

Moving up the charts

Quality-improvement advice from top-ranking clinics.

IN NOVEMBER, MN Community Measurement will come out with its third set of physician group performance rankings that will be publicly displayed for patients and fellow doctors to see.

What does it take for a group to make it to the top of the list? Here's a look at some clinics that improved their standings between 2004 and 2005 or managed to stay at the top of the heap:

Motivating diabetics

Family Health Services of Minnesota, P.A., zoomed to the top ranking in optimal diabetes care in 2005. The joint venture by East Metro Family Practice, P.A., and MinnHealth Family Physicians, P.A., nearly quadrupled its percentage of diabetic patients who met all five criteria for well-controlled diabetes: HbA1c level at or below 8 percent, blood pressure below 130/85 mmHg, LDL cholesterol below 130 mg/dl, daily aspirin use if the patient is age



Photo by Scott Walker

Larry Morrissey, M.D., Stillwater Medical Group, examines an 8-week-old infant during a well-baby visit. An astonishing 83 percent of the group's infant patients receive six or more well-baby visits in the first 15 months of life, compared with the state average of 60 percent.

41 to 75, and tobacco-free status.

The physician group boosted the percentage of patients who met the five criteria from 11 percent in 2004 to 40 percent in 2005, far above the 17 percent average among all physician groups.

A key factor in the group's success was its physicians' decision to accept the measurements and strive to achieve benchmarks, even if they didn't agree

with all of them, says the group's co-medical director David C. Thorson, M.D.

For example, some physicians objected to tobacco-free status being a measure of quality diabetes care, he says. "We felt it was important to counsel patients to stop smoking," Thorson says. "But the concern was, how can we as physicians be accountable for people

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A supplement to *Minnesota Medicine*

Owner and Publisher
Minnesota Medical Association

Editor
Scott D. Smith

Manager, Quality Improvement
Rebecca Schierman

Graphic Designers
Janna Netland Lover
Joanna Ryan

Advisory Committee
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Peter J. Dehnel, M.D.
Kurtis M. Hoppe, M.D.
David D. Luehr, M.D.
Prathibha Varkey, M.D.

**To Submit an Article,
Idea or Comment**
Contact Scott Smith at
ssmith@mnmed.org or 612/362-3726

MMA Address
1300 Godward Street, Ste 2500
Minneapolis, MN 55413
Phone: 612/378-1875 or
800/DIAL MMA (342-5662)
Fax: 612/378-3875
E-mail: mma@mnmed.org
Web site: www.MMAOnline.net

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Pursuing excellence



David D. Luehr, M.D.

Photo by Scott Walker

I'M PLEASED to introduce the first edition of the *MMA Quality Review*.

The MMA Quality Committee called for the creation of this publication last spring. Since the 1999 Institute of Medicine report "To Err is Human: Building a Safer Health System" was published, health care professionals have recognized the need to develop systems approaches to reducing errors and ensuring quality. As a practicing physician, I think we are in an exciting, new era of medicine, where the power of information technology is going to change the way we practice medicine.

This publication will highlight how physicians in Minnesota and around the country are improving the care they provide by taking a systematic approach to measuring, tracking, and enhancing patient outcomes.

In the *MMA Quality Review*, we will share methods and opportunities for improving care by providing tangible examples of what works.

This first issue does this by addressing questions such as, Is it time to buy an in-clinic hemoglobin A1c testing machine?

And could you better integrate depression screening into your practice?

The publication will also serve as a forum for physicians to discuss the strengths and weaknesses of the benchmarks, guidelines, and pay-for-performance programs that go along with the quality movement.

I view the quality movement as very positive. But it must be led by physicians. That is one reason the *Quality Review* has a physician advisory board, which also checks the clinical relevance and accuracy of articles.

Minnesota is known for its high-quality health care. By aggressively continuing our quality improvement efforts, we can show leadership, help our patients, and get a head start on meeting standards being set by the government, employers, and insurers.

Finally, we want the publication to represent the physician voice in the quality movement. Please help us succeed by contributing your ideas about techniques, practices, and technologies that will help physicians get results and improve patient care.

Dr. Luehr is the chair of the MMA's Quality Committee, former MMA president, and a practicing family physician in Cloquet, Minn.

**" I view the quality
movement as very
positive. But it must be
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NEWS

YOU CAN USE

Can telemedicine compete with face-to-face care?

Issue: High approval ratings from rural patients and the lack of specialists in rural areas have led some private insurers and the Centers for Medicare and Medicaid Services to reimburse for selected telemedicine services. But does the evidence support this?

Research says: Researchers affiliated with the Oregon Evidence-Based Practice Center conducted a review of literature published between 2000 and 2004 to determine whether such coverage was justified.

