HEALTH POLICY CORPORATION OF IOWA

Chartbook of the Quality and Financial Performance of the Health Industry in the Greater Iowa Area.

2013

HPCI CHARTBOOK

www.hpci.org

HEALTH POLICY CORPORATION OF IOWA

We invite your comments and suggestions regarding this 2013 Health Care Industry Quality and Financial Performance report for Iowa and the Greater Iowa Market Area.

Email: health@hpci.org **Phone: 515-252-2530**

To learn more about HPCI log on to our website www.hpci.org. To obtain a copy or copies of this report please call the office at 515-252-2530 or email us at health@hpci.org.

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Message to Iowans

We are pleased to issue this chartbook. It presents information on the quality and financial performance of the health industry in Iowa and the surrounding market area. We hope you will find it to be an informative and useful resource.

The purpose of this chartbook is to provide a valuable fact-based resource for all Iowans. Our goal is to help promote the continued improvement in the quality and cost (affordability) of health care for Iowans by providing knowledge and understanding of results and to encourage additional transparency through public reporting.

This chartbook is a compilation of key results from many of the important studies that have been done. Our aim in preparing this publication is to give an overview of the health industry performance using accurate, meaningful, and relevant information from the most reliable and recent data sources possible. We wanted to keep it brief and reader friendly. References and sources are included so the supporting information and additional information can be readily found.

This is the first of what is planned to be many such resources released by the Health Policy Corporation of Iowa (HPCI). It establishes a baseline so that change and progress can be measured and reported on over time. Also, specific issues and priorities can be identified for improvement by all interest groups and organizations. HPCI intends to follow-up with action steps as well.

A very important closing thought. In order to make improvement, Iowa should make increased transparency and public reporting of the quality and cost of health care a high priority. We all need better and more complete information. Transparency and public reporting is vital to achieve our shared goal of improving the quality, value and affordability of health care. With transparency comes clarity and accountability.

HPCI Chartbook Steering Committee

CDS Global
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HEALTH POLICY CORPORATION OF IOWA

Executive Summary

The purpose of this HPCI Chartbook is to provide a valuable fact-based resource for all Iowans. It is compilation of key results from many important studies.

Chartbook Highlights:

- Overall the quality of care in Iowa is high when compared to all states. However, there is wide variation and many opportunities for improvement by type of care, setting of care, and care by clinical area (pages 24 and 25).
- Hospital quality of care for Iowa privately insured is in the average range compared to the U.S. overall (page 26).
- Ten (10) hospitals in the greater Iowa market received an "A" grade on their Hospital Safety Scores (page 28).
- The percentage of patients who would "definitely recommend" the Iowa hospital they used ranged from 59% to 87%. Top rated hospitals included: Saint Mary's of Rochester, MN; Olmsted Medical Center, Rochester, MN; Mercy – Iowa City; Mayo Clinic Methodist, Rochester, MN; Pella Regional Health Center – Pella; Gunderson Lutheran – La Crosse, WI and Mercy Medical Center – Cedar Rapids (page 30).
- There is very little quality or cost performance information currently available for physicians or group practices. Iowa clinicians are now being recognized by the Nation Committee for Quality Assurance (pages 22 and 23).
- Health insurance premiums in Iowa are about the same as the U.S. overall average when the difference in the cost of living is considered (page 9).
- While average Iowa health insurance rate increases vary by year, the increase each year is multiple times that of average wage increase (page 10).
- Employee contribution to medical insurance continues to increase as does the employer contribution and total premium (page 11).
- Employers offering health insurance in Iowa was 81.2% in 2012. This is a drop from 96.0% in 2000 (page 12).
- There are three major payers in Iowa: Medicare, Wellmark of Iowa and Medicaid. Government payers (Medicare and Medicaid) account for over 60% of Iowa hospital inpatient charges (page 13).
- Customers of health plans are seeking more information on how much they would have to pay for health care services and equipment (page 19).
- Health information technology can make an important contribution to improve quality and value (pages 34 and 35).
- Transparency of health provider performance can drive improvement in quality, patient safety and overall health care value (page 5 and 33).
- The Institute of Medicine recommended performance transparency in its recently released landmark report Best Care at Lower Cost - The Path to Continuously Learning Health Care in America (page 33).

Chartbook Insights and Common Themes for Improvement:

1) There are many positive aspects of the health industry in greater Iowa and tremendous opportunity for improvement.
2) Health care costs continue to rise at an unsustainable rate. Cost in Iowa is about the same as the U.S. average.
3) The quality of care varies by type of care, setting of care, and care by clinical area. There is also wide variation in hospital quality of care and patient safety.
4) There is very little public information available describing the quality, cost or financial performance of individual physicians or group practices.
5) More and better price and cost information is needed. Consumers and patients are seeking more information on how much they would need to pay for health care services and equipment.
6) Increased performance transparency and public reporting on the cost and quality of care and service is essential. With transparency comes clarity and accountability.
7) Health information technology has the potential to dramatically improve health care as well as increase information and knowledge.

Table of Contents

HEALTH POLICY CORPORATION OF IOWA

About this report and HPCI

About HPCI

The Health Policy Corporation of Iowa (HPCI) is Iowa's business group on health. It develops joint initiatives, conducts research and education, and applies solutions to improve the quality and affordability of health care in Iowa. HPCI has identified two goals as follows:

Goal 1: Employers (purchasers) receive the greatest value for dollars invested in health care in local markets and providers receive economic and other incentives to improve performance.

Goal 2: Contribute to improvements in the health of the community.

Individual employers and other purchasers use many strategies for addressing health care costs and quality on their own. HPCI adds value by helping focus attention and mobilize actions that are best done on a collective or coalition basis involving numerous employers, other purchasers and consumers across Iowa markets.

About this Report

The purpose of this HPCI Chartbook is to provide a valuable fact-based resource for all Iowans. It contains information from a variety of reliable sources. These include:

- Health Insights (QIO)
- Iowa Insurance Division
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare and Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)
- David P. Lind Benchmark
- Security and Exchange Commission (SEC)
- Commonwealth Fund
- Kaiser Family Foundation
- Iowa Department of Public Health
- Iowa Hospital Association
- The Leapfrog Group
- Institute of Medicine (IOM)
- The Dartmouth Atlas of Health Care

Report available

This report is available through the HPCI office.

Data Limitations and Cautions

HPCI has made every effort to provide accurate information. As with any analysis of health care industry data, a note of caution is recommended. HPCI depends upon the accuracy of the data sources. Please read and become familiar with the sources and technical discussions while reviewing the data contained in this report.

Acknowledgments

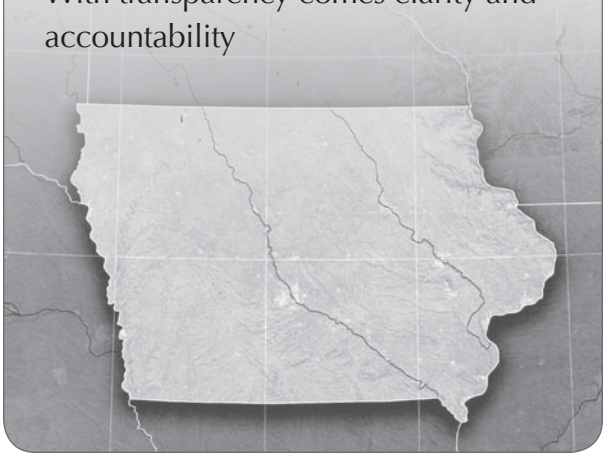
HPCI would like to thank the many organizations and individuals that contributed to the development and content of this report. HPCI especially thanks those Iowa companies that provided funding to make this publication possible.

Importance of Transparency and Public Reporting

Greater transparency of provider performance is necessary to improve the quality, safety, and cost of health care and give consumers much needed information to make decisions. In addition, reports on provider performance give health plans and others information to guide contracting, tiering, benefit design, and pay–for–performance programs.

Other industries provide comparative information on performance to enable consumer decision-making and stimulate market improvements. Health care should be no different. In fact, in health care, there is an even greater imperative to make useful information available because patients' lives and well–being are at stake.

With transparency comes clarity and accountability



"What will it take to improve patient safety? Of the three major approaches – regulation/ accreditation, financial incentives, and public reporting – the most promising is public reporting and feedback to providers. Transparency is an idea whose time has come."

Lucian Leape, M.D., Harvard, 2010

"An essential component of meaningful performance information is the need for clinical standards of care and a commitment to improved clinical outcomes. Without standard work, there can be no measurement. Without measured outcomes, we cannot hope for improvement."

Dale Andringa M.D., Vermeer Corporation, 2012

HEALTH POLICY CORPORATION OF IOWA

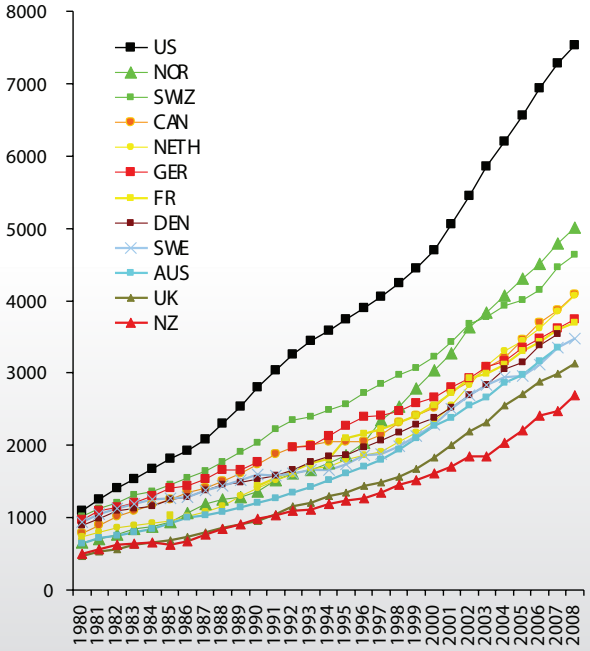
International Comparison of Spending on Health, 1980-2008

Health care spending growth in the U.S. since 1980 has dwarfed that of twelve industrialized countries, both per capita and as a percentage of GDP.

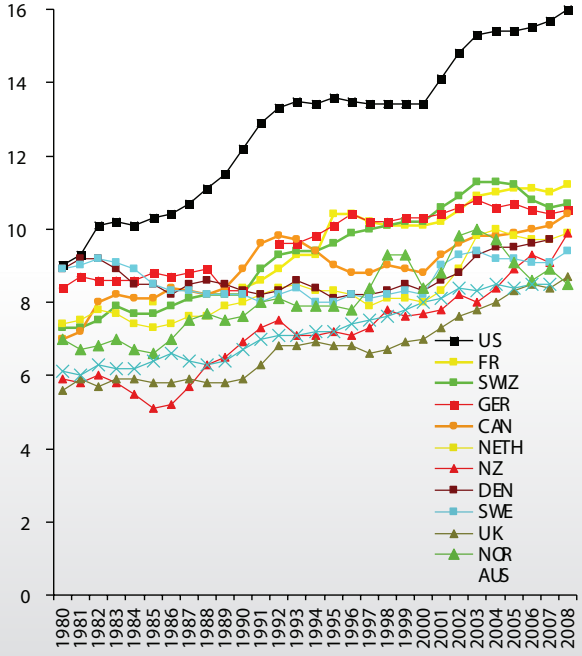
Why international comparisons are important:

- Iowa and other U.S. companies compete in the global market and health care costs are a large and growing expense. Wellness and productivity are also important.
- There are opportunities for cross-national learning to improve health system improvement.

Average spending on health per capita ($US PPP)



Total expenditures on health as percent of GDP



Note: PPP = purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.
Source: OECD Health Data 2010 (Oct. 2010).

Source: The Commonwealth Fund, 2011

How U.S. Compares Internationally

The chart below shows how the performance of the U.S. health care system compares internationally. Among the seven industrialized nations studied by the Commonwealth Fund, the U.S. ranks last overall, as it did in 2007, 2006, and 2004.

Health care in America has experienced an explosion in knowledge, innovation, and capacity to manage previously fatal conditions. Yet, paradoxically, it falls short on such fundamentals as quality, outcomes, cost, and equity. Institute of Medicine, September, 2012.

