health event reporting process, effective July 1.
  - MHA staff continue to collaborate with MDH and DHS on various statewide initiatives such as the State Innovation Model implementation, Health Care Home Program, antibiotic stewardship and the Collaborative Healthcare-Associated Infection Network (CHAIN).
  - MHA and LeadingAge Minnesota convened a Post-Acute Care Work Group to better understand and define metrics that members of each association could use for purposes of increasing the value of care provided to residents.
  - MHA invited the Minnesota Medical Association to participate in a portion of the strategic planning retreat discussions which will result in a new, multi-year strategic plan for the association.
  - MHA drafted a proposal for MHA and the Minnesota Council of Health Plans to collaborate to develop a single attestation process for hospitals and Qualified Health Plans (QHP) to use to ensure that hospitals in a QHP’s network complied with federal law requiring participation in patient safety improvement activities.
  - MHA is partnering with MDH to convene a multi-stakeholder coalition aiming to improve the safety of Minnesotans in law enforcement custody needing hospital-level care. The initial coalition meeting
of MHA members, MDH, law enforcement, counties, EMS agencies and other key stakeholders is scheduled for Aug. 2016. The goal is to co-create a set of best practices or protocols to improve communication between health care entities and law enforcement agencies, ensure consistent implementation of state and federal regulations, and improve patient and staff safety when patients are in law enforcement custody.

- MHA worked with NAMI Minnesota to develop a grant program to subsidize mental health first aid training through MHA members. NAMI Minnesota is producing similar training sessions through a grant with DHS, so this initiative enables our organizations to extend the available training even further. So far, one training session has been completed with MHA’s grant funds, and more are being planned.

- Survey MHA members with respect to the value they find in the association, their assessment of the association’s performance, and their suggestions for how the association can become even more effective in enhancing our members’ ability to achieve their missions.
  - A needs assessment was developed and distributed to members with a return rate of 67 percent. The assessment will be used at the MHA board retreat in August to develop the association’s future strategic vision and work plan.