

MMA QUALITY REVIEW

Physicians in pursuit of excellence

Paying for performance

Physicians support it but want it tweaked, tested, and watched closely.

THE GENERAL CONSENSUS among Minnesota's providers and health plans is that pay-for-performance programs have the potential to improve patient care by aligning payment and quality measures. But being good scientists, many Minnesota doctors want to see these programs tested and scrutinized.

Physicians point out there is scant evidence that pay-for-performance programs will yield results. Nationwide more than 100 pay-for-performance plans affect more than 30 million people. In Minnesota, eight payer- or purchaser-based programs basing bonuses on 43 criteria are already operating, according to a Minnesota Medical Association study.

After living with these programs for a few years, Minnesota doctors have ideas for improving them.

Carrot's too small

Barry Bershaw, M.D., medical director for quality and informatics, for Fairview Health Services, supports pay for performance but questions the size and the timing of the rewards payers are offering. He says the payments offered by health plans provide little incentive for doctors and nurses to go the extra mile. The reward can also be delayed gratification in the extreme, coming as long as two years after meeting the performance goal.

"It's difficult to teach a porpoise to jump through a flaming hoop when you throw him a herring 18 months after he jumps through it," Bershaw says. "I think that's a serious problem with all our pay-for-performance [programs]."

Basically, he says, the carrot needs to be bigger, and Fairview got good results when it instituted an in-house program that offered rewards worth working for.

Fairview started rewarding doctors at about 10 percent of their salaries for performance in five areas. "We give adequate money so that it's worth

people's time," he says. Fairview's research found that the potential pay hike got people's attention and yielded positive results.

That seems to jive with research from business that indicates a possible bonus of 10 to 25 percent is often needed to change performance. That's significantly higher than the 3 percent typically offered in health care pay-for-performance initiatives, said national quality expert, Robert Wachter, M.D., said during a recent speech in Minnesota.

Others have criticized pay-for-performance programs in Minnesota that reward physician groups, rather than individual physicians, which also dilutes the link



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PAYING continued on p. 4

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Not really what the doctor ordered



David D. Luehr, M.D.

Photo by Scott Walker

IN THE LAST ISSUE, I talked about how the *MMA Quality Review* was going to provide you with tangible ways to improve care at your clinic.

And now, this issue is mostly about pay for performance, which isn't something that will directly help a doctor in the examining room. So why focus on it?

The answer is that many (such as the folks at the Centers for Medicare and Medicaid Services and the Institute of Medicine) believe pay for performance is the lever that needs to be applied to the U.S. health care system to lift it to a higher level of quality.

As a physician, I view pay for performance as just another unproven tool that may or may not help patients. As is pointed out in this publication, there is scant evidence that pay for performance will actually improve the quality of care in Minnesota or the United States.

It may even lead to unintended consequences such as unfairly penalizing and further impoverishing clinics that work with poor or high-risk patients.

On the other hand, the idea of pay for performance fits the spirit of the quality movement, which is dedicated to improving care by measuring and rewarding performance. And let's face it, it just might work. Money is one way our society calculates worth, and it gets people's attention and motivates them.

Pay for performance is already in place in Minnesota and will increasingly become a part of our professional lives. So I see this issue of the *MMA Quality Review* as part of an ongoing evaluation of the concept that needs to occur. Just as is the case with other parts of the quality movement, pay for performance should stand or fall as scientific evidence accumulates over time.

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

**“Pay for performance
should stand or fall
as scientific evidence
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time.”**

NEWS

YOU CAN USE

Helping diabetics help themselves

Issue: Empowering diabetics to self-manage their disease

Research says: A Robert Wood Johnson Foundation Diabetes Initiative conducted 14 demonstration projects, of which one was in Minnesota at the Minneapolis American Indian Center. The projects focused on finding effective ways to help diabetic patients self-manage their disease. The demonstrations lasted three years, with most of them wrapping up in 2006. The projects shared the importance of offering these services and resources to help patients manage their diabetes:

- Ongoing follow up, support, and encouragement that helps patients adjust their plans to individual circumstances.
- Access to community health workers who can facilitate interaction between the patient and a health care team and provide a friendly face for follow up and support.
- Assistance with managing emotional issues related to diabetes.
- Partnerships between health care providers, clinics, and community organizations to create a support network and opportunities for healthy living with diabetes.

