

Building medical homes in Minnesota

Top primary care groups are constructing a new way of delivering care.

FOR JENNIFER WELSH, M.D., creating a medical home for her patients means caring for them in and out of the exam room.

For example, one of her female patients has severe mental illness, is morbidly obese, and has serious leg swelling. After each visit with this patient, Welsh calls four members of the woman's care team to update them and assign tasks.

Is making those calls really her job? She says it is.

"I am supposed to be helping my patients to function to the best of their ability, and [those calls] decrease that patient's utilization and help to keep her in her own home rather than in a group home," says Welsh, residency director at the University of Minnesota Smiley's Family Practice Clinic, which has 12 faculty physicians and 18 residents.

A medical home is a way to provide comprehensive care that is accessible, continuous, comprehensive, family- and



Photo by Steven Wewerka

Jennifer Welsh, M.D., residency director, says the University of Minnesota Smiley's Family Practice Clinic has spent about three years focusing on making the clinic a medical home.

patient-centered, coordinated, compassionate, and culturally effective. In a medical home, a team of providers works in partnership with the patient to ensure that all of the medical and nonmedical needs of the patient are addressed.

In fact, the concept is touted as the future of primary care by the American Academy of Family Practice, the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA).

In 2004, Smiley's Clinic, which is in Minneapolis, set out to become a medical home for its patients by focusing on continuity of care, installing electronic medical records, and adding services. Dozens of studies have demonstrated the effectiveness of medical homes in improving quality.

Smiley's started its project by using a \$40,000 grant to build a searchable patient registry to track its diabetic patients to prevent them from falling through the cracks. The clinic

Inside this issue

- Knowing what patients think can improve care, p. 3
- Local doctor, recently in *JAMA*, talks about patient-centered care, p. 8
- Feds, state, consider funding medical homes, p. 11



A supplement to *Minnesota Medicine*

Owner and Publisher
Minnesota Medical Association

Editor
Scott D. Smith

Manager, Quality Improvement
Rebecca Schierman

Graphic Designers
Joanna Kapke
Janna Netland Lover

Advisory Committee
Thomas J. Arneson, M.D.
Joseph L. Campanelli, M.D.
Gretchen S. Crary, M.D.
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

**MMA Quality Review is a
quarterly publication of the
Minnesota Medical Association
and is sponsored with financial
support from the MMIC Group
and the Minnesota Physicians
Foundation.**

 The MMIC Group



▶▶▶ gave nurses standing orders to check and update medication lists, give immunizations, and initiate chronic illness care by ordering needed labs.

Electronic medical records that went live in October 2005 allowed physicians to better coordinate care and prompt them to follow evidence-based practice guidelines. Now, for example, physicians must answer five questions tied to quality measures, such as how they plan to