In general, the researchers concluded there is still a lack of evidence proving that telemedicine works as well as face-to-face encounters. But video conferencing can be an effective way to conduct psychiatric and neurological assessments. Teleophthalmology was also particularly effective for assessing diabetic retinopathy.

Fast fact: The evidence for the efficacy of telemedicine in dermatology is mixed.

Into practice:

Ways to use telemedicine . . .

- Diabetic patients in need of close monitoring are given home-based telemedicine equipment to record and forward daily glucose readings and other vital statistics to nurses. Nurses contact patients as needed to offer advice, adjust medications, and schedule appointments.
- Children with asthma are regularly monitored using peak flow meters. The system forwards test results to clinic nurses and flags abnormal results. Nurses change asthma management as needed. ▴

Source: Hersh W.R. Telemedicine for the Medicare Population: Update. Evidence Report/Technology Assessment No. 131 AHRQ Publication No. 06-E007. Rockville, MD: Agency for Healthcare Research and Quality. February 2006.

Help for Physicians: Quality Tools Online



Where can physicians find practical, ready-to-use tools to measure and improve the quality of their care? AHRQ's Quality Tools Website (www.qualitytools.ahrq.gov) is a clearinghouse for databases, reports, fact sheets, and guides to assist physicians in improving health care quality in their practice.

Alerting doctors to prescribing errors

Issue: Prescribing alert systems can result in a cry-wolf phenomenon.

Research says: It's possible to design relevant e-prescribing alert systems that physicians will override less frequently, according to a study in the *Journal of the American Medical Informatics Association*.

Previous studies have found that doctors dismiss as many as 91 percent of the warnings they receive from computerized prescription entry systems. Harvard University researchers got better results by creating a prescribing alert system that focused on the most important reasons not to prescribe a drug. Using this system, physicians in 31 primary care clinics in the Boston area accepted 67 percent of the 5,182 alerts that interrupted their orders. The doctors canceled their orders in 19 percent of the cases and altered 48 percent of their orders.

Fast fact: Clinicians often override alerts for sound reasons. Commonly overridden alerts were those indicating a patient was pregnant when she was not and those indicating a duplicate drug was being prescribed when, in fact, the patient was changing from one drug to another.

Into practice: Selective and tiered alerts increase physician acceptance. When designing clinical drug alerts for the ambulatory setting, it is important to minimize workflow interruptions. Physicians should have the ability to modify e-prescribing systems to meet the needs of their practice and to note why they overrode an alert. ▴

Source: Shah N. Improving acceptance of computerized prescribing alerts in ambulatory care. *J Am Med Inform Assoc.* 2006;13(1): 5-11.

who ignore our advice?"

Nevertheless, FHSM's physicians agreed to hold each other accountable for all of the diabetes care measurements, including tobacco-free status. Years before, the group had developed a process for documenting tobacco use, advising patients to quit, and providing resources. "That is probably one of the things that allowed us to move so quickly" to achieve a high score on the diabetes care measurements, he says.

A second factor was that the group installed glycosated hemoglobin machines in all its clinics. The in-house machines process patients' HbA1c readings in about 10 minutes. Physicians can then report results to the patient during the visit, which has been a huge advantage, Thorson says.

"We can counsel patients and make adjustments at the point of service, which is better than following up with them even a day later with a letter or a phone call."

Pressure performers

Northstar Physicians, a network of 22 independently owned clinics in northeastern Minnesota and northwestern Wisconsin, significantly increased the percentage of

its patients age 46 years to 85 years whose blood pressure was under control.

From 2004 to 2005, the percentage of hypertensive patients with blood pressure less than or equal to 140/90 mm/Hg increased from 48 percent to 70 percent.

The average among all groups was 64 percent in 2005, with Edina Family Physicians, P.A., topping the list with a score of 84 percent.

Although Northstar is not at the top of the rankings, the network's physician staff is proud of its improved score, says Bruce Penner, R.N., director of clinical operations. "Our physicians sense the importance and are striving for maximum performance [on hypertension control]," Penner says. Their goal is to reach 77 percent in 2006.

Credit for Northstar's success goes to its quality-improvement program for hypertension, which includes internal goal setting, audits of patient charts, and financial incentives, says Glenn Nordehn, D.O., chief medical officer and an internal medicine physician at the Gateway Clinic in Moose Lake.

"I presume our physicians went from 48 [percent] to 70 [percent] because the qual-

ity-improvement program has heightened their awareness of how well their patients' hypertension is controlled," he says.

The network's physicians are also treating high blood pressure more aggressively than in the past, says Penner. "Sometimes physicians don't want to add a second or third medication to a patient's medication list. But we helped them understand that more aggressive treatment of hypertension is appropriate."