Fast fact: The individual who only receives updated medications and test results from a physician several times a year isn't receiving state-of-the-art diabetes care.

Into practice: Visit www.diabetesinitiative.org and go to the resources section to access an extensive catalogue of forms, screenings and other tools used by clinics in the project. ▀

Source: www.diabetesinitiative.org

Pediatricians find goal setting gets results

Issue: Improving preventive care for children

Research says: Vermont has 35 pediatric practices and nearly all of them participated in a statewide quality-improvement project. Every practice that participated improved in one or more preventive measures for children younger than 5 years.

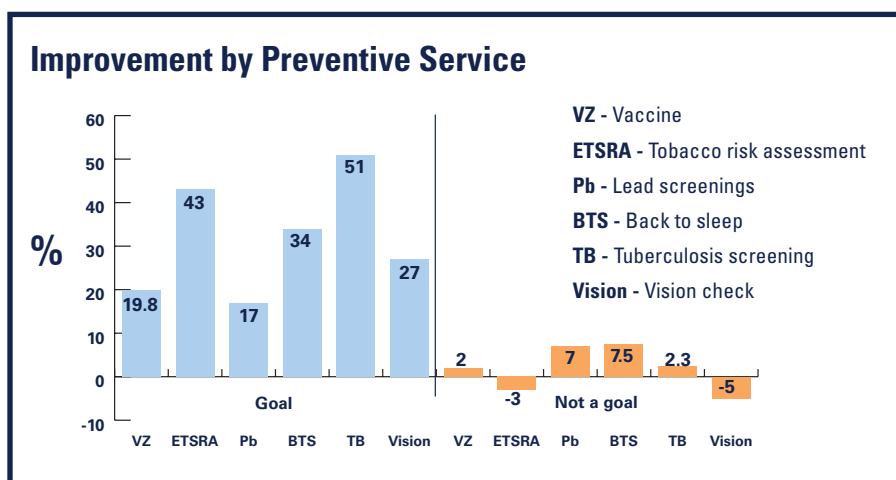
The state of Vermont spent about \$350,000 or about \$16 per child in the state on the project. State health officials reviewed charts to set baseline scores on nine measures. Practices were asked to identify an area in which they want to improve. Teams including at least one physician and nurse. They attended three to four training sessions on quality-improvement methods, then reported results monthly.

As a group, the clinics improved in areas including assessing risk for tobacco smoke-exposure, lead screening, sleep position counseling, anemia screening and tuberculosis screening.

One clinic improved its rate of documenting that staff had advised parents to place their infants on their backs to sleep from 10 percent to 100 percent by reviewing the topic with staff, revising their well-child visit flow sheet, and updating parent hand-outs.

Fast fact: Practices that did not identify a service for improvement did not improve in that area.

Into practice: It is necessary to consciously focus on a specific preventive service as a quality improvement goal in order to see improvement in that area. ▀



Source: Shaw JS, et al. Statewide Quality Improvement Outreach Improves Preventive Services for Young Children. *Pediatrics*. 2006;118:1039-47.

between an individual doctor's performance and their reward.

Data must be right

Physicians point out that if payment is linked to performance, then it's crucial that the data are reliable.

Health plans often use billing data to determine how well a provider is performing, and that data is sometimes downright wrong, says William Davis, M.D., a family physician at the Family Medicine Clinic of Winona.

One plan, he says, used billing information on the number of Pap smears done at his practice as the basis for a reward. "We were doing many more than their data showed," Davis says. He advises physicians to measure their own performance so they can check the accuracy of health plan data.

Some physicians also say it's unfair to hold them accountable for patient behaviors that happen outside the

clinic, such as in the case of a diabetic who continues to smoke, said Babette Apland, senior vice president of health and care management at HealthPartners. The counter argument has been that research shows that physicians can influence patient behavior and that payment methods should reward physicians who provide that element of care.

Other physicians question whether bonus programs should reward clinics for reaching an absolute benchmark or for merely improving their performance. Many physicians are also concerned about more administrative red tape and are calling for the health plans and government agencies to adopt common measures.

Dan Arom, Medica's manager of provider relations and health management projects, believes that will happen over time. "It wouldn't be that difficult to at least get some overlap on the overwhelming majority of the measures."