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

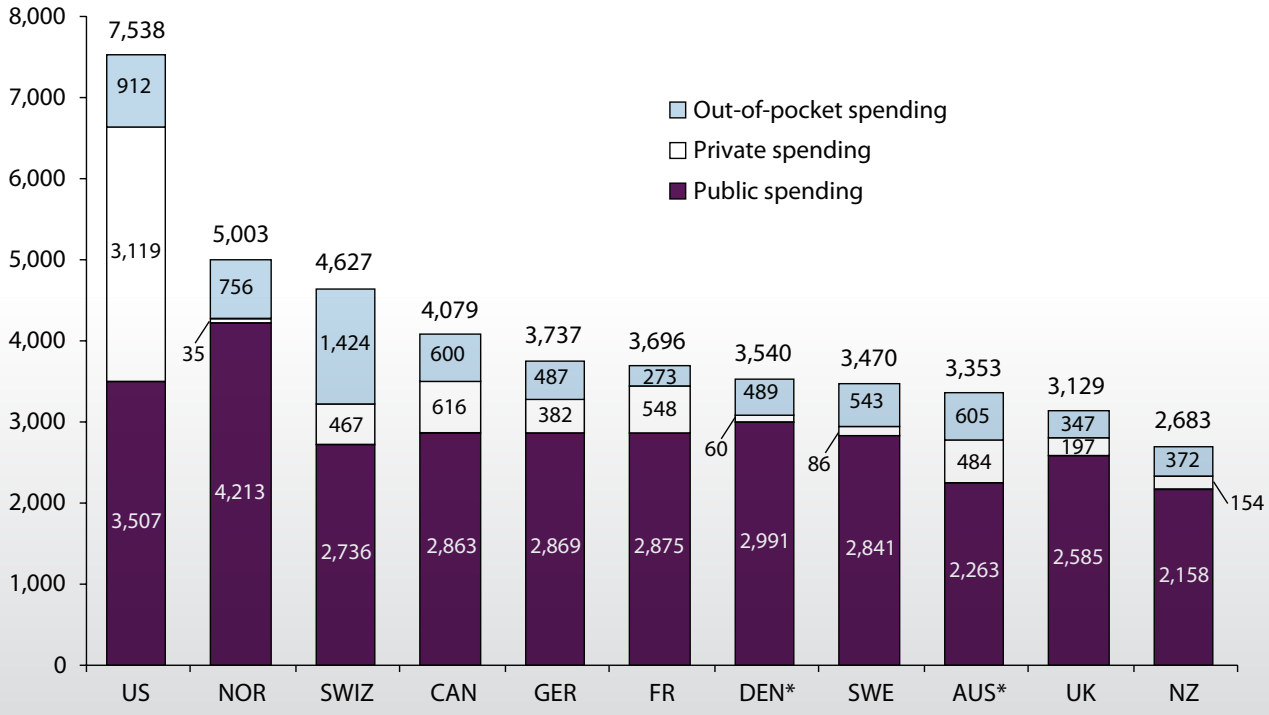
	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Source: The Commonwealth Fund, 2010 Update

Healthcare Expenditures per Capita by Source of Funding 2008 — Adjusted for Differences in Cost of Living

The U.S. stood out with far greater private health care spending excluding out-of-pocket payments ($3,119) than ten industrialized countries, which rely on government-payer or social insurance models rather than private insurance.



*2007.
Source: OECD Health Data 2010 (Oct. 2010) .

Source: The Commonwealth Fund, 2011

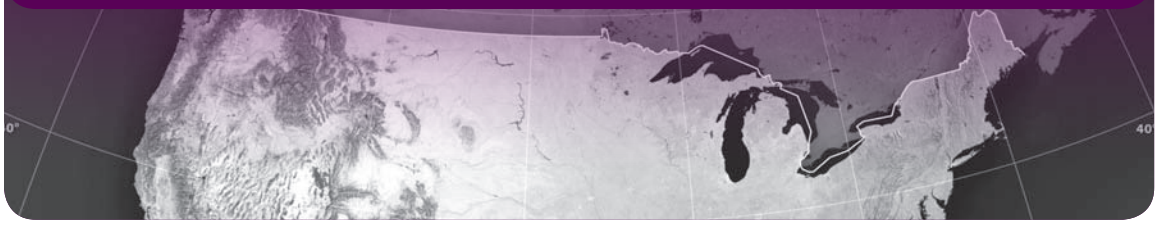
Health Insurance Premiums: Iowa Compared to U.S.

Health insurance premiums in Iowa are about the same as the national average (50 state comparison) when the difference in the cost of living is considered. See chart below and note on Consumer Price Index.

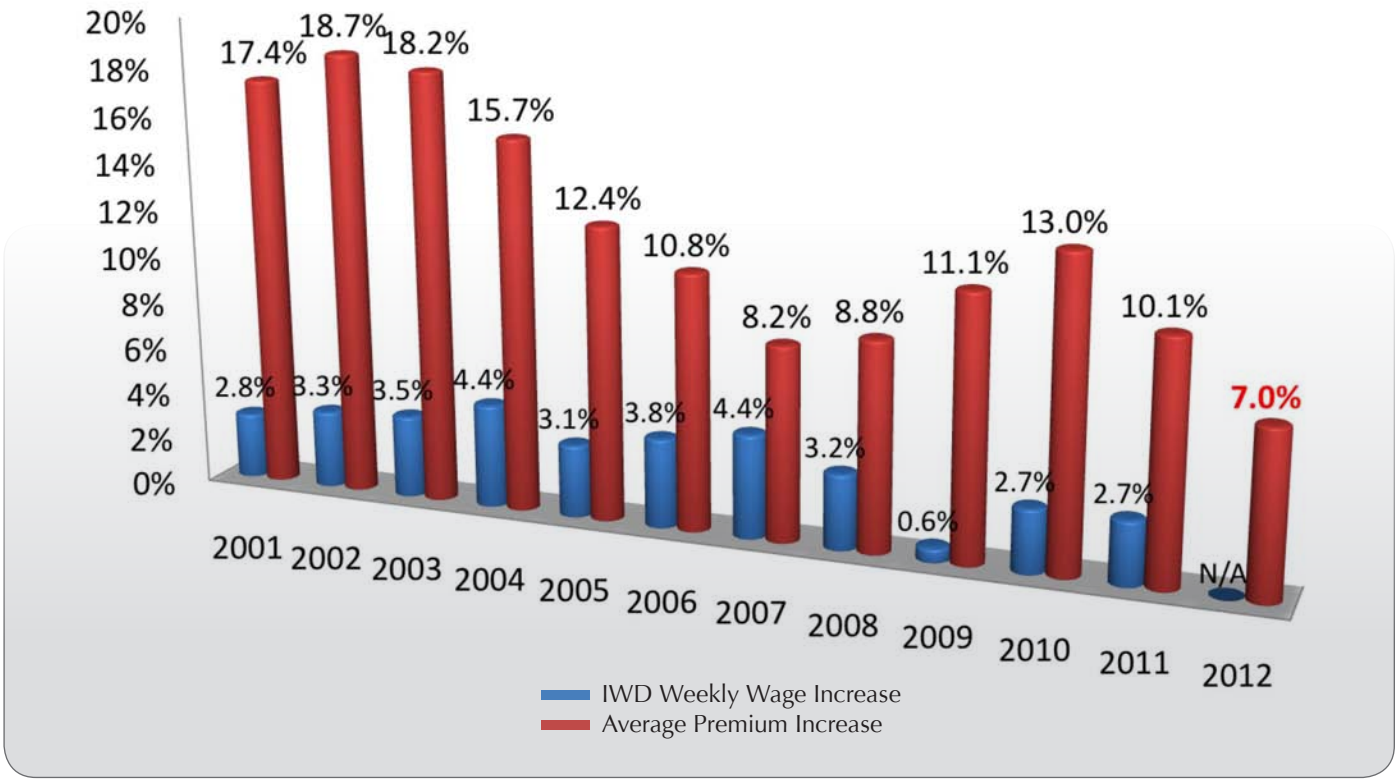
Type of Plan	Iowa	U.S.
Average Single Premium per Enrolled Employee For Employer-Based Health Insurance, 2011	$4,742	$5,222
Average Employee-Plus One Premium per Enrolled Employee For Employer-Based Health Insurance. 2011	$9,630	$10,329
Average Family Premium per Enrolled Employee for Employer-Based Health Insurance, 2011	$13,030	$15,022

Source: Kaiser Family Foundation, State Health Facts, 2012

At the same time, the cost of living in Iowa was 9.8% lower than the U.S. average as measured by the Consumer Price Index (CPI).

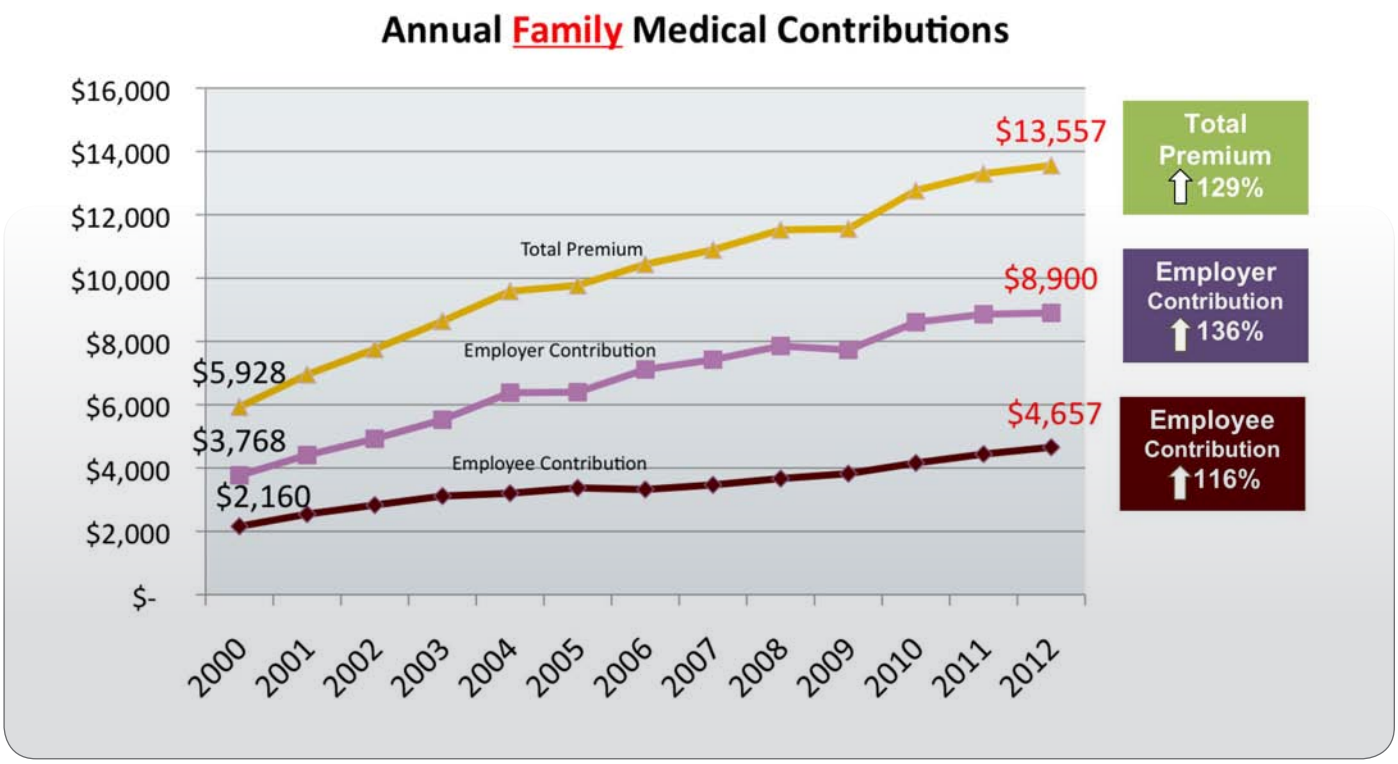


Average Iowa Health Insurance Rate Increases Compared to Iowa Average Weekly Wage Increases — 2001 to 2012