Visiting healthy babies

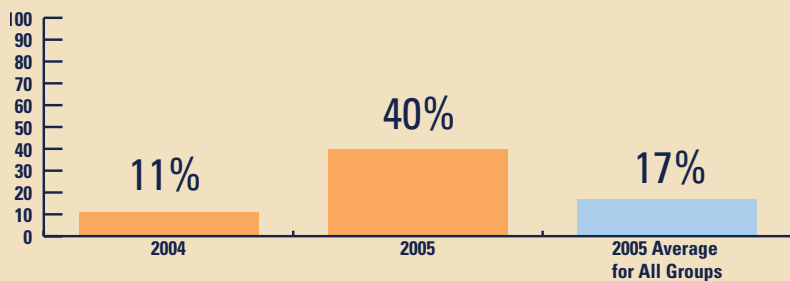
Stillwater Medical Group topped the rankings in 2005 for the second year in a row for the percentage of babies who received six or more well-baby visits by 15 months of age.

An eye-popping 83 percent of babies cared for by the Stillwater Medical Group received six or more well-baby visits by age 15 months, up from 75 percent in 2004. By comparison, the physician group average was 60 percent in 2005, up from 53 percent in 2004.

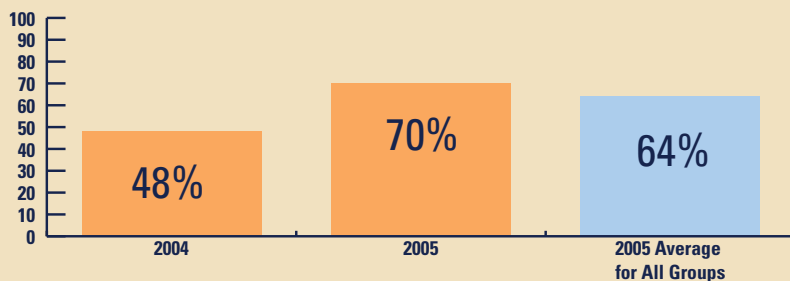
Why does the group score so well?

"To be honest, we haven't done anything," says Larry Morrissey, M.D., pediatrician and group medical director for quality improvement. The group hasn't imple-

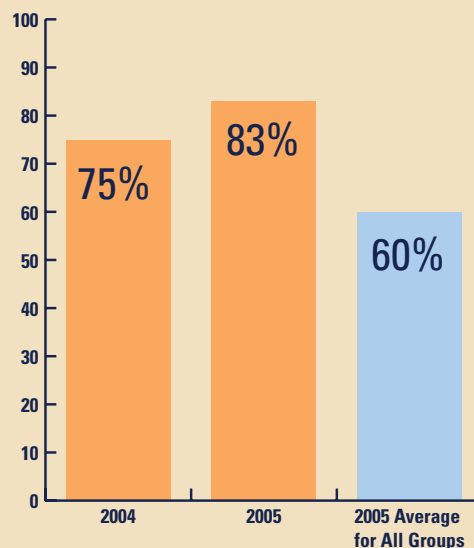
Family Health Services of Minnesota patients meeting all five diabetes measures



Northstar Physicians patients with blood pressure less than or equal to 140/90 mm/Hg



Stillwater Medical Group infants receiving 6 or more well-baby visits



Source: Minnesota Community Measurement

Tips from successful clinics

- Install glycated hemoglobin machines in clinics to allow diabetics to immediately see HbA1c scores
- Aggressively prescribe medication for hypertension
- Ask parents for seven instead of six well-baby visits

mented a specific quality-improvement program to increase well-baby visits, he says. Nor has it made pay-for-performance dollars available. “But there are things we do in the normal course of our process that led to our success.”

For example, the group routinely asks parents for seven well-baby visits by age 15 months of age — not six visits, which is more common, Morrissey says. The group schedules visits at 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, and 15 months. “The trend is to get away from the 9-month visit, but we’ve always felt it was really valuable, so we kept it in,” he says.

National guidelines do not specify a specific schedule for well-baby visits. The American Academy of Pediatrics (AAP) recommends seven visits during this time period, while ICSI recommends only six visits. But recommending seven visits, rather than six, offers several benefits, says Morrissey. Patients are more apt to remember appointments when the visits are more regular. And patients have an additional opportunity to make up a missed visit, he says. The 9-month visit is also a valuable opportunity to talk with parents, assess the development of their baby, and answer any questions that may arise.

Finally, Morrissey credits staff efforts to maintain good relationships with increased patient compliance. “From the reception desk to the time they leave, we try to make it a good experience for them,” he says. ▀

By Amy Snow Landa

MMA Quality Review correspondent

Mayo gets curiously mixed grades

When Mayo gets a low score, is it time to doublecheck the test?