Go to MMA's Web site

To see the MMA's comprehensive report about pay for performance in Minnesota is available at www.mmaonline/quality.

House of cards?

The central question is whether the current quality measures are sophisticated enough to serve as a sign post for quality care.

In a study published in a December issue of *JAMA* that looked at performance data from 3,657 U.S. hospitals, researchers concluded that performance measures predicted only small differences in hospital risk-adjusted mortality rates and called for the development of measures that are tightly linked to patient outcomes.

In a commentary in that same issue, Susan D. Horn, Ph.D., of the Institute for Clinical Outcomes Research, said the study raised questions about the validity of basing pay-for-performance programs on the measures currently available.

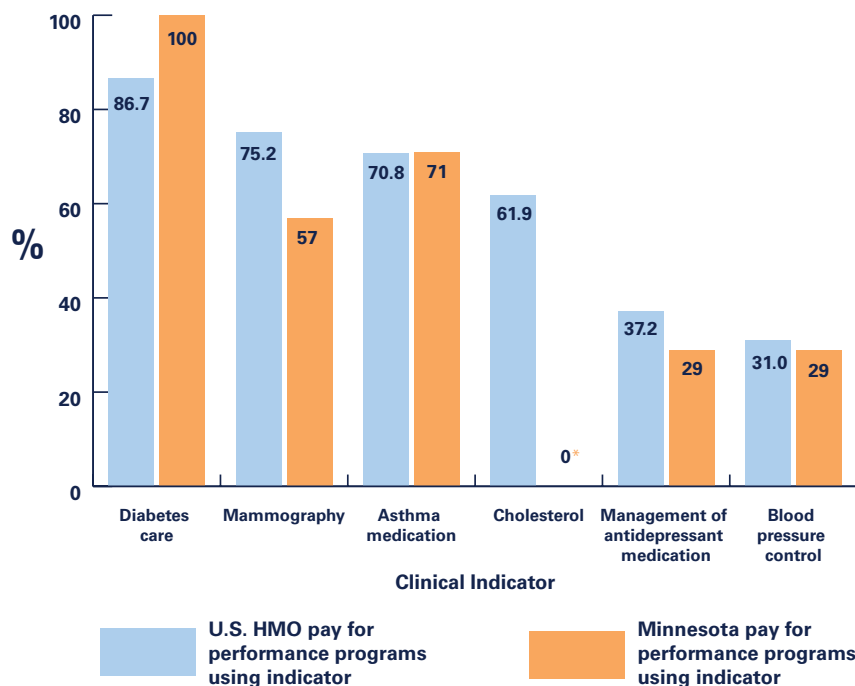
John Ipsen, M.D., a physician at Mount Royal Medical Center in Duluth, believes pay-for-performance programs are reasonable ways to prompt adherence to guidelines. But he sees potential conflicts when physicians follow standardized guidelines too closely. For instance, health plans reward hypertension control. But dropping the blood pressure of a patient with occlusive vascular disease and a stenotic carotid artery too much could cause a stroke. "The guidelines may push you to do things your clinical judgment might not encourage," he says.

He's also concerned the health plans aren't applying enough scientific testing to their own programs and they're more interested in profits than raising quality. "I think some are using pay for performance to avoid paying doctors rather than to reward them." ▀

By Andrew Tellijohn

MMA Quality Review Correspondent

Common Pay-for-Performance Measures



Source: Rosenthal MB N Engl J Med, 2006 ;355(18):1895-902. Minnesota Medical Association research.

* Measured only as part of diabetes care composite.

Is everything negotiable?

Physicians find they often have some leeway to negotiate pay-for-performance goals with health plans.

IT MIGHT BE A LITTLE-KNOWN SECRET that insurers are willing to negotiate on pay-for-performance goals, pay levels and cost and quality tiers.

William Davis, M.D., a family physician with the Family Medicine Clinic of Winona, says during his clinic's negotiations a couple of years ago, he went back and forth with a health plan about a percentage goal for generic drug use. The two sides ended up settling on about 47 percent.

"It doesn't make sense for us to pick a level we will never get to," he says. "It doesn't create goodwill if they create a goal that nobody can reach."

Davis says his clinic of five doctors doesn't have as much clout as some larger providers. But he still has been impressed with how flexible health plans are about goal set-

ting. "They're not going to push you into something you don't have a chance to be successful at," he says. "Their goal is to get you to use generics. They're more than willing to incent you to do that."