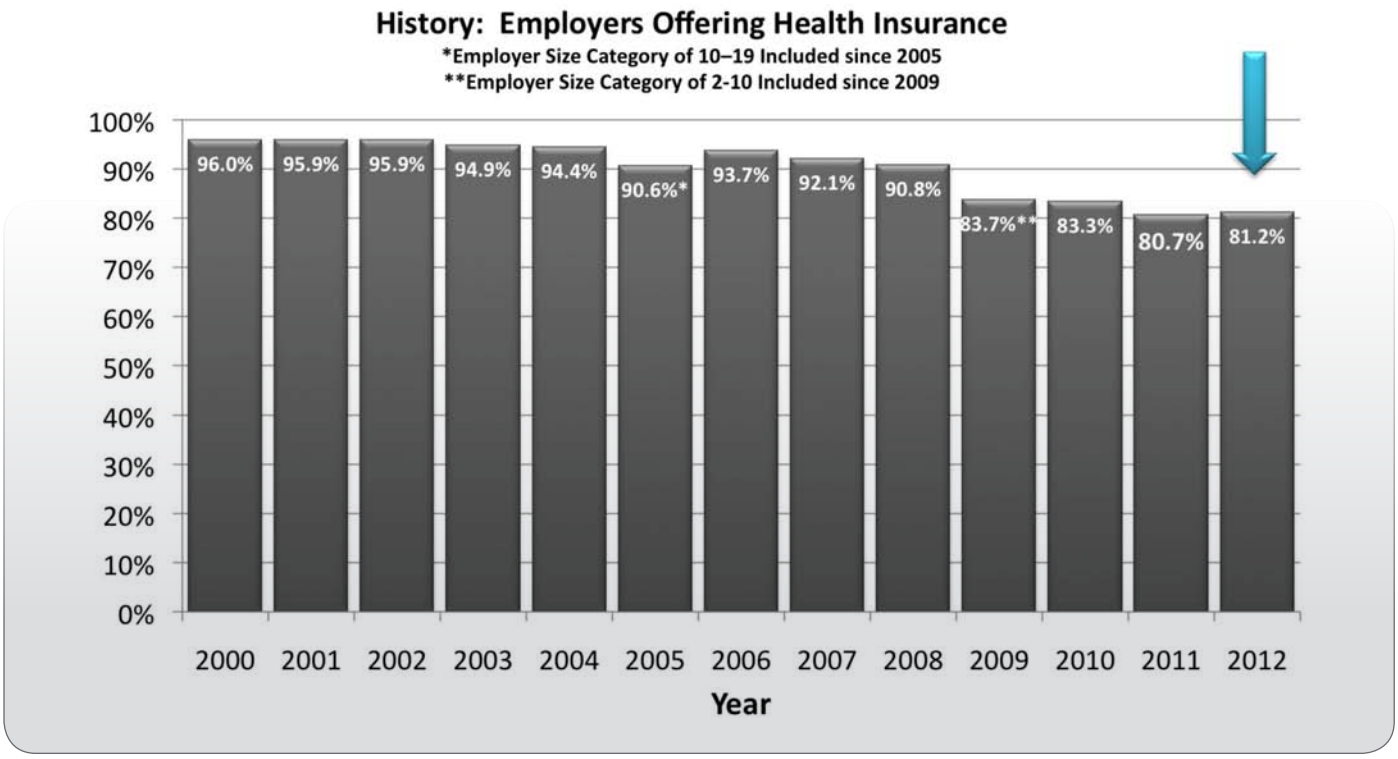
Source: David P. Lind Benchmark

Average Annual Iowa Family Medical Insurance Contributions for all Medical Plans Combined (HMO, PPO, Traditional Indemnity, HSAs)



Source: David P. Lind Benchmark

Employers Offering Health Insurance in Iowa

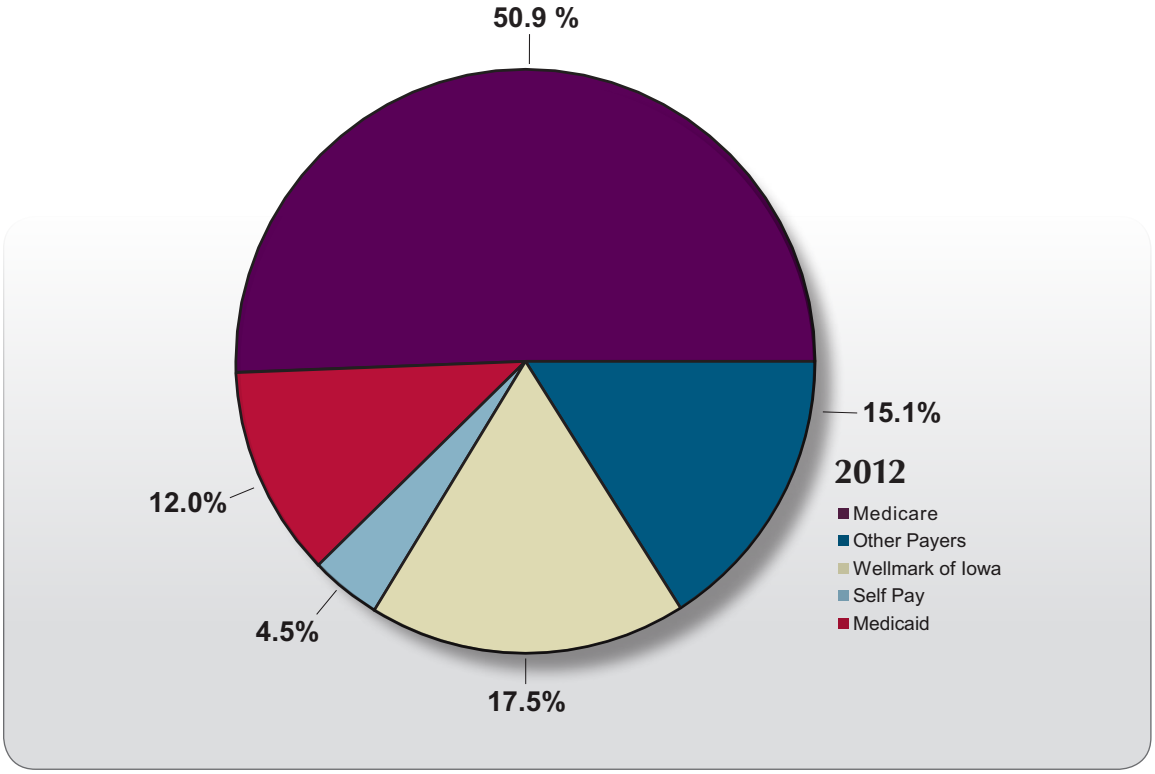


Source: David P. Lind Benchmark

Market Share by Payer
Iowa Hospital Inpatient Charges by Payer

There are three (3) major payers in Iowa: Medicare, Wellmark of Iowa and Medicaid.

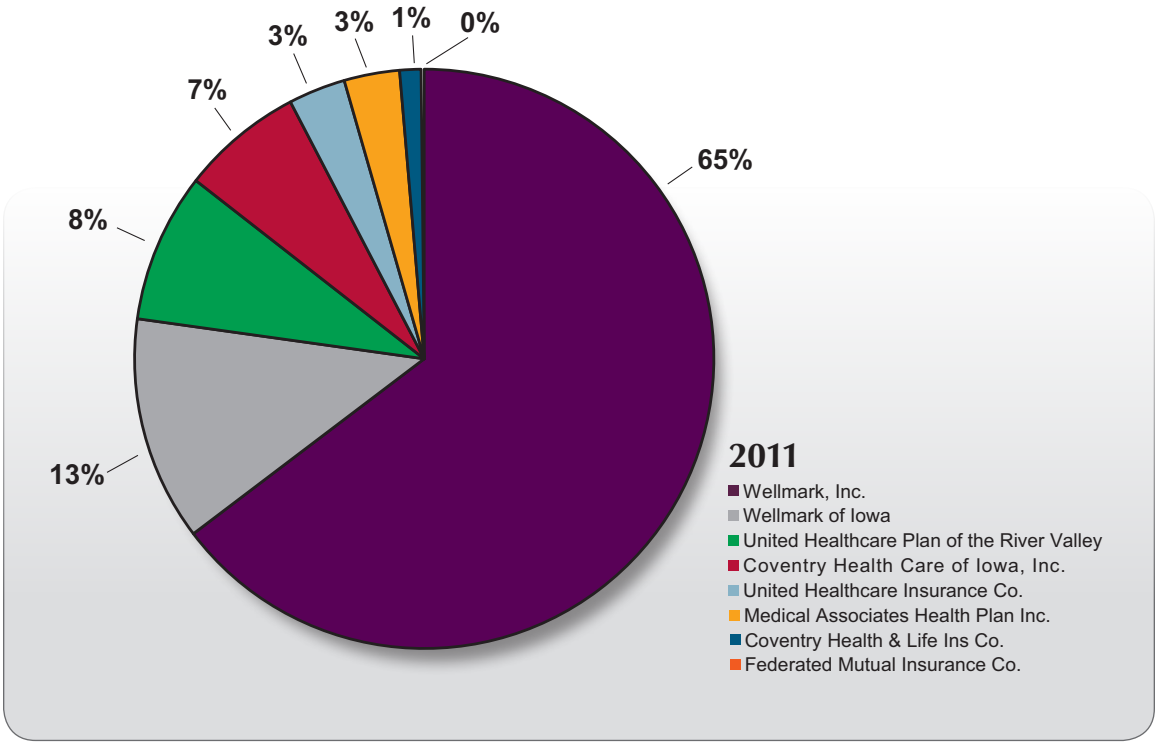
Medicare recipients account for 50.9 percent of total inpatient charges in Iowa hospitals. Wellmark of Iowa subscribers account for 17.5 percent. Medicaid recipients account for 12.0 percent. Utilization by patients with all other insurance coverage and the uninsured account for the forth and fifth highest percentage of inpatient charges, respectively.



Source: Iowa Hospital Association

Market Share by Company
Large Group Member Months by Percent

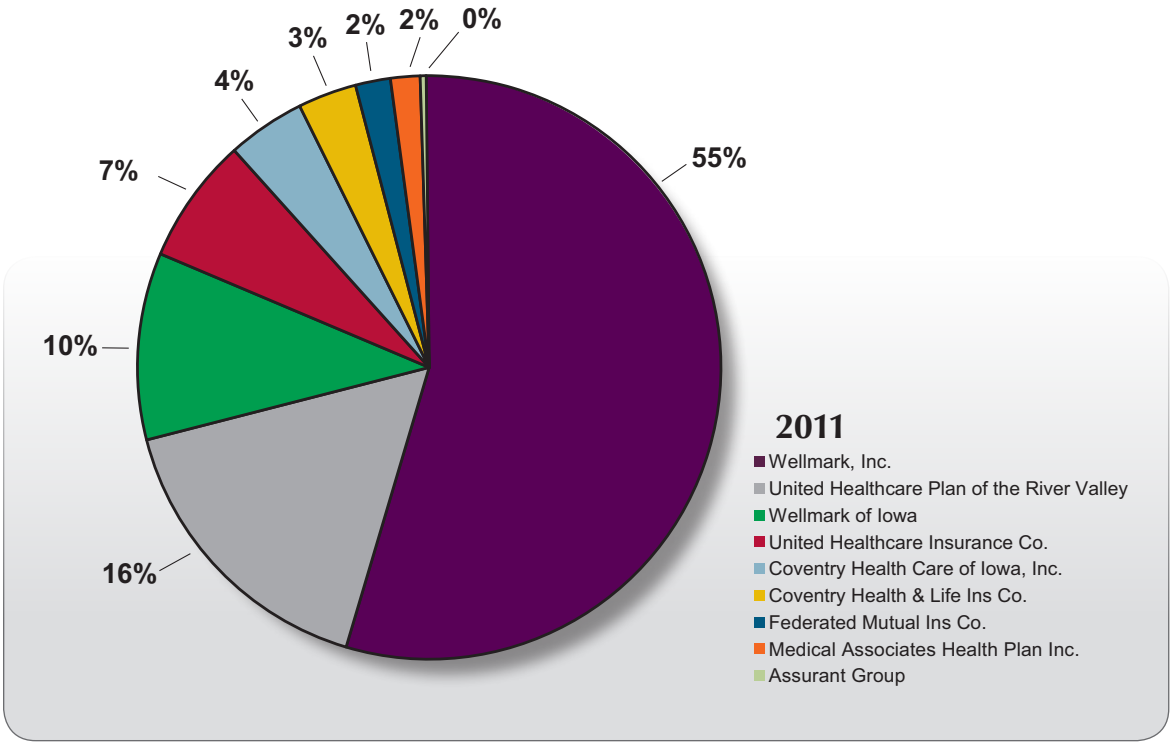
Wellmark holds the major share of the market of health insurance companies serving large groups (employers with 51 plus employees) in Iowa with 78% market share (Wellmark, Inc. at 65% plus Wellmark of Iowa at 13%).



Source: Iowa Insurance Division, 2012
Note: This information does not include health plans sponsored by ERISA self insured employers. Nationally, about an equal number of people are covered by self insured plans as those covered by purchased insurance according to information from the Census Bureau and the Department of Labor.

Market Share by Company
Small Group Member Months by Percent

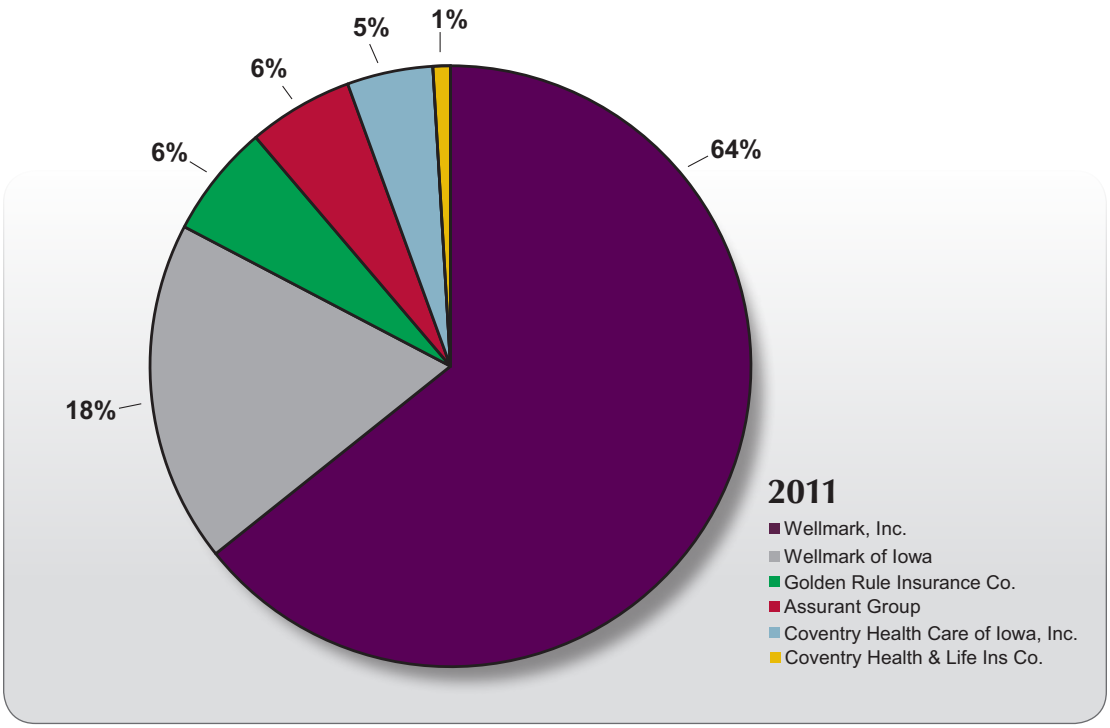
Wellmark holds the major share of the market of health insurance companies serving small groups (employers with 2 to 50 employees) in Iowa with 65% market share (Wellmark, Inc. at 55% plus Wellmark of Iowa at 10%).