SOME OF MINNESOTA'S largest employers were so impressed with the Mayo Clinic's diabetes care that they gave the clinic a cash bonus in June.

That payment, part of the Bridges to Excellence program, was based on Mayo's high placement in the MN Community Measurement (MNCM) 2005 Health Care Quality Report's diabetes care category.

That Mayo scored well in this and other categories isn't surprising for a system with an international reputation for quality care. More perplexing is the fact that Mayo ranked near the bottom of the list in categories such

as asthma medication and cervical cancer screening. Mayo isn't alone. Other clinics had similar mixed results, leaving some to wonder why.

Mayo considers scores

Mark Nyman, M.D., a Mayo internist, who sits on the MNCM board, says Mayo has been actively engaged in quality-improvement initiatives as a member of the Institute for Clinical Systems Improvement for at least the last 12 years.

Nyman says Mayo's administration sees the MNCM project as an important extension of its existing quality >>



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Mark Nyman, M.D., supports goals of MN Community Measurement but advocates for more refinement of data collection efforts. Photo courtesy of Mayo Clinic.

▶▶ work, and leaders are concerned about some of the clinic's low scores. "We'd like to be No. 1 in all of the categories," Nyman says.

However, there is also recognition within Mayo that some of the project's data collection methods need refinement.

"There are definitely some areas we need to improve, but there are also other areas where our internal numbers differ, and there is concern that MNCM numbers may not reflect the level of care we are providing," Nyman says.

For example, Mayo's internal data suggest the organization is doing a better job with asthma medication than the MNCM assessment would suggest, Nyman says. Mayo ranked 47th out of 47 clinics for use of appropriate medication for people with asthma ages 5 to 56 years.

Mayo also ranked nearly last in cervical cancer screenings and percent of patients that remained on antidepressants for 180 days. On the upside, Mayo scored in the top 10 for childhood and adolescent immunizations, chlamydia screening, and high blood pressure and diabetes treatment.

Nyman explains that the asthma discrepancy, for example, could be tied to

the fact that MNCM uses asthma billing codes to collect its data. Claims data is not obtained directly from the medical chart, which can lead to incomplete or erroneous information. If done incorrectly, this method of data collection can include billing codes for patients who do not really need asthma medication.

MNCM is aware of this problem and is using a different method for its 2006 report that is expected to raise asthma medication scores across the board, Nyman says.

Sample size is another factor that affects the quality of MNCM data.

"When they sample our data, it's really a small fraction of our overall patient population," Nyman says. The project uses a minimum sample of 30

"We'd like to be No. 1 in all of the categories."

— Mark Nyman, M.D.

patients for some measures and 60 patients for others. Mayo Clinic saw 322,772 patients in 2005, according to its Web page.

These small sample sizes can lead to large confidence intervals that make it difficult to accurately compare one clinic with the other, Nyman says.

Statisticians use confidence intervals to quantify the probability that a particular number is true.

For example, the 2005 MNCM report found that 66 percent of Mayo Clinic patients between ages 5 years and 56 years were taking recommended medications for long-term control of asthma.

This score put Mayo at the lower end of this category.

However, the reported confidence interval for Mayo on this measure stretches from about 55 percent to 80

percent, which means it is possible that the actual percentage of patients treated correctly could be much higher than 66 percent.

Considering this, it is entirely possible, based on MNCM's own numbers, that Mayo physicians' asthma prescribing practices may out-perform the average for Minnesota providers of 77 percent of patients.

Or considered another way, 44 out of the 47 clinics in the category have overlapping confidence intervals, which from a statistical perspective means it is difficult to make comparisons between any of these 44 clinics in regards to the asthma care delivered, Nyman says.

But that uncertainty is not included in the rankings displayed on MNCM's Web page, although confidence intervals are included in the full report.

Striving for better data

Jim Chase, executive director of MNCM, recognizes that some of the numbers might be affected by small sample sizes.

MNCM is exploring ways to collect larger samples and improve the quality of its data in the future. "Our goal is to collect results on all patients directly from the medical group," Chase says.

But he cautions patients and doctors against placing too much importance on the rankings. The goal of the project is to discover and communicate best practices in an effort to improve patient care in Minnesota, he says.

"The results we have today are useful for medical groups to compare how they are doing compared with others, and that can help spur improvement," Chase says. "But we need to improve our methods to prepare for what the public ultimately needs — reliable information to help them make choices about their care." ▾

By Andrew Telljohn

MMA Quality Review correspondent

MMA announces first quality award winners

THREE PHYSICIANS have been honored with the MMA Leadership in Quality Award. This is the first year that the award has been given.