Sometimes flexible, sometimes not

What Davis says is true, but not necessarily across the board, health plan officials say.

At HealthPartners, which has been conducting pay-for-performance programs longer than any other Minnesota health plan, some standards can be negotiated and others can't. For its Partners in Excellence bonus program, goals are intentionally set at an attainable but challenging level that is the same for all medical groups, says Babette Apland, vice ►

Negotiating with the state

IN 2002, the Minnesota Department of Employee Relations (DOER) introduced the Minnesota Advantage Health Plan, a tiered-network plan for state employees. Employees in the system select a primary care clinic with the expectation that most care will be coordinated by the clinic through referrals.

The plan is administered by Blue Cross and Blue Shield of Minnesota, HealthPartners, and PreferredOne. Providers are placed into tiers based on their risk-adjusted costs. Employees are encouraged to access provider quality information through links on the DOER Web site to MN Community Measurement results. The state also participates in the Bridges to Excellence program as a way to reward clinics demonstrating superior performance.

Members pay the same premiums regardless of the clinics they chose, but what varies by cost level is their out-of-pocket expenses when they seek care. "It's pretty effective in reinforcing the message that there are some really important differences in costs and to be mindful of

those differences," says Dave Haugen, director of DOER's Center for Health Care Purchasing Improvement.

The tiers are set by a formula that ranks clinics one through four, with level 1 the lowest cost, and level 4 the highest. One nuance of the plan is that all state employees get access to at least a cost level 2 provider, as a result of a union negotiation. However, in some parts of the state there are no providers in cost level 1 or 2 providers. In those cases, the state has made level 3 and 4 clinics available at lower cost levels.

The state has also allowed some clinics to negotiate to a lower tier in competitive markets, so they don't lose patients to a lower-cost competitor. A couple of providers in the metro area and a couple in greater Minnesota have done so during the last two years. "They have negotiated some lower rates or terms that are sufficient to bring their overall cost levels down to go to the lower cost levels," Haugen says. ▾

▶▶▶ president of health and care management.

“At the beginning of the year, we put out the goals and if the medical groups meet it, they get a bonus for that performance,” she says. “That really isn’t negotiable.”

HealthPartners’ Partners in Progress program, however, takes a look at what the medical group’s baseline performance is and negotiates a level of progress necessary to achieve a reward.

Flexibility helps meet goals

St. Mary’s Duluth Clinic Health System (SMDC) has negotiated on pay-for-performance components in its contracts with Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica Health Plans, and First Plan of Minnesota.

The clinic also has negotiated some contracts with individual employers such as St. Louis County largely because SMDC sees pay for performance as consistent with its goals of actually treating patients better, not just seeing more of them.

“That really comes from the philosophy of the physicians at Duluth clinic,” whose chief goal is to improve quality, says John Smylie, chief administrative officer at SMDC.

The whole negotiation process starts as a dialogue, Smylie says. SMDC representatives meet with health plan officials to discuss current care levels, what they hope to achieve, and what the challenges are in reaching those goals.

“It’s a really nice cycle,” Smylie says. “We’re really pleased with our commercial payers. They are all working with us.” ▀

By Andrew Tellijohn

MMA Quality Review Correspondent

Clinics get mixed scores

MINNESOTA PHYSICIANS IMPROVED the quality of the care they provide for patients with diabetes, asthma, and hypertension but made no headway on cancer screenings and lost ground in areas such as well-child visits and treatment of depression, according to the MN Community Measurement 2006 Health Care Quality report.

The nonprofit MN Community Measurement posted results on its Web site in October and plans to release its final report in January.

“Results are up for most of our measures, which is good news,” says Jim Chase, executive director of MN Community Measurement, which receives some funding from the MMA.

MN Community Measurement tracks and publicly reports the performance of more than 75 provider groups on measures that indicate how well doctors manage chronic diseases. It has become the most important source of quality performance data in the state.

Since the organization released its 2005 report, the number of asthma patients receiving appropriate care increased from 76 percent to 91 percent. However, Chase noted the definition of an asthma patient changed, which could have partially accounted for improved scores. Likewise, during the same time period, providers improved the percentage of patients who had their blood pressure under control from 64 percent to 68 percent.