Source: Iowa Insurance Division, 2012

Market Share by Company
Individual Member Months by Percent

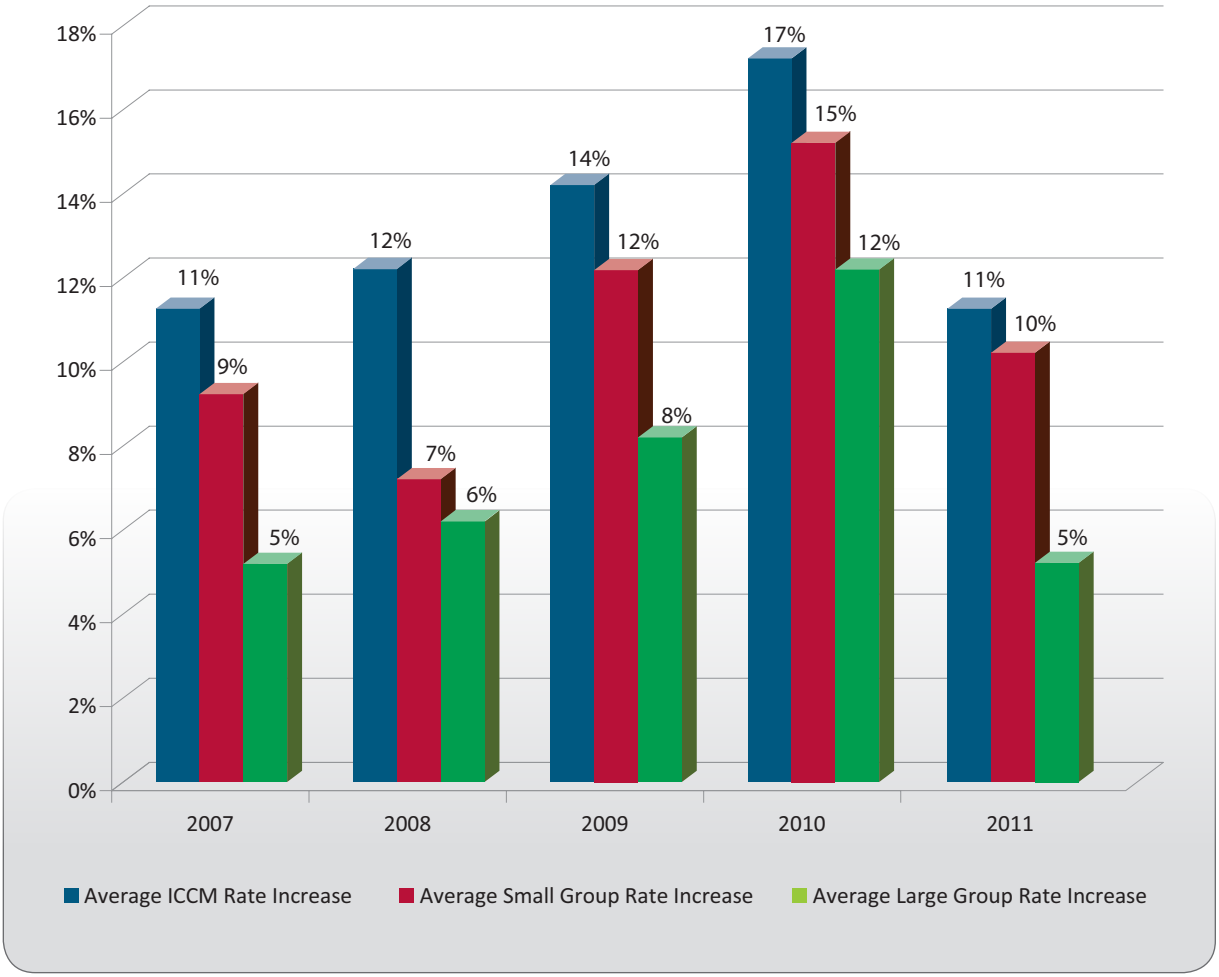
Wellmark holds the majority share of the market of insurance companies serving individuals in Iowa with 82% (Wellmark, Inc. at 64% plus Wellmark of Iowa at 18%).



Source: Iowa Insurance Division, 2012

Iowa State Rate Increases 2007 - 2011

The chart below shows the average rate increases for individuals (Individual Comprehensive Major Medical or ICMM), small groups (employers with 2 to 50 employees), and large groups (employers with 51 plus employees) in Iowa.



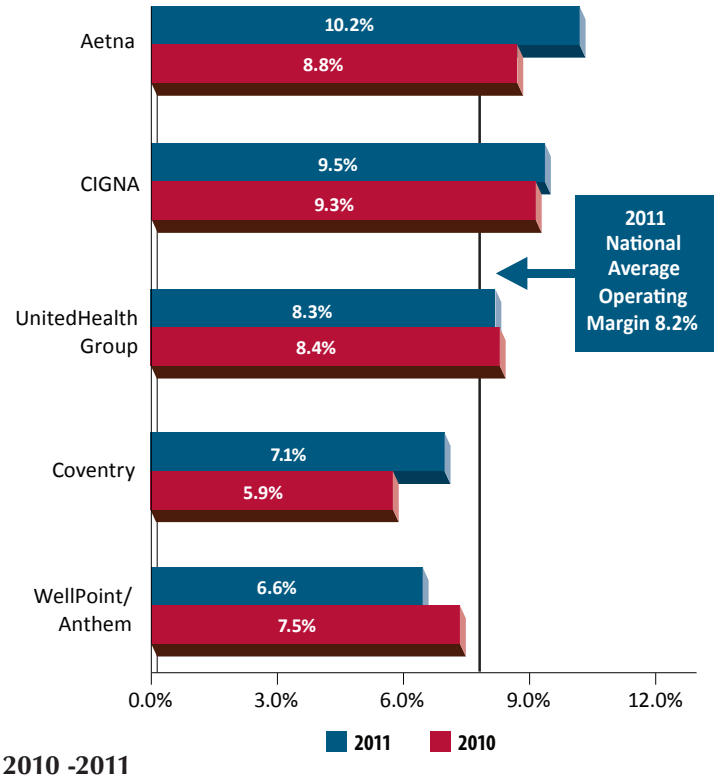
Source: Iowa Insurance Division, 2012
Note: This information does not include health plans sponsored by ERISA self insured employers. Nationally, about an equal number of people are covered by self insured plans as those covered by purchased insurance according to information from the Census Bureau and the Department of Labor.

Health Plan Financial Performance

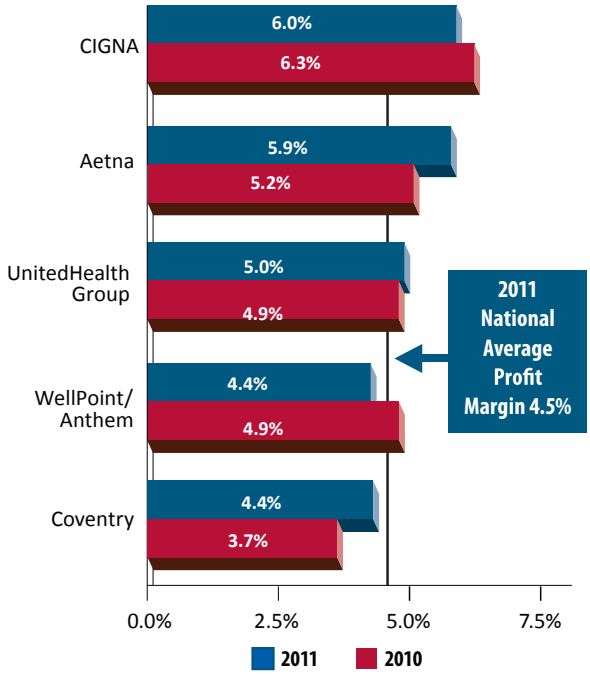
Two financial performance measurements are shown below: Operating margins and profit margins.

Operating margins measure the percentage of profit earned, or lost, from the management of a firm's core business. It is a measure of what proportion of a company's revenue that is left over after paying for variable costs of production such as wages, raw materials, etc. Non-operating revenue such as a firm's investment income is excluded.

National Health Plan Operating Margins, 2010 - 2011



National Health Plan Profit Margins, 2010 -2011



Profit margin is a ratio of profitability calculated as net income divided by revenues, or net profits divided by sales. It includes non-operating revenue from investments as well as interest and tax expense. The percent is usually lower than an operating margin.

Source: Health plan 10-K statements provided to the SEC

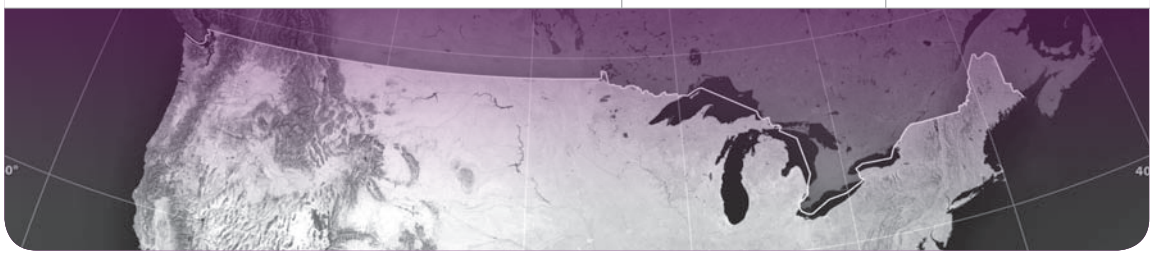
Health Plan Customer Service

The Consumer Assessment of Health Plans (CAHPS) is a nationally standardized survey from the National Committee for Quality Assurance (NCQA).

When asked, "How often did your health plan's customer service give you the help you needed?" only 10% of health plan members nationally responded with a score of 84.5% or above in 2010. Health plans in this region ranged from 63% to 80%.

Nationally, only 10% of health plans scored 73% or above during 2010 for providing members information on the cost of health care. Health plans in this region ranged from 58% to 68%.