Gordon Mosser, M.D., the former director of the Institute for Clinical Systems Improvement (ICSI) was given the award in recognition of his contribution toward making Minnesota a leader in the quality-improvement arena. During the past decade, Mosser has advanced quality health care in Minnesota through his efforts to build ICSI, a statewide collaborative focused on health care quality improvement.

His vision for ICSI included defining quality through the development of health care guidelines and technology assessment reports. He also worked to create a model by which providers and ICSI could collaborate, share data, and implement best practices.

John D. Bergseng, D.O., a general surgeon at Glencoe Regional Health Services (GRHS), has been in the trenches actively working to implement best practices based on ICSI guidelines in several clinics. Bergseng, vice president of medical affairs at GRHS, chairs the clinic's case management committee. He has helped develop integrated care plans (also known as



Anticipated Recovery Pathways) to help patients recover from or manage acute myocardial infarction, congestive heart failure, pneumonia, and surgery. He has also assisted with the implementation of diabetes, asthma, and preventive care guidelines, and educated physicians in several clinics about the protocols.

"Prior to Dr. Bergseng taking the reins, we had resistance by many physicians, but with Dr. Bergseng's support and in turn educating the physicians, the resistance is disappearing," says Patty Henderson, R.N., case manager at GRHS.

William Davis, M.D., a family physician, has been a champion of the community wide electronic medical record system in Winona, which makes electronic patient records available to area providers.



Davis practices at the four-physician group Family Medicine of Winona. He also serves as the chief medical information director of WinonaHealth, a nonprofit health care system including Winona Community Hospital and several practice groups.

Davis has been instrumental in bringing this electronic medical record system to Winona. He was a strong advocate for implementing the system and for making it community-based, according to David Allen, executive director of Winona Choice. "Davis is a champion of the electronic medical record in Winona and is a leader nationally in this undertaking." ▾

The MMA Quality Committee concluded the following physicians deserved an honorable mention:

- Barry Bershaw, M.D.**, Fairview Health Services, for promoting use of evidence-based medicine in clinics and encouraging participation in MN Community Measurement and payer initiatives
- Barbara Daniels, M.D.**, University of Minnesota Physicians, for leading her group in the implementation of electronic health records
- Luis Haro, M.D.**, Mayo Clinic, for using measures to achieve acute myocardial infarction "door to balloon" times that are among the fastest in the country
- Timothy Malling, M.D.**, Paynesville Area Medical Clinic, for championing electronic health records adoption in his clinic
- Richard Morris, M.D.**, Allergy and Asthma Care, PA, for leading efforts in allergy/immunotherapy
- Eugene Ollila, M.D.**, Allina Medical Clinic Nicollet Mall, for developing provider training in optimum diabetes control
- Michael Osborn, M.D.**, Mayo Clinic - St. Mary's Hospital, for establishing and implementing a root cause analysis process
- Marilyn Peitso, M.D.**, CentraCare Clinic - Women & Children, for developing and implementing a Medical Home project
- Thomas Timmons, M.D.**, North Memorial Medical Center, for implementing a rapid response teams to reduce CPR/cardiac arrest by almost 40 percent

Q&A

treating depression



Denny Peterson, M.D.

Family Practice Medical Center in Willmar has found that integrating a depression screening tool with its electronic medical record has allowed physicians to more accurately diagnose and track depressed patients.

DENNY PETERSON, M.D., staff physician at Family Practice Medical Center, says his group's five-year partnership with the Institute for Clinical Systems Improvement (ICSI) has helped his relatively small practice tackle quality-improvement projects.

By implementing an electronic medical record system that includes a depression screening tool called Patient Health Questionnaire (PHQ-9), his group has seen the results of better care of depressed patients.

Q: Can you describe PHQ-9?

A: PHQ-9 is a tool to improve how you are quantifying a patient's depression ... It is a scoring tool we incorporated into our system that uses a series of 10 questions and a scale to measure where patients fit.

Q: How do you use it?

A: If a patient exhibits symptoms indicating depression, I pull up the 10-question form on screen. When the patient has answered all of the questions, the computer analyzes it and pulls up a score that corresponds to a scale that helps determine follow-up treatment.

If their score is less than 9, they may not need acute treatment, but they may benefit from counseling and close follow-up to ensure they are improving and not worsening. If they are between 10 and 19, they probably need treatment and counseling and monthly follow-up. If they are 20 or above, weekly follow-up is advised and appropriate contact with psychiatry is recommended.

Q: Why is PHQ-9 important?

A: Depression has to follow a pattern. There are specific criteria in the DSM-IV that you have to meet. We wanted to make sure we were diagnosing it appropriately. Another part of the issue is recognizing that it is difficult to treat, diagnose, and to ensure that people are improving and not falling through the cracks.