As for treating the more than 100,000 diabetics in Minnesota, providers increased the percentage of patients receiving optimal care from 16 percent to 20 percent based on a less strict standard and from 6 percent to 9 percent using a stricter standard.

Immunization rates also increased from 68 percent to 78 percent, and Chlamydia screenings improved from 32 percent to 36 percent.

On the downside, clinics did not do a better job of treating depression. In the future, Chase said MN Community Measurement may include other depression measures, such as the PHQ-9 measure, to better understand depression care in the community.

The percentage of children receiving well-child visits also dropped. Screenings for cervical and breast cancer basically stayed flat with about three-quarters of female patients receiving these tests. ▀

Chronic-Disease-Management Results

Patients	2003	2004	2005	2006
Used asthma medications	71%	74%	76%	91%
Kept blood pressure <140/90	57%	60%	64%	68%
Used depression medications	49%	51%	49%	42%
Met diabetes 1 (looser) targets	12%	12%	16%	20%
Met diabetes 2 (tighter) targets	NA	4%	6%	9%

Source: MN Community Measurement

Top-scoring clinics

Adult asthma treatment

Lakeview Clinic

99% of patients ages 5 to 56 years with persistent asthma were continuously enrolled in their health plan during the measurement year and were appropriately prescribed medication during that year.

Cancer screening combo

HealthPartners Medical Group

65% of adults ages 50 to 80 years were up to date on all appropriate cancer screenings (colorectal, breast, cervical).



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Sore throats

MinuteClinic and Priority Pediatrics

100% of children ages 2 to 18 years who were diagnosed with pharyngitis and were prescribed an antibiotic on or within three days of the episode date received a group A streptococcus (strep) test—from three days prior to three days after the episode date.

High blood pressure

Mayo Clinic

86% of patients ages 46 to 85 with a diagnosis of high blood pressure had their blood pressure under control (less than or equal to 140/90 mmHg).

Well-child visits

Western Wisconsin Medical Associates

94% of patients who turned 15 months old during the measurement year received five or more well-child visits with a primary care practitioner during their first 15 months of life.



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Childhood vaccinations

Mayo Clinic

95% of children who turned 2 years old during the measurement year received the following: DTP or DTaP, OPV or IPV, MMR, HiB, Hepatitis B, VZV, and Pneumococcal conjugate.

Chlamydia screening

United Family Practice Health Center

62% of women ages 16 to 25 years who were identified as sexually active had at least one test for Chlamydia.

Diabetes care

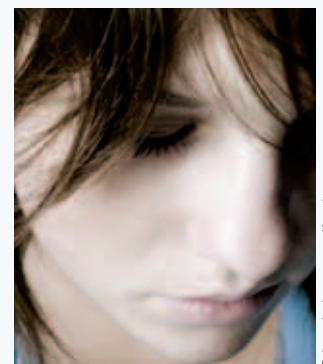
Camden Physicians and Winona Clinic

23% of patients with diabetes (type 1 and type 2) ages 18 through 75 years achieved all of the following five treatment goals: 1) hemoglobin A1c (HbA1c) less than or equal to 7.0%; 2) blood pressure less than 130/80 mmHg; 3) LDL-C less than 100 mg/dl; 4) daily aspirin use after age 41; and 5) documented tobacco free.

Depression treatment

Sioux Valley Clinic

63% of patients age 18 years and older diagnosed with a new episode of major depression were treated with antidepressant medication and had at least three follow-up contacts with a nonmental health practitioner or mental health practitioner coded with a mental health diagnosis during the 180-day effective continuation treatment phase.



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Q&A

Medicare and pay for performance



Susan Nedza, M.D.

Many say Medicare is the payer that will make pay for performance the norm. In December, Congress passed a 1.5 percent bonus for some Medicare payments dependent on voluntary reporting of quality data. Susan Nedza, M.D., chief medical officer for Region V of the Centers for Medicare & Medicaid Services (CMS), took time to discuss what care providers in Minnesota can expect in the months ahead.

Q: Describe Medicare's voluntary reporting program. How many physicians in the region have signed up? How does it relate to the information technology assistance program named Doctors Office Quality - Information Technology (DOQ-IT)?