	Range for Health Plans in Region	National 90th Percentile
How often did your health plan's customer service give you the help you needed?	63% to 80%	84.5%
How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?	58% to 68%	73%



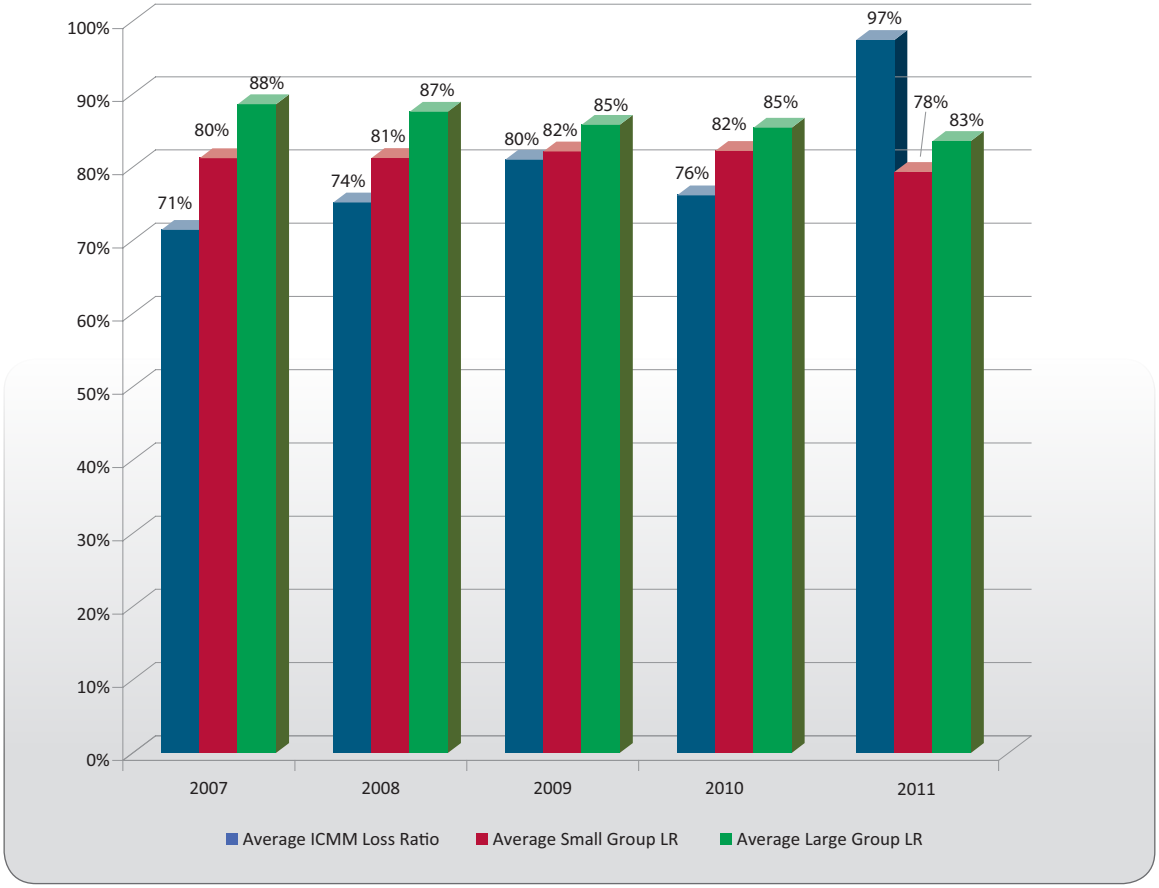
Source: National Committee for Quality Assurance (NCQA) Note: Information on Iowa health plans is currently not available.

State of Iowa Medical Loss Ratios 2007 - 2011

The chart below shows the average medical loss ratios (MLR) by size of group: individual (ICMM), small group, and large group. The MLR is the ratio of total medical claims paid out divided by the total premiums.

80%/85%

The Affordable Care Act (ACA) requires most insurance companies that cover individuals and small businesses to spend at least 80% of their premium dollars on health care (i.e. medical claims) and quality improvement, leaving no more than 20% for administration, marketing, and profit. Large group plans must spend at least 85% of their premium dollars on health care. Insurers failing to meet these standards will have to pay rebates to consumers beginning in late 2012.



Source: Iowa Insurance Division, 2012

Note: This information does not include health plans sponsored by ERISA self insured employers. Nationally, about an equal number of people are covered by self insured plans as those covered by purchased insurance according to information from the Census Bureau and the Department of Labor.

Commissions and Administrative Costs

Health insurance premiums include cost factors in addition to claims for health care services. These include agent commissions, health plan administrative costs as well as premium taxes.

The information below shows the ranges for commissions and health plan administrative costs by group. This information summarizes data taken from reports of the Iowa Insurance Division except for ERISA self insured employer information is from HPCI.

Individuals

Commissions as a percent of premium ---------- 8 to 11% +
Administrative costs as a percent of premium------- 12 to 17% +

Small Groups (2 to 50 employees)

Commissions as a percent of premium---------- about 5 to 6% +
Administrative costs as a percent of premium------- about 11%

Large Groups (51 plus employees)

Commissions as a percent of premium---------- about 4%
Administrative costs as a percent of premium-------- about 7%

ERISA Self Insured Employers*

Commissions---------- Zero – fee based**
Administrative costs---------- Cost based***

*Based upon HPCI experience working with large self insured Iowa employers
**May use a consultant and if so, pay a direct fee for service basis
***Actual cost may be based upon # of employees or whatever is negotiated

Note: National health reform includes the establishment of Health Insurance Exchanges by 2014. These exchanges are aimed at making health insurance more affordable for individuals and small employers.

Source: Iowa Insurance Division and HPCI

Physicians and Group Practices

There is currently very little public information available describing the quality or financial performance of individual physicians or group practices.

At this time the **CMS Physician Compare** website is simply a listing of physicians and other health care professionals by specialty with their name – along with their address and contact information – and whether or not they are likely to take Medicare assignment. Accepting Medicare assignment means a physician agrees to the approved amount as payment in full and cannot require the patient pay the difference.

In response to a national need for objective ways to demonstrate the quality of care rendered by clinicians, the **National Committee for Quality Assurance (NCQA)** offers and reports on a series of programs. The programs were developed in collaboration with panels of national experts and are based on evidence-based standards and demonstrated outcomes. There are six clinical recognition programs at this time:

- Patient-Centered Speciality Practice Recognition Program
- Patient Centered Medical Home
- Diabetes Recognition Program
- Heart/Stroke Recognition Program
- Physician Practice Connections
- Back Pain Recognition Program (Retired)

Tens of thousands of U.S. clinicians are now recognized for high clinical quality. Of the more than 6,000 physicians practicing medicine in Iowa, 222 were recognized through one of these programs as of fall, 2012. Of these, there were 116 recognized under Patient Practice Connections - Patient Centered Medical Homes, Level 3 and Patient Centered Medical Homes. Their names are listed on the following page.

Source: National Committee for Quality Assurance (NCQA)

Iowa List: Clinician Recognition Program
National Committee for Quality Assurance (NCQA)

Patient Practice Connections – Patient Centered Medical Home, Level 3

Jonathan Abele, MD, Medical Associates
Matthew Baughman, MD, McFarland Clinic
Joseph Berger, MD, Medical Associates
Michael Bird, MD, McFarland Clinic
William Bitsas, MD, Pella Regional Health Center
Mitchell Blom, DO, Pella Regional Health Center
Bethann Bonner, MD, Medical Associates
James Brock, MD, Medical Associates
Robert Bruxvoort, MD, Pella Regional Health Center
Spencer Carlstone, MD, Pella Regional Health Center
David Carlyle, MD, McFarland Clinic
Ronald Childerston, DO, Pella Regional Health Center
Debbie Cihak, MD, Medical Associates
Danielle Clark, DO, Pella Regional Health Center
Marsha Collins, PA, Pella Regional Health Center
Diana Daoud, MD, Medical Associates
Diane Dejong, PA, Pella Regional Health Center
Gary Erbes, MD, McFarland Clinic
David Fredrickson, MD, Pella Regional Health Center
Jared Freiburger, DO, Medical Associates
Ryan Grandgenett, MD, McFarland Clinic
Julie Hanson, MD, Medical Associates
Anne Hellbusch, MD, Pella Regional Health Center
James Hubbard, MD, Medical Associates
Mark Janes, MD, Medical Associates
Bradley Jordison, DO, McFarland Clinic
Stewart Kanis, DO, Pella Regional Health Center
Julie Lautenbach, PA, Pella Regional Health Center
Kevin Mace, DO, Pella Regional Health Center
McFarland Clinic, PC – Family Practice East
McFarland Clinic, PC – Family Practice North
Medical Associates Clinic – East Campus
Medical Associates Clinic, PC, Internal Medicine – West Campus
Trupti Mehta, MD, Medical Associates
Mark Moore, MD, Medical Associates
Kevin Mullen, MD, Medical Associates
Chadwick Nachtman, MD, Medical Associates
Laura Neal, MD, Medical Associates
Erika O'Donnell, MD, Medical Associates
Douglas Olk, MD, Medical Associates
Pella Regional Health Center – Bussey
Pella Regional Health Center – Knoxville
Pella Regional Health Center – Monroe
Pella Regional Health Center – Pella
Pella Regional Health Center - Sully
Richard Posthuma, MD, Pella Regional Health Center
Donald Reyerson, MD, Medical Associates
Andrea Ries, MD, Medical Associates
Rhonda Rippey, NP, McFarland Clinic
Mark Runde, MD, Medical Associates
Douglas Schmid, MD, Medical Associates
Thomas Schreiber, MD, Medical Associates
Christine Sinsky, MD, Medical Associates
Thomas Sinsky, MD, Medical Associates
Donald Skinner, MD, McFarland Clinic
Christopher Stille, MD, Medical Associates
Brian Sullivan, MD, Medical Associates
Peter Tinsman, MD, Medical Associates
Todd Treimer, DO, Pella Regional Health Center
Amanda Van Wyk, PA, Pella Regional Health Center
Galyn Vande zande, DO, Pella Regional Health Center
Dale Vander broek, DO, Pella Regional Health Center
Nancy Vander broek, DO, Pella Regional Health Center
Robin Vandevoort, MD, Pella Regional Health Center
Tereasa Vanzee, DO, Pella Regional Health Center
Jennifer Wadle, PA, Pella Regional Health Center
Craig Wittenberg, MD, Pella Regional Health Center
Jessica Zellweger, PA, McFarland Clinic

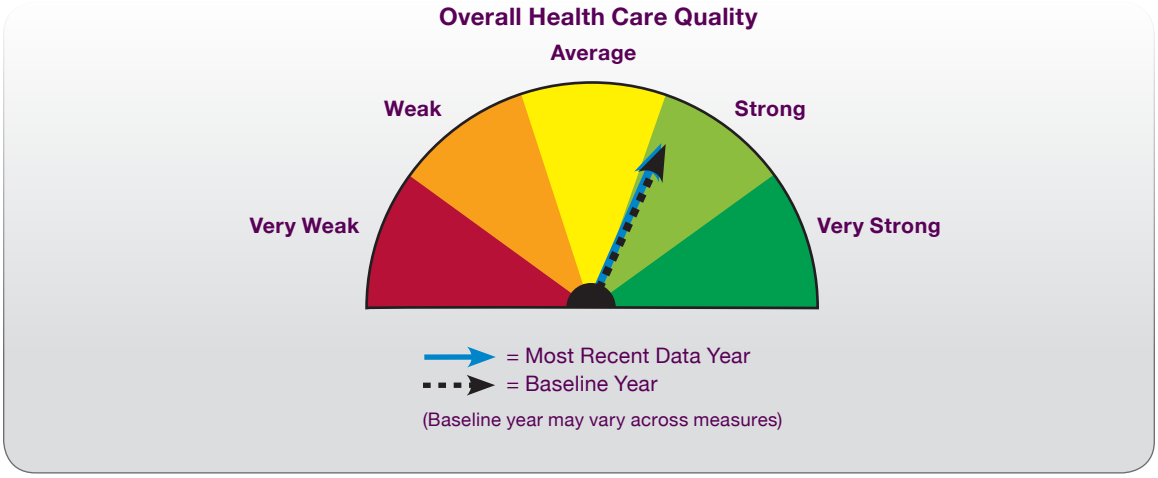
Patient Centered Medical Home

Mabra Abernathy, MD, UI Health Care – Primary Care North
Angelia Atzen, DO, Broadlawns Medical Center
Hussain Banu, MD, UI Health Care - Primary Care North
Broadlawns Medical Center
Elizabeth Chilton, NP, Siouxland Community Health Center
Dana Danley, MD, Broadlawns Medical Center
Cynthia Doyle, ANP, UI Health Care – Primary Care North
Molly Earleywine, PA, Siouxland Community Health Center
David Faldmo, PA, Siouxland Community Health Center
Diane Fitch, PA, Siouxland Community Health Center
Nicholas Galioto, MD, Broadlawns Medical Center
Steven Gordon, MD, Siouxland Community Health Center
Randy Guerdet, PA, Siouxland Community Health Center
Cynthia Guthmiller, NP, Siouxland Community Health Center
Gary Hattan, MD, Siouxland Community Health Center
Julia Heaton, MD, Siouxland Community Health Center
Hamza Ismail, MD, UI Health Care – Primary Care North
Christopher Jacobs, NP, Siouxland Community Health Center
Theresa Keller, FNP, UI Health Care – Primary Care North
Lori Krause, PA, Siouxland Community Health Center
Rebecca Leidal, MD, UI Health Care – Primary Care North
Christopher Matson, DO, Broadlands Medical Center
Catherine Messinger, ANP, UI Health Care – Primary Care North
Jolyn Morgan, ANP, UI Health Care – Primary Care North
Nealy Neukirch, PA, UI Health Care – Primary Care North
Stephen Pallone, MD, Siouxland Community Health Center
Ann Pick, NP, Siouxland Community Health Center
Nicola Prater, ANP, UI Health Care – Primary Care North
Primary Health Care Corporation
Danielle Prince, MD, Siouxland Community Health Center
Shannon Remington, DO, Broadlawns Medical Center
Salman Saad, MD, Broadlawns Medical Center
Larry Severidt, MD, Broadlands Medical Center
Shalina Shaik, MD, UI Health Care – Primary Care North
Siouxland Community Health Center
Lisa Soldat, MD, Broadland Medical Center
Joshua Stubblefield, DO, Broadlawns Medical Center
Thor Swanson, MD, Siouxland Community Health Center
Jonathan Taylor, DO, Siouxland Community Health Center
Vanaja Thondapu, MD, Broadland Medical Center
Maria Tudor, MD, Siouxland Community Health Center
UI Health Center – Primary Care North
Dennis Walter, MD, Broadlands Medical Center
Kristi Walz, MD, Siouxland Community Health Center
Clifford Wilkinson, PA, Siouxland Community Health Center
Mary Wilson, NP, Siouxland Community Health Center
Douglas Workman, MD, Broadlands Medical Center
Rachel Wurth, ACNP, Siouxland Community Health Center

Dashboard on Health Care Quality —Iowa Compared to All States

The Agency for Healthcare Research and Quality (AHRQ) produces and annually releases a Dashboard on Health Care Quality Compared to All States. **Over 150 measures** are in the National Healthcare Quality Report (NHQR) report at the state level. For the Dashboard released June 2012 Iowa ranked 5th in overall health care quality. Minnesota was first followed by Wisconsin, Maine, Massachusetts and then Iowa.