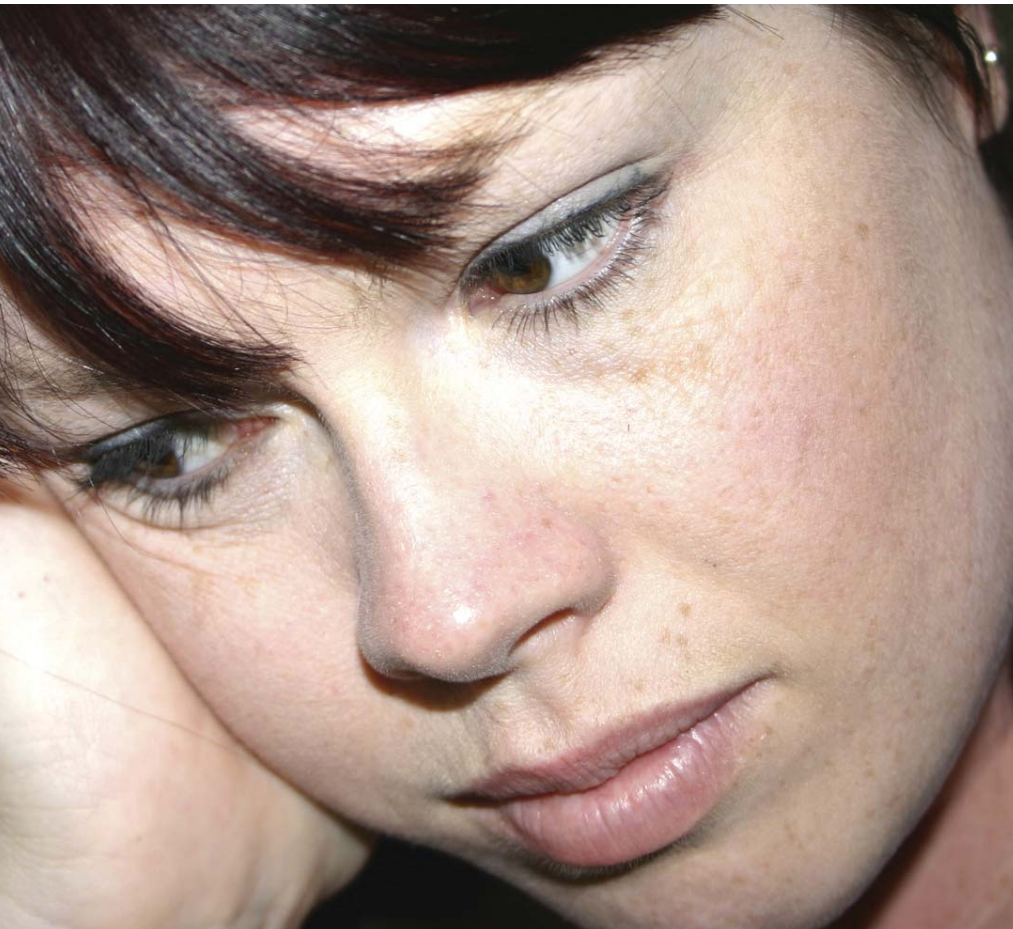
Q: Why was PHQ-9 chosen over other depression screening tools?

A: There are two or three alternatives across the country. ICSI felt PHQ-9 was better because it's been used for quite a while and there's data to support its ease of use.

Q: What kind of an impact has it had?

A: One of the difficulties in creating a diagnosis for depression was that often DSM-IV criteria were not documented. Since documentation is so important for reimbursement, we realized we needed to have some method for being consistent. When we started back in 2004, fewer than 10 percent of our depressed patients actually had all five of the DSM-IV criteria documented. Over two years, we've reached almost 65 percent. Is that good enough? No, but it shows improvement, and we're shooting for 100 percent. Another goal is to have consistent follow-up. Our numbers looked good in the past, but that was because we had few people who were accurately diagnosed. As we get into more diagnoses, that number might have dropped, but in general we are doing a much better job of evaluating and appropriately diagnosing people.





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PHQ-9 depression assessment

Patients answer options: Not at all (0 points); several days (1 point); more than half the days (2 points); nearly every day (3 points). Scorer then adds up points. Assessment form is available at www.pfizer.com.

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead, or of hurting yourself in some way

Scoring scale:

Score	Depression severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A diagnosis of major depressive disorder also requires impairment of function. The following question addresses this.

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Answers: not difficult at all; somewhat difficult; very difficult; and extremely difficult.

Available at www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved.

Q: How does PHQ-9 work with your electronic records?