A: The Physician Voluntary Reporting Program (PVRP) is a voluntary program for submitting data to test how a physician practice would submit administrative data quality measures. We have broad participation across specialties and with small and large practices nationwide. They can participate as groups or individuals. I don't have specific numbers, but there are Minnesotans participating. There are two other projects: the Physician Group Practice Demonstration [the first pay-for-performance initiative under Medicare for physicians] that Park Nicollet is part of and the separate DOQ-IT Project to help small physician practices adopt medical information technology. Participants submitting quality measures in that program get credit for PVRP. It's completely separate, though they do share similar measures.

Q: How does the work of the AMA's physician consortium relate to Medicare's efforts to further its pay-for-performance program?

A: The consortium is an independent organization convened in part by the AMA to develop physician-level performance measures. It has measures that are in the DOQ-IT project. They've gone through the National Quality Forum and most recently they've had a contract with CMS to produce specialty-specific measures for utilization by CMS.

Q: Is it inevitable that Medicare implement some kind of pay-for-performance program, and what should physicians be doing to prepare for this?

A: Based on the strain being faced by Medicare, Medicaid, and private payers to pay for appropriate care versus volume of care, a basic transformation will occur in nursing homes, hospitals, and all sites. Since physicians are paid independently and in places where they practice, they will be affected. Physicians that practice in hospitals are already measured.

Q: Do you have any advice for physicians?

A: Stay informed about policy discussions in your local communities and at the state and federal level. Then take what you learn and consider what the impact of those potential changes might be. For example, Medicare is considering reimbursing for episodes of care. How would they define their value—both in terms of quality and efficiency—within an episode of care, for instance, of heart failure. Look at your relationships with patients, your own group processes, your performance in a hospital and your referral patterns, and how your payments will be affected. Then you should work within organizations such as the MMA, specialty societies, and hospitals to define the quality and value that they should be reimbursed for. It will depend on physician's practice, spe-

cialty, and what part of the care continuum they are responsible for.

Q: What is Medicare's timeline for implementing pay for performance?

A: Medicare has already implemented pay for reporting on the hospital side. On the physician side, current congressional conversations are looking at pay for participation related to Medicare payment rates in 2007 or 2008. [Congress did pass a 1.5 percent bonus for some payments in December].

Q: What is the latest thinking about how physician payment rates, via the sustainable growth rate formula (SGR), should be linked to pay for performance and quality initiatives?

A: It is recognized that the current SGR formula is flawed. The current effort is to use this opportunity to fix the SGR to imple-

ment value-based payments. In other words, paying physicians for quality and efficiency.

Q: As a physician, what are your impressions of value-based competition in the health care marketplace?

A: Value-based competition is based on transparency and the idea that people can make good decisions. Involving patients, purchasers, and health professionals in changing current delivery systems to provide value and then allowing patients to make decisions based on that value will benefit all of us.

Q: Health and Human Services Secretary Michael Leavitt has stated his vision of providing tools for patients to make informed health care decisions. What tools and resources should physicians receive from the government in order to improve quality and safety of care?

A: I don't know of any tool. Physicians will need to implement systems that allow for data transmission. CMS recently has clarified how local health care entities, hospital systems, and payers can provide or subsidize technologies for physician practices. CMS can also provide opportunities for physicians to take part in and lead local efforts to define value for their patients, such as through MN Community Measurement.

Q: Is there anything else you'd like to add?

A: It's a time of uncertainty but also one of opportunity. To do this correctly, we need to focus on what has always mattered, which is taking care of people within the context of our local community. Physician focus on clinical care will be crucial to the success of these efforts to reform Medicare payments. ▀

Medicare quality pilot program planned

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES plans to start a three-year demonstration project in 2007 that will compensate physicians for the quality of care provided to Medicare beneficiaries with chronic conditions.

The three-year program will begin in 800 practices in Arkansas, California, Massachusetts, and Utah. To participate, physicians must be in a small- or medium-sized practice and provide primary care for at least 50 fee-for-service Medicare beneficiaries.

Participating physicians will submit data annually on up to 26 quality measures related to the care of patients with diabetes, congestive heart failure, and coronary artery disease, as well as preventive health services delivered to high-risk patients with a range of chronic diseases.

Medicare will still pay the physicians in the pilot on a fee-for-service basis.

During the first year, the program will be a "pay-for-reporting" initiative. It will establish baseline measures and familiarize physicians with the quality-measurement process. In subsequent years, practices can earn up to \$10,000 per physician and up to \$50,000 per practice a year based on their performance on quality measures.