Iowa Quality Performance Meter: All Measures



Source: Agency for Healthcare Research and Quality

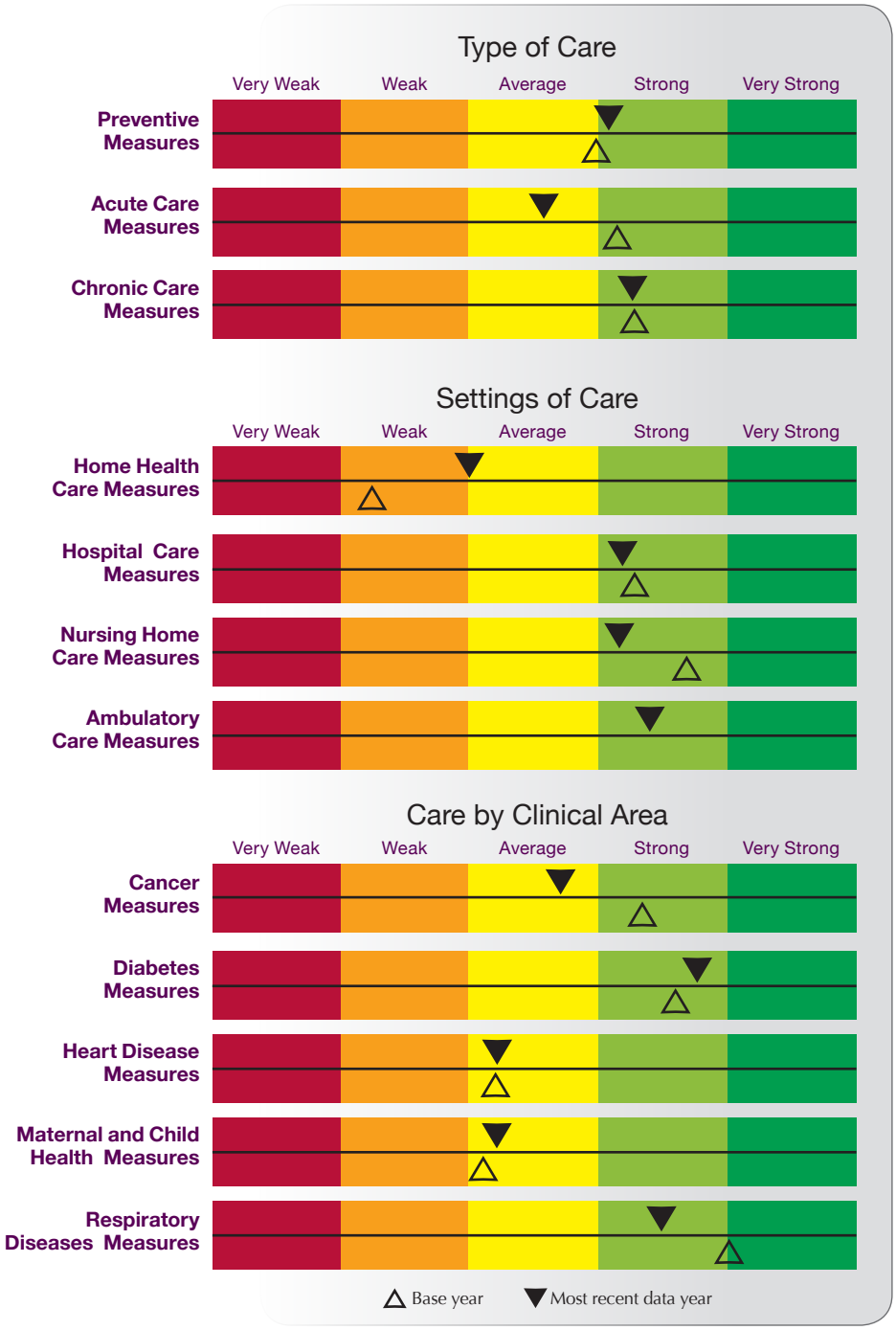
The Commonwealth Fund also ranks Iowa in the top ten percent of states in its 2012 State Scorecard report. This rank is based upon measurements in five dimensions: 1) Access 2) Prevention and Treatment 3) Avoidable Hospital Use and Costs 4) Equity and 5) Healthy Lives.

The graphics on this page describe specific types of care, settings of care, and care in clinical areas. Iowa ranked #8 on Preventive Measures, #17 on Acute Care Measures, #5 on Chronic Care Measures, #7 on Hospital Care Measures, #22 on Heart Disease Measures and #32 on Maternal and Child Care Health Measures.

Each graphic shows a State's balance of below average, average, and above average measures compared to all States reporting such data in the United States. The graphics have five categories: Very Weak, Weak, Average, Strong, and Very Strong. The United State's performance for the most recent data year is described by a solid arrow or solid triangle; a dashed arrow or hollow triangle describes the baseline year, A missing arrow or triangle means there were insufficient data to create the summary measure.

An arrow or triangle pointing to "Very Weak" means all or nearly all included measures for a State are below average within a given data year. An arrow or triangle pointing to "Very Strong" indicated that all or nearly all available measures for a State are above average within a given data year.

Source: Agency for Healthcare Research and Quality

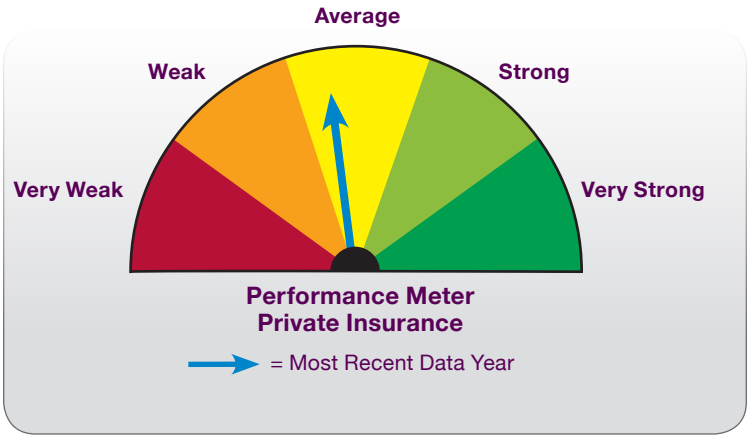


Quality of Hospital Care for Iowa Privately Insured — Iowa Compared to the U.S.

Compared to the U.S., the performance for Iowa hospitals is in the average range. The score is based on up to **thirteen (13) measures** of quality of care including hospital mortality, hospital safety, and hospital birth/obstetrics.

The performance meter for Iowa Medicaid is also in the average range while Iowa Medicare is in the weak range.

This information was released in June 2012 by the Agency for Healthcare Research and Quality (AHRQ).



Source: Agency for Healthcare Research and Quality

State Hospital Care Measures for Privately Insured Compared to the U.S.
These AHRQ Inpatient Quality Indicators and Patient Safety Indicators refer to inpatient deaths and potentially avoidable complications.

Hospital Care Measures	IA Rate (Private)	US Rate (Private)	IA Compared to US (Private)
Hospital Mortality			
Deaths per 1,000 admissions with abdominal aortic aneurysm (AAA) repair	DSU	37.95	DNC
Deaths per 1,000 admissions with coronary artery bypass surgery (CABG), age 40 and over	DSU	24.68	DNC
Deaths per 1,000 discharges for acute myocardial infarction (AMI)	52.45	60.55	■
Deaths per 1,000 adult admissions with congestive heart failure (CHF)	77.04	35.84	▼
Deaths per 1,000 adult admissions with pneumonia	46.70	39.36	■
Deaths per 1,000 adults with percutaneous transluminal coronary angioplasty (PTCA), age 40 and over	17.87	13.28	■
Hospital Safety			
Deaths per 1,000 admissions in low-mortality DRGs	DSU	0.42	DNC
Latrogenic pneumothorax per 1,000 discharges	1.30	1.34	■
Postoperative septicemia per 1,000 elective surgical discharges of 4 or more days	7.73	13.84	▲
Postoperative abdominal wound dehiscence per 1,000 discharges	2.51	2.12	■
Hospital Birth/Obstetrics			
Birth trauma injury to neonate per 1,000 selected live births	2.95	2.25	■
Obstetric trauma per 1,000 instrument-assisted deliveries	189.53	166.18	▼
Obstetric trauma per 1,000 vaginal deliveries without instrument assistance	32.31	29.32	■

State Compared to U.S.:
▲ indicates that the State is performing better than the U.S.
▼ indicates that the State is performing worse than the U.S.
■ indicates that the State is performing similar to the U.S.

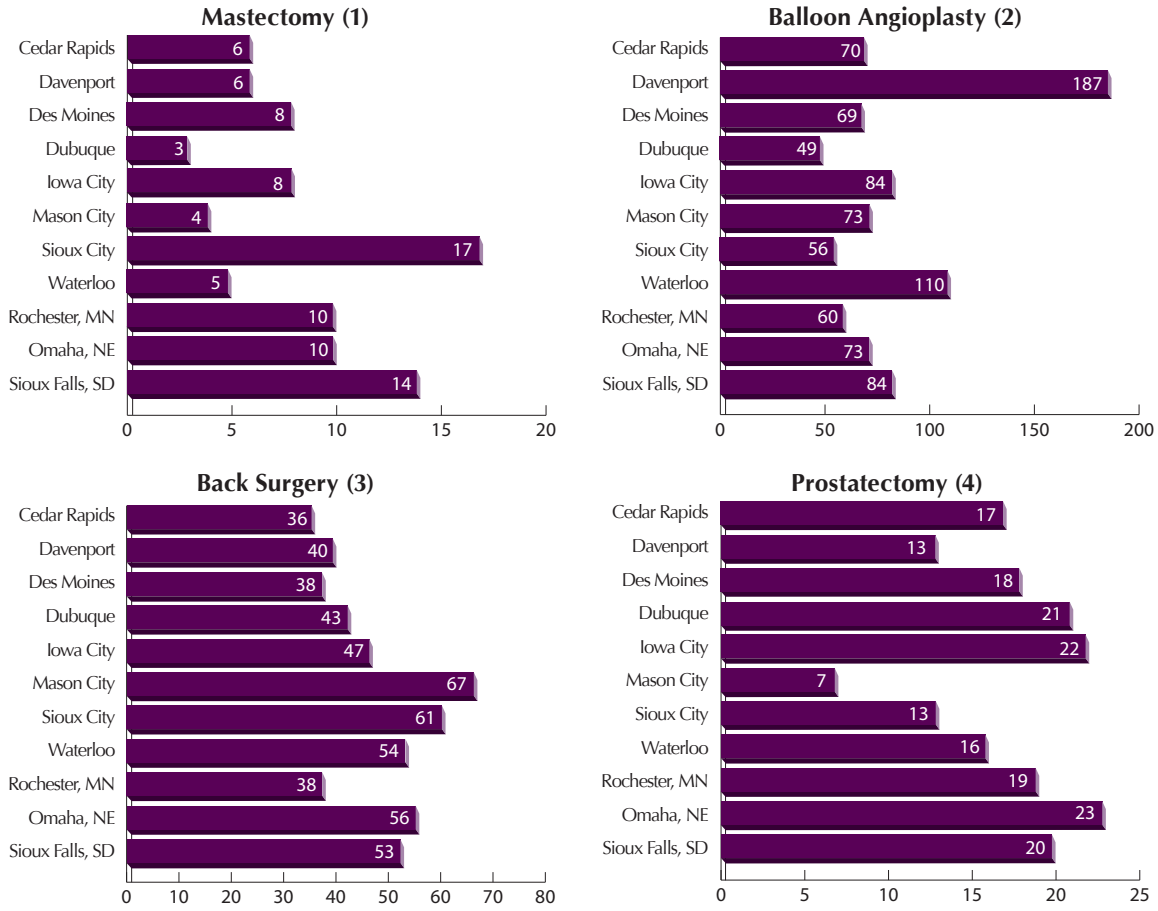
The symbols are based on a differential of at least 10 percent.
DSU: Data does not meet the criteria for statistical reliability, data quality, or confidentiality.
DNC: Data was not collected.