A: If PHQ-9 scores him this month having an 18 and last month he was a 15, it's worsening. Having those records, I'm prompted to ask what is wrong. Before, we had to find the patients that were diagnosed with depression, pull those charts, and go through them by hand to find out if we did everything. It was extremely time-consuming and labor intensive.

Q: Do you have any advice for caregiver groups that want to implement this system?

A: ICSI is a wonderful thing. They saved our life in quality. They gave us the opportunity to become a leader, we think, across the state in improving quality and showing that small clinics can do it as well as large clinics, if they have the right system.

Q: How else has PHQ-9 affected you?

A: This year by appropriately diagnosing our patients using DSM-IV criteria we more accurately defined our patients as depressed and were able to achieve higher reimbursements per patient and achieved a higher rate of accurate diagnosis.

Q: How have the patients reacted?

A: Wonderfully. I think anyone who has concerns about depression wants to know they are being listened to and know if there is an improvement or a worsening.

Q: Are patients diagnosed with PHQ-9 more likely to follow through on treatment?

A: I think so. We set follow-up visits based on their scores. And if they don't come in, we're going to call them. The EMR helps us recall them for follow-up. ▀

MINNESOTA ROUNDUP

State raises the bar

GOV. TIM PAWLENTY signed an executive order that directs the state to use its buying power—it spends \$4 billion a year on health care—to achieve health care quality targets in four areas: diabetes, cardiac diseases, hospital stays and prevention. Pawlenty predicts that meeting these goals could save Minnesota’s health care system about \$150 million a year.

The program, QCare, sets ambitious quality goals and will judge physician performance based on MN Community Measurement (MNCM) scores.

Cal Ludeman, commissioner of the Minnesota Department of Human Services, says the administration expects to release details about the annual targets and rewards by the end of the year. He expects, for example, the practice benchmark for diabetes in 2007 will be for groups to provide 22 percent of their diabetic patients optimal care based on MNCM standards, with an 80 percent goal at the end of four years.

A bipartisan panel of state officials, physicians, hospital and business representatives, insurers, and other health care providers developed the goals under the auspices of a National Governors Association program. Mayo cardiologist Douglas Wood, M.D., who served on the panel that set the goals, says the targets are “stretch goals,” but are achievable. “I look forward to the future with a great deal of optimism, and I know that we will not fail,” Wood says. ▀



Mayo cardiologist Douglas Wood, M.D., served on goal setting panel. Photo by Scott Smith.

Employers pay bonuses to doctors

PAY FOR PERFORMANCE took another step forward in June, when seven of Minnesota’s largest employers gave medical groups bonus payments for quality diabetes care.

3M, Medtronic, Carlson Companies, Wells Fargo, the Minnesota Department of Employee Relations, General Electric, and Honeywell gave top-performing physician groups a \$100 bonus for each successfully managed diabetic employee.

The employers are members of the of the Buyer’s Health Care Action Group, which has helped implement the national Bridges to Excellence program in Minnesota.

Awards were based on MN Community Measurement data. ▀

Next step

The group plans to start a bonus program for cardiovascular disease in 2007.

2006 Bridges winners

- Affiliated Community Medical Center, Willmar
- Columbia Park Medical Group, Fridley
- Family Health Services of Minnesota, St. Paul
- HealthPartners Central Minnesota Clinics, St. Cloud
- HealthPartners Medical Group, Minneapolis, and Central Minnesota Clinics, St. Cloud
- Mayo Clinic, Rochester
- Multicare Assoc., Twin Cities
- Superior Health Med. Group, Duluth
- Western Wisconsin Medical Assoc., Hudson

Governor’s goals for outpatient care

Preventive care	Percent of patients meeting goal		Percent increase
	2005 Baseline	2010 Goal	
Child immunization	68	90	32
Teen immunization	39	90	131
Well-child visits	59	90	53
Breast cancer screening	74	90	22
Cervical cancer screening	78	90	15
Chlamydia screening	32	90	181
Diabetes care	6	80	1,233
Cardiovascular care	38	90	137

Source: Gov. Tim Pawlenty’s office.

NATIONAL ROUNDUP

AMA develops benchmarks

IN 2006, the American Medical Association (AMA) promised Congress it would develop more than 100 performance measures for physicians, which the federal government would also use to judge physician performance.

The AMA group doing this work is the six-year-old Physician Consortium for Performance Improvement.

The consortium has developed 93 performance measures on 16 clinical topics, and has become a leading source for clinical performance measures. It started with common conditions such as diabetes, cardiac problems, depression, and asthma. More recently, it has been tackling conditions such as osteoarthritis, gastroesophageal reflux disease, and skin cancer. Physician involvement in the development of measurements helps keep them focused on what is important clinically, says Gail Amundsen, M.D., HealthPartners' medical director of quality, measurement, and provider incentives.