CMS and the Agency for Healthcare Research and Quality will jointly fund an independent evaluation to determine the impact of the demonstration on quality of care, outcomes, and Medicare expenditures.

A complete list of the measures is available on the demonstration Web site: www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp. ▀

MINNESOTA & NATIONAL ROUNDUP

New never event: wrong egg



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THE NATIONAL QUALITY FORUM (NQF), a Washington, D.C.-based nonprofit group, recently updated its lists of safe practices and reportable adverse events to include artificial insemination with the wrong donor sperm or donor egg.

In October, the NQF announced that it had added the event to its original list of 27 adverse medical events that should never happen. Minnesota's adverse event reporting law, passed in 2003, is based on the NQF's original list.

The organization also updated its list of 30 safe practices. Most of the practices concern hospital care. But here are a few that apply to clinics:

- Ask each patient or legal surrogate to “teach back” or explain key information about proposed treatments or procedures for which he or she is asked to provide informed consent.
- For verbal or telephone orders of test results, have the person “read-back” the complete order or result.
- Every patient on long-term oral anticoagulants should be monitored by a qualified health professional using a careful strategy to ensure an appropriate intensity of supervision. ▴

Complete versions of NQF's safe practice and reportable adverse event lists can be found at www.qualityforum.org/news.

MAPS announces Patient Safety Award winners

THE MINNESOTA ALLIANCE FOR PATIENT SAFETY (MAPS) announced its 2006 Patient Safety Award winners in November. The award recipients are:

Alison Page, Fairview Health Services's chief safety officer, for her outstanding work to advance the culture of safety at Fairview.

Peggy Sietsema, R.N., associate administrator for clinical services and chief nursing officer at Rice Memorial Hospital Willmar, for her numerous accomplishments in improving patient care and safety.

Fairview Lakes Health Services for driving down the number of medication adverse health events by 31.3 percent in two years, from 40 percent in 2004 to 8.7 percent in 2006.

Park Nicollet Health Services for creating its rapid evaluation teams.



Alison Page



Peggy Sietsema

MAPS is a partnership among the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health, and more than 50 public and private health care organizations. ▴

MAPS wins Eisenberg Safety and Quality Award

MAPS NOT ONLY GAVE AWARDS, it also received the nation's most prestigious health care quality award, the 2006 John M. Eisenberg Patient Safety and Quality Award in October. MAPS received the award for improving patient safety by building partnerships and helping to pass the nationally groundbreaking Minnesota Adverse Health Care Event Reporting Act, the first U.S. law requiring hospitals to publicly disclose the occurrence of 27 kinds of adverse health events.



MMA launches quality online

MMA MEMBERS now have access to tools and resources that support clinical quality improvement at the click of a mouse. Visit the MMA's new quality Web page at www.mmaonline.net/quality/index.htm.

Wisconsin nurse faces criminal charge for medication error

IN NOVEMBER, nurse Julie Thao, 41, became the first health care worker in Wisconsin criminally charged for an unintentional error. The case has alarmed quality-improvement experts who say it is the kind of thing that could work against efforts to create a blameless culture in health care that fosters the finding and correcting of errors.

Thao's felony charge of neglect of a patient causing great bodily harm could result in her spending years in jail. Thao caused the death of a pregnant teenager at St. Mary's Hospital in Madison by mistakenly giving her an epidural anesthetic intravenously instead of penicillin.

The *Wisconsin State Journal* reported on November 3 that according to the criminal complaint, Thao "improperly removed the epidural bag from a locked storage system, which the patient's physician never ordered; didn't scan the bar code on the epidural bag, which would have told her it was the wrong drug; ignored a bright pink label on the bag that said in bold letters, 'FOR EPIDURAL ADMINISTRATION ONLY'; and disregarded hospital and nursing rules in failing to confirm a patient's 'five rights' when receiving drugs: right patient, right route, right dose, right time, and right medication."

Despite the error, about 150 supporters, mostly nurses, rallied in defense of Thao at her court appearance November 9, according to the *Wisconsin State Journal*. The president of St. Mary's also provided a written statement saying the nurse's error was not a crime and she should not have been charged. ▀



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The Wisconsin case of Julie Thao is a rare example of a nurse facing criminal charges for an unintended mistake.