Elective Surgery in Greater Iowa: Location Matters

Where you live and the physician(s) you see have a strong influence on whether you undergo surgeries that might be optional according to new research from the Dartmouth Atlas of Health Care. For example, a woman from Sioux City is nearly six times more likely than a woman from Dubuque to have a breast removed to treat breast cancer. If you have heart disease and live in Davenport, you are more than three times as likely to undergo balloon angioplasty than if you live in Sioux City. Mason City residents are nearly twice as likely as Cedar Rapids residents to undergo back surgery. And men from Iowa City are three times as likely as men from Mason City to have a prostatectomy.

These figures come from Dartmouth researchers, who noted that there are pluses and minuses to each decision to have one of the procedures. These disparities suggest that patients are not being fully informed of their options. "Decisions around elective procedures should be made with patients, not for them", according to the researchers.

Different Towns, Different Treatments - Disparity of Surgery Rates



(1) Number of mastectomies performed annually per 10,000 women, adjusted for age and race
(2) Number of operations annually per 10,000 Medicare members
(3) Number of operations annually per 10,000 Medicare members
(4) Number of surgeries annually per 10,000 men on Medicare

Source: The Dartmouth Atlas of Health Care, 2012
For more than 20 years, the Dartmouth Atlas Project has documented glaring variation in how medical treatments are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians.

HEALTH POLICY CORPORATION OF IOWA

Hospital Safety Scores for Greater Iowa Hospitals

The Hospital Safety Score grades hospitals on how safe they are for patients. Each A, B, C or D score assigned to a hospital comes from The Leapfrog Group which used an expert analysis of infections, injuries, and medical and medications errors that frequently cause harm or death during a hospital stay.

"Over 2,600 hospitals" across the U.S. were graded. There were a wide range of hospitals serving all walks of life able to score an A on the Hospital Safety Score. These include academic medical centers, rural, urban, and suburban hospitals, safety net hospitals, community hospitals, nonprofit and for-profit hospitals. Expert analysis found that there was no correlation between the Hospital Safety Score grade and hospital size, ownership or teaching status.

The Leapfrog Group worked under the guidance of the nine-member Leapfrog Blue Ribbon Expert Panel to select measures and develop a scoring methodology. The Panel is made up of patient safety experts from across the country, including:

- Lucian Leape, Harvard
- Arnold Millstein, Stanford
- John Birkmeyer, University of Michigan
- Ashish Jha, Harvard
- Peter Pronovost, Johns Hopkins
- Patrick Romano, University of California, Davis
- Sara Singer, Harvard
- Tim Vogus, Vanderbilt
- Robert Wachter, University of California, San Francisco

Note – The expert panel required at least 14 of the 25 measures for a hospital in order to calculate a Hospital Safety Score. Leapfrog measures were not considered for those hospitals that did not report to Leapfrog.

Source: The Leapfrog Group, November, 2012

GP= Grade Pending (less than a C)
NA= not enough data available

Hospital	Safety Score
Alegent Health Bergan Mercy Hospital, Omaha	A
Genesis Medical Center, Davenport	A
Grinnell Regional Medical Center, Grinnell	A
Mary Greeley Medical Center, Ames	A
Mayo Clinic Methodist, Rochester, MN	A
Mercy Medical Center, Cedar Rapids	A
Mercy Medical Center, Dubuque	A
Saint Mary's, Rochester, MN	A
Spencer Municipal Hospital, Spencer	A
Trinity Medical Center at Terrace Park, Bettendorf	A
Alegent Health Lakeside Hospital, Omaha	B
Allen Memorial Hospital, Waterloo	B
Gunderson Lutheran, La Crosse, WI	B
Iowa Lutheran Hospital, Des Moines	B
Mercy Medical Center, Des Moines	B
Mercy Medical Center, Sioux City	B
Nebraska Methodist Hospital, Omaha	B
Sanford USD, Sioux Falls	B
Skiff Medical Center, Newton	B
St. Luke's Hospital, Cedar Rapids	B
Unity Hospital, Muscatine	B
Alegent Health Mercy Hospital, Council Bluffs	C
Alegent Health Immanuel Medical Center, Omaha	C
Avera McKennan Hospital & University Health Center, Sioux Falls	C
Covenant Medical Center, Waterloo	C
Creighton University Medical Center, Omaha	C
The Finley Hospital, Dubuque	C
Iowa Methodist Medical Center, Des Moines	C
Jennie Edmundson Hospital, Council Bluffs	C
Lakes Regional Healthcare, Spirit Lake	C
Mercy Hospital, Iowa City	C
Nebraska Medical Center, Omaha	C
Sartori Memorial Hospital, Cedar Falls	C
Trinity Medical Center, Rock Island	C
University of Iowa Hospitals & Clinics, Iowa City	C
St. Luke's Health System, Sioux City	D
Broadlawns Medical Center, Des Moines	NA
Fort Madison Community Hospital, Fort Madison	NA
Great River Medical Center, Burlington	NA
Keokuk Area Hospital, Keokuk	NA
Mercy Medical Center, Clinton	NA
Mercy Medical Center, Mason City	NA
Ottumwa Regional Health Center, Ottumwa	NA
Trinity Regional Medical Center, Fort Dodge	NA

What patients "say" about their experience with hospital care in the Greater Iowa Area?

The HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national, standardized survey of patients' perspectives of hospital care. The survey asks a random sample of discharged patients 27 questions about their recent hospital stay. For each participating hospital results on 10 measures are publicly reported on Hospital Compare website.

10 Measures:

1. Nurse Communications
2. Doctor Communications
3. Hospital Staff Responsiveness
4. Pain Management
5. Medication Communication
6. Hospital Room and Bath Cleanliness
7. Hospital Room Quietness
8. Discharge Information
9. Overall Hospital Rating
10. Patient Would Definitely Recommend

Greater Iowa Hospitals National Ranking Composite Score

Hospital	National Ranking Composite Score
Pella Regional Health Center, Pella	92
Saint Mary's, Rochester, MN	91
Grinnell Regional Medical Center, Grinnell	90
Mercy Iowa City, Iowa City	86
Olmsted Medical Center, Rochester, MN	84
Mayo Clinic Methodist, Rochester, MN	83
Jennie Edmundson Hospital, Council Bluffs	80
Gunderson Lutheran, La Crosse, WI	79
Mercy Medical Center, Cedar Rapids	77
The Finley Hospital, Dubuque	72
Alegent Mercy, Council Bluffs	72
Trinity Medical Center, Bettendorf	71
Sartori Memorial Hospital, Cedar Falls	71
Mercy Medical Center, Dubuque	70
Alegent Lakeside, Omaha	61
St Luke's Hospital, Cedar Rapids	61
Iowa Methodist Medical Center, Des Moines	61
Sanford USD Medical Center, Sioux Falls	60
Iowa Lutheran Hospital, Des Moines	58
Genesis Medical Center, Davenport	58
Alegent Immanual, Omaha	56
Mary Greeley Medical Center, Ames	54
Trinity Regional Medical Center, Fort Dodge	51
Mercy Medical Center, Sioux City	50
Nebraska Medical Center, Omaha	50
Great River Medical Center, Burlington	49
Creighton University Medical Center, Omaha	47
Mercy Medical Center, Clinton	46
Mercy Medical Center, Mason City	46
Ottumwa Regional Health Center, Ottumwa	45
Alegent Bergan Mercy, Omaha	44
Mercy Medical Center, Des Moines	44
Nebraska Methodist Hospital, Omaha	43
Avera McKennan Hospital & University Health Center, Sioux Falls	35
St Luke's Health System, Sioux City	35
Broadlawns Medical Center, Des Moines	32
Allen Health System, Waterloo	31
University of Iowa Hospitals & Clinics, Iowa City	31
Covenant Medical Center, Waterloo	24
Trinity Medical Center, Rock Island	23

Source: CMS Hospital Compare from Health Insight (QI), 2012

HEALTH POLICY CORPORATION OF IOWA

Percentage of patients who reported "YES" they would definitely recommend the hospital

Hospital	Definitely Recommend
Saint Mary's, Rochester, MN	87%
Olmsted Medical Center, Rochester, MN	87%
Mercy Hospital, Iowa City	85%
Mayo Clinic Methodist, Rochester, MN	85%
Pella Regional Health Center, Pella	83%
Gunderson Lutheran, La Crosse, WI	83%
Mercy Medical Center, Cedar Rapids	82%
Mercy Medical Center, Dubuque	79%
St. Luke's Hospital, Cedar Rapids	79%
Alegent Mercy, Council Bluffs	78%
Alegent Lakeside, Omaha	78%
Iowa Methodist Medical Center, Des Moines	78%
Iowa Lutheran Hospital, Des Moines	78%
University of Iowa Hospitals & Clinics, Iowa City	78%
Trinity Medical Center, Bettendorf	77%
Sanford USD Medical Center, Sioux Falls	77%
Nebraska Medical Center, Omaha	77%
St. Luke's Health System, Sioux City	77%
Mary Greeley Medical Center, Ames	76%
The Finley Hospital, Dubuque	75%
Sartori Memorial Hospital, Cedar Falls	75%
Genesis Medical Center, Davenport	75%
Mercy Medical Center, Sioux City	75%
Mercy Medical Center, Des Moines	75%
Nebraska Methodist Hospital, Omaha	75%
Grinnell Regional Medical Center, Grinnell	74%
Jennie Edmundson Hospital, Council Bluffs	74%
Avera McKennan, Sioux Falls	74%
Alegent Immanuel, Omaha	73%
Mercy Medical Center, Mason City	71%
Alegent Bergan Mercy, Omaha	71%
Great River Medical Center, Burlington	70%
Allen Health System, Waterloo	70%
Creighton University Medical Center, Omaha	67%
Broadlawns Medical Center, Des Moines	67%
Trinity Regional Medical Center, Fort Dodge	66%
Covenant Medical Center, Waterloo	66%
Trinity Medical Center, Rock Island	66%
Mercy Medical Center, Clinton	63%
Ottumwa Regional Health Center, Ottumwa	59%

Source: CMS Hospital Compare from Health Insights (QIO), 2012

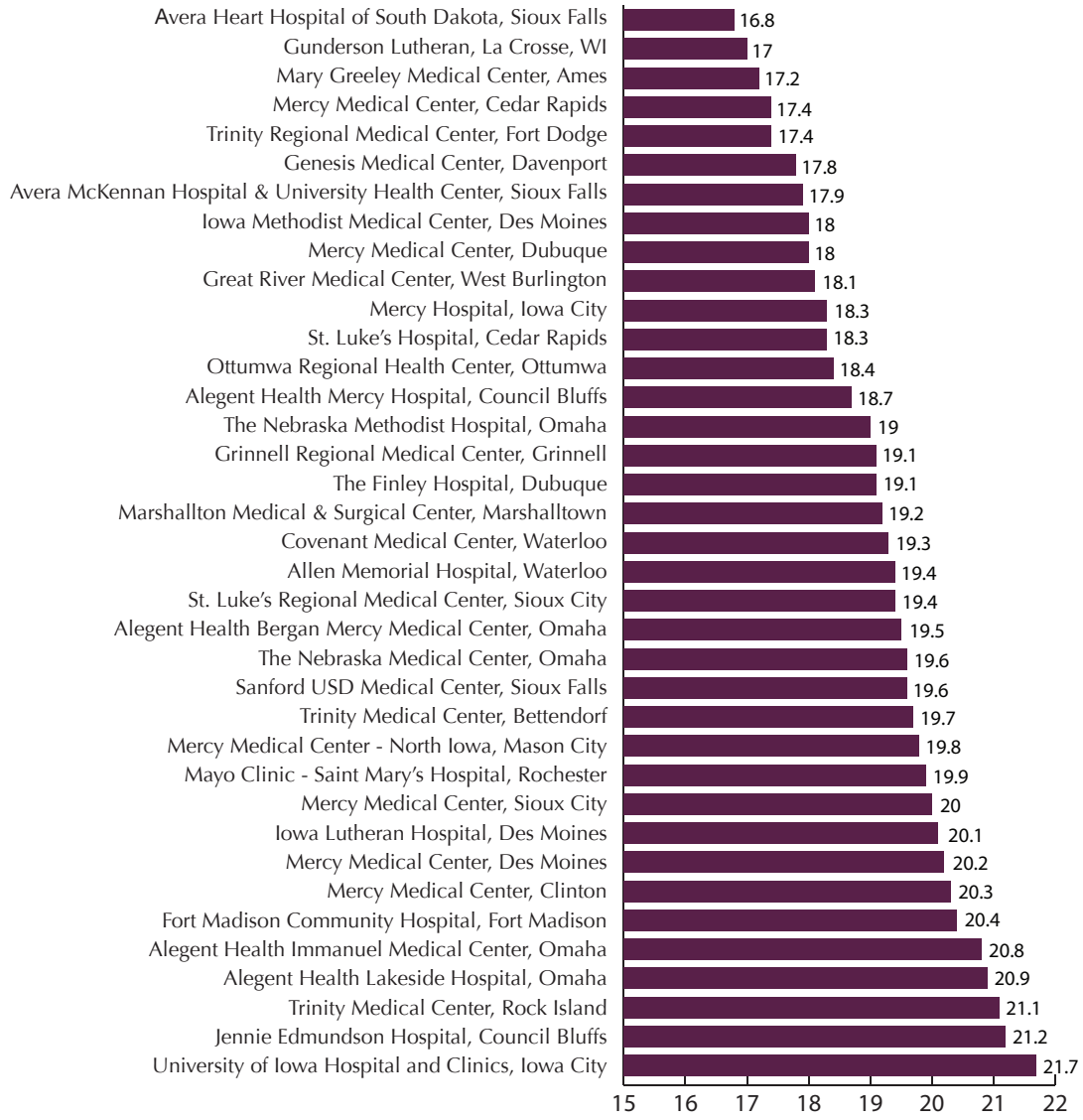
"Interest in the Consumer Assessment of Healthcare Providers and Systems survey among providers has never been greater – in part, because later this year, the Centers for Medicare & Medicaid Services will begin using data from the survey, HCAPS, to help calculate Medicare payments."