Amundson is a member of the consortium that represents 70 national medical specialty and state medical societies, government agencies, and other stakeholders. ▀

Bush calls for transparency

PRESIDENT BUSH traveled to Minnesota in August to sign an executive order in Minnetonka directing the federal government to foster more price and quality transparency in the nation's health care system.

The order calls for federal agencies to share information about prices paid to health care providers for procedures and the quality of services provided by doctors, hospitals, and other providers, according to a White House fact sheet.

It also instructs the agencies to use improved health information technology systems and to develop and to identify approaches that facilitate high-quality and efficient care.

The affected agencies are the Health and Human Services Department, which oversees Medicare; the Defense Department, which oversees health care for the military; the Veterans Affairs Department; and the Office of Personnel Management, which oversees the Federal Employees Health Benefit Program. Bush chose to sign the order in Minnesota

CMS seeks physicians for quality reporting

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) is moving toward implementing pay for performance.

As an early step, it's offering physicians the chance to participate in the Physician Voluntary Reporting Program launched earlier this year.

Physicians choosing to participate will capture data about the quality of care provided to Medicare beneficiaries. At this time, participating physicians are submitting data on a starter set of 16 primary care and specialty care process measures.

In 2007, CMS will add specialty measures currently being developed by the AMA's Physician's Consortium for Performance Improvement.

The question for doctors is whether participating will be worth the effort.

At the June meeting, physicians on the MMA's Quality Committee agreed that Medicare is moving toward pay for performance, and they encouraged physicians to preemptively get in the habit of collecting data, reviewing reports, and improving care.

On the other hand, they said the downside of the voluntary program is that it lacks financial incentives and its costs are unknown.

CMS has developed a Web-based application for physicians interested in the program. If you want to learn more or participate, visit: www.qualitynet.org. ▀



President Bush greets invited guests after signing an executive order in Minnetonka. Photo by Scott Smith

because Minnesota's employers, insurers, and health care providers are already making cost and quality information available to patients through programs such as MN Community Measurement. ▀

Building a safer hospital

Hospitals give themselves safety makeovers



In August, St. Joseph's Hospital in St. Paul broke ground on a new building pictured in this rendering.

Rendering courtesy St. Joseph's Hospital.

HOSPITALS IN MINNESOTA and across the nation are designing safety into their very walls.

One such Wisconsin hospital is St. Joseph's Hospital in West Bend, an 80-bed facility. When it opened its doors in August 2005, the size and design of every patient room was identical, allowing doctors and nurses to find equipment quickly.

Nurse stations are placed so patient rooms are visible and don't obstruct nurses' views.

Filters and ultraviolet devices kill germs and other particles in the air.

Blinds have been placed within window glass to reduce germ-breeding dust and condensation.

And lighting simulates natural light, so physicians no longer have to wheel newborns to a window to check for jaundice.

"We added technologies to eliminate errors, redid processes, and created a safety culture design using tech-

niques [the hospital's lab] suggested," says John Reiling, former CEO of St. Joseph's. "What you are trying to do is create an environment where people are less likely to make mistakes."

Popular strategy

Minnesota hospitals have made similar attempts to enhance patient safety with architecture.

According to the Minnesota Hospital Association, Fairview Health Services, the Mayo Clinic, North Memorial Health Care, Regions Hospital, St. Cloud Hospital, St. Joseph's Medical Center in Brainerd, and St. Mary's Regional Health Center in Detroit Lakes all have incorporated patient and employee safety design principles into one or more of their care centers.

St. Joseph's Hospital in St. Paul broke ground on a new building in August that is designed using the latest safety principles, says Phyllis Novitskie, associate administrator.

Safety trends in hospital design

- Identical patient room design to ease finding equipment
- Slip-proof floors and sound-proof walls
- Lighting simulating natural light
- Glass-fronted alcove with a computer next to each room for ordering drugs or entering data
- Nurse stations placed so that pillars don't block views to patient rooms
- Blinds placed inside window glass

Rooms will be nearly identical so caregivers can memorize layouts, and will be built on a diagonal orientation to hallways so nurses, as they walk by, can observe patients. Floor-mounted toilets in bariatric rooms will be able to accommodate patients weighing up to 800 pounds.

Thus far, the design has bucked one trend: While many hospitals are using carpeting to decrease noise, St. Joseph's went with hard floors because caregivers said the smooth surfaces make it easier to move patients and equipment.

"We have to acoustically design elements so they absorb noise," Novitskie says. ▴

By Andrew Telljohn

MMA Quality Review correspondent