IOM urges Medicare to adopt pay for performance

THE U.S. DEPARTMENT of Health and Human Services should gradually replace Medicare's current way of paying providers with a new pay-for-performance system, according to a report from the Institute of Medicine released in September, "Rewarding Provider Performance: Aligning Incentives in Medicare."

"Medicare beneficiaries are not getting the highest possible quality of care because the program's payment system encourages volume rather than efficiency and quality," said the chair of the committee that authored the report, Steven A. Schroeder, M.D., professor of health and health care at the University of California. About 88 percent of Medicare payments are fee for service.

The committee that authored the report said Congress should reduce base Medicare payments across the board and use the money to fund rewards for strong performance during a period of three to five years, according to a press release from The National Academies.

As for whether involvement in such a pay-for-performance program should be voluntary, the authors of the report said Medicare should require participation by providers with the capacity to submit performance data and give other providers time to develop such abilities.

Some physicians criticized the committee's recommendations. The committee itself acknowledged that there were fewer than 20 studies about pay for performance in health care, and those studies came to differing conclusions about the effectiveness of pay for performance. ▀

Pay for whose performance?

Minnesota clinics carve up the bonus pie in different ways.

WITH PAY-FOR-PERFORMANCE PROGRAMS EXPANDING, care providers now have the enviable task of figuring out what to do with their bonus pay.

When the St. Mary's Duluth Clinic Health System (SMDC) negotiated several pay-for-performance elements in its most recent negotiations with payer groups, its physicians' quality and compensation committees met to discuss how to use their bonus dollars.

Unanimously, they decided that instead of paying out the money to physicians and employees, they would reinvest the funds to provide improved infrastructure around the goal of improving care.

"That really comes from the philosophy of the physicians at Duluth Clinic," says John Smylie, chief administrative officer. "Their top goal is to increase quality. They see that happening through collaborative teams that have good systems and tools."

Since receiving its rewards, SMDC has used its funds to supplement initiatives such as adding nurse care coordinators at each of its 21 locations, creating a registry for all patients with chronic diseases to facilitate follow-up care, investing in improved electronic records programs and software, and adding a work station at its business service center so payers have a place to sit and do their research. "All those things lead to elevating the quality and the outcomes," Smylie says.

People or infrastructure

Although many follow the same route as SMDC, others have decided to reward doctors and other staff with the rewards they reap.

If Fairview Health Services didn't already have Epic medical records software, it probably would focus bonus payments on infrastructure, says Barry Bershaw, M.D., medical director for quality and informatics.

Instead, Fairview rewards physicians with bonus payments.

At Mount Royal Medical Center in Duluth, physicians and others who contribute to quality improvement receive pay-for-performance bonuses. John Ipsen, M.D., who sits on the board of Northstar Physicians, through which the bonuses are paid, says he doesn't know how the other clinics in the network use their bonuses, but the physicians at his clinic felt everyone should benefit from success.

"In our clinic, we doctors got together and decided if we really wanted to do better, we should pass the incentive awards on to our support staff," he says. "They are very



Photo by Jack Rendulich, SMDC Health System

The Duluth Clinic is part of SMDC Health System which chose to reinvest its bonus payments in improved infrastructure.

important in improving our adherence to the pay-for-performance guidelines."

William Davis, M.D., a family physician at Family Medicine of Winona, says his clinic also pays the dollars out to employees but through investments in their retirement plans rather than upfront.

Davis worries that changing this would have a psychological impact on the people providing the care.

"If it goes into the waiting room furniture, people don't get quite as excited," he says.

Not up to the health plans

Babette Apland, senior vice president of health and care management with HealthPartners, says clinics can use the payments for infrastructure, individual incentives, or even operating budgets.

"Our program is designed to drive systems change for quality improvement, and that is how most clinics use the money. That said, when we pay our bonuses out it's really up to the medical groups to determine what they use those funds for," she says.

Other payers do try to encourage clinics to improve systems.

"We encourage that they use the money on a systematic level," says Dan Arom, manager of provider relations and health management projects at Medica. "One of the things we talk about is the infrastructure pieces. Some clinics have used it to hire a diabetes coordinator. There's some that want individual doctor breakdowns. We believe pretty strongly that it should be a systematically based reward." ▀

By Andrew Tellijohn

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