Hospitals and Health Networks Magazine, July, 2012

Heart Attack 30 Day Readmission Rates

The chart below shows the heart attack 30 day readmission rates for greater Iowa hospitals. These rates have been risk-standardized.

Tracking the number of patients who experience unplanned readmissions to a hospital after a previous hospital stay is another category of data used to judge the quality of hospital care. One example of an unplanned readmission would be someone who is admitted to the hospital for a surgical wound infection that occurred after his or her initial hospital stay.



Source: CMS Hospital Compare from Health Insight (QIO), 2012

Hospital Quality: Recommended Care Measures

The chart below shows the frequency (%) that greater Iowa hospitals provided recommended care and their national performance ranking.

Frequency of Recommended Care and National Performance Ranking, 2010

	Frequency of Recommended Care Goal = 100%				
Hospital	**Heart Attack**	**Heart Failure**	**Pneumo-nia**	**Surgical Infection**	**National Performance Ranking**
Alegent Heath Mercy Hospital, Council Bluffs	99%	98%	100%	99%	96th
Alegent Health Immanuel Medical Center, Omaha	99%	99%	99%	99%	95th
Avera Heart Hospital Hospital of South Dakota, Sioux Falls	100%	99%	82%	99%	94th
Alegent Health Lakeside Hospital, Omaha	99%	98%	99%	99%	92nd
Trinity Bettendorf, Bettendorf	98%	97%	98%	99%	90th
Spencer Municipal Hospital, Spencer	Not Reported	98%	98%	99%	90th
Mayo Clinic - Methodist Hospital, Rochester	Not Reported	69%	91%	99%	89th
Marshalltown Medical & Surgical Center, Marshalltown	100%	95%	98%	99%	89th
Fort Madison Community Hospital, Fort Madison	98%	99%	99%	98%	85th
Allen Memorial Hospital, Waterloo	100%	97%	96%	99%	85th
Mary Greeley Medical Center, Ames	100%	96%	96%	98%	82nd
Winneshiek Medical Center, Decorah	100%	100%	100%	93%	79th
Mercy Medical Center, Des Moines	100%	100%	97%	96%	79th
Alegent Health Bergan Mercy Hospital, Omaha	100%	97%	98%	97%	79th
Creighton University Medical Center, Omaha	100%	98%	98%	97%	78th
Mercy Medical Center - North Iowa, Mason City	99%	97%	96%	98%	78th
Trinity Medical Center, Rock Island	99%	98%	97%	97%	77th
Trinity Regional Medical Center, Fort Dodge	99%	94%	97%	98%	77th
Mercy Medical Center, Dubuque	99%	95%	98%	97%	76th
Grinnell Regional Medical Center, Grinnell	96%	93%	97%	98%	72nd
Genesis Medical Center, Davenport	99%	97%	97%	97%	71st
St Luke's Hospital, Cedar Rapids	99%	98%	98%	96%	71st
Mercy Medical Center , Cedar Rapids	100%	91%	97%	97%	70th
Mercy Medical Center, Sioux City	99%	98%	96%	97%	70th
Mercy Medical Center, Clinton	98%	94%	97%	97%	68th
Mayo Clinic - Saint Mary's Hospital, Rochester	100%	97%	96%	97%	60th
Sanford USD Medical Center, Sioux Falls	99%	93%	95%	97%	60th
St Luke's Regional Medical Center, Sioux City	98%	98%	99%	95%	56th
Iowa Methodist Medical Center, Des Moines	98%	90%	94%	97%	54th
The Finley Hospital, Dubuque	98%	88%	97%	97%	53rd
Nebraska Methodist Hospital, Omaha	98%	100%	91%	96%	52nd
Great River Medical Center, West Burlington	95%	85%	96%	97%	50th
Iowa Lutheran Hospital, Des Moines	99%	87%	96%	96%	48th
Nebraska Medical Center, Omaha	98%	97%	92%	95%	44th
Gunderson Lutheran Medical Center, La Crosse	100%	100%	95%	94%	44th
Sartori Memorial Hospital, Cedar Falls	86%	91%	98%	95%	44th
Avera McKennan & University Health Center, Sioux Falls	96%	98%	97%	93%	42nd
Mercy Hospital, Iowa City	98%	98%	98%	94%	42nd
Keokuk Area Hospital, Keokuk	90%	93%	98%	93%	42nd
University of Iowa Hospitals & Clinics, Iowa City	98%	88%	92%	96%	41st
Covenant Medical Center, Waterloo	97%	98%	96%	93%	37th
Broadlawns Medical Center, Des Moines	100%	82%	97%	94%	35th
Pella Regional Health Center, Pella	80%	97%	91%	95%	32nd
Jennie Edmundson Hospital, Council Bluffs	97%	96%	91%	92%	29th
Skiff Medical Center, Newton	89%	78%	84%	96%	26th
Mercy Medical Center, Centerville	87%	96%	90%	89%	22nd
Cass County Memorial Hospital, Atlantic	83%	100%	94%	74%	21st
Ottumwa Regional Health Center, Ottumwa	90%	81%	91%	91%	20th
Boone County Hospital, Boone	64%	88%	89%	91%	19th

Source: CMS Hospital Compare through Health Insight (QIO), 2012

Recommended Care Measures

Heart Attack (Acute Myocardial Infarction or AMI)

- Aspirin at arrival
- Aspirin at discharge
- ACE Inhibitor for Left Ventricular Systolic Dysfunction (LVSD)
- Beta Blocker at discharge
- Thrombolytic agent within 30 minutes of arrival
- PCI within 90 minutes of arrival
- Smoking cessation advice

Heart Failure

- Assessment of Left Ventricular Function (LVF)
- ACE Inhibitors for LVSD
- Discharge instructions
- Smoking cessation advice

Pneumonia

- Initial Antibiotic Timing
- Pneumococcal Vaccination
- Influenza Vaccination
- Blood culture prior to first antibiotic received
- Smoking cessation advice
- Appropriate antibiotic

Surgical Infection Prevention

- Antibiotic 1 hour prior to surgical incision
- Antibiotic stopped within 24 hours after end of surgery
- Appropriate Antibiotic
- Glucose controlled for cardiac patients after surgery
- Appropriate hair removal
- Blood Clot Prevention Ordered
- Blood Clot Prevention Treatment
- Beta Blockers before & after surgery to designated patients
- Urinary catheter removed within 2 days after surgery

Analysis Methodology

The score for each clinical area (frequency of recommended care) represents the hospital's combined performance forall measures.

To compute national rankings, each hospital's performance on each measure was ranked on a 0 – 1 scale (similar to grading each measure on a curve). An average rank was computed across all 26 measures for each hospital in contrast to the national comparison group and expressed as a percentile.

Best Care at Lower Cost - The Path to Continuously Learning Health Care in America

Characteristics of a Continuously Learning Health Care System

Science and Informatics

- Real-time access to knowledge—A learning health care system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality
- Digital capture of the care experience—A learning health care system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.

Patient-Clinician Relationships

- Engaged, empowered patients—A learning health care system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.

Incentives

- Incentives aligned for value—In a learning health care system, incentives are actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.
- Full transparency—A learning health care system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients, and their families.

Culture

- Leadership-instilled culture of learning—A learning health care system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.
- Supportive system competencies—In a learning health care system, complex care operations and processes are constantly refined through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.

IOM Recommendation on Performance Transparency

Increase transparency on health care system performance.

Health care delivery organizations, clinicians, and payers should increase the availability of information on the quality, prices and cost, and outcomes of care to help inform care decisions and guide improvement efforts.

Strategies for progress toward this goal:

- Health care delivery organizations should collect and expand the availability of information on the safety, quality, prices and cost, and health outcomes of care.
- Professional specialty societies should encourage transparency on the quality, value, and outcomes of the care provided by their members.
- Public and private payers should promote transparency in quality, value, and outcomes to aid plan members in their care decision making.
- Consumer and patient organizations should disseminate this information to facilitate discussion, informed decision making, and care improvement.

In its report the Institute of Medicine concluded that the entrenched challenges of the U.S. health care system demand a transformed approach. Left unchanged, health care will continue to underperform; cause unnecessary harm; and strain national, state, and family budgets. The actions required to reverse this trend will be notable, substantial, sometimes disruptive—and absolutely necessary. The imperatives are clear, but the changes are possible—and they offer the prospect for best care at lower cost for all Americans.

Meaningful Use of Health Information Technology
What it is and Why it is so important?

To stimulate investment and use of health information technology (IT) to improve health care, the federal government has established a combination of voluntary financial incentives and eventual penalties to encourage the "meaningful use" of electronic health records (EHR). If implemented effectively (e.g. "meaningfully") EHRs can dramatically improve how care is delivered.

The Centers for Medicare and Medicaid (CMS) is making $34 billion ($44 billion in total) in financial incentives available to physicians and hospitals when they use certified electronic health records (EHR) to achieve specified improvements in care delivery. For providers, the financial implications will extend far beyond the $34 billion in incentives, with Medicare providers facing what will become substantial payment reductions if they are not meaningful users of health IT after 2015.

The concept of meaningful use supports several critical goals:

1) increase care coordination and fostering better doctor-patient communication
2) reducing medical errors and improving patient safety
3) supporting delivery of evidence-based care
4) reducing disparities by recording demographic information
5) improving quality of care while fostering more cost-effective delivery
6) advancing payment reform (by supplying needed data on provider performance)
7) providing patients with their own portable health information

<u>There are three general requirements for providers to be considered meaningful users of EHRs:</u>

1) Use EHRs certified technology in a meaningful manner, including e-prescribing
2) Demonstrate capability of exchanging electronic health information to improve quality
3) Submit information on clinical quality measures

<u>Payment incentives are tied to improvements in health care process and outcomes. Incentive criteria are staged in three stages:</u>

1) Stage 1 (2011-2012) – Centers on health information collection
2) Stage 2 (2013) – Focuses on exchanging and using information
3) Stage 3 (2015) – Concentrates on promoting systematic improvement

Institute of Medicine, September, 2012

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CMS seeks to align the Medicare and Medicaid meaningful use programs. For Medicaid, providers don't experience payment cuts and incentives continue until 2021.

The program is reaching a lot of providers in Iowa and across the U.S. The number of hospitals using health IT nationally has more than doubled in the last two years. Many health systems and doctor's offices are implementing health IT even though they are not eligible for incentive payments.

Source: CMS and the Iowa Department of Public Health

Iowa Health Information Exchange Created

Iowa's health information exchange, the Iowa Health Information Network (IHIN), is in production and providers have begun exchanging data via the system's first service, Direct Secure Messaging. The IHIN, which was authorized by legislation in 2008, is a public-private collaborative effort led by the Iowa Department of Public Health. When full query functionality is available to Iowa providers in early 2013, the IHIN will coordinate the interoperability of disparate electronic health records (EHR) systems and allow for the robust exchange of electronic patient information. Additionally, a patient portal is scheduled to be available by the end of 2013, enabling patients to access their personal health information via the IHIN.

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Sources of Additional Information

Agency for Healthcare Research and Quality (AHRQ) – www.ahrq.gov

The Dartmouth Atlas of Health Care – www.dartmouthatlas.org

CMC Health Care Compare – www.healthcare.gov/compare

The Leapfrog Group – www.leapfroggroup.org

Hospital Safety Score – www.hospitalsafetyscore.org

National Committee for Quality Assurance (NCQA) – www.ncqa.org

Institute of Medicine (IOM) – www.iom.edu

Kaiser Family Foundation – www.kff.org

The Commonwealth Fund – www.commonwealthfund.org

Consumer-Purchaser Disclosure Project – www.healthcaredisclosure.org

Catalysis for Payment Reform – www.catalyzepaymentreform.org

David P. Lind Benchmark – www.dplindbenchmark.com

Iowa Insurance Division – www.iid.state.ia.us

Iowa Department of Public Health – www.idph.state.ia.us

Iowa Healthcare Collaborative – www.ihconline.org

Iowa Hospital Association – www.ihaonline.org

Iowa Health Buyers Alliance – www.ihbaonline.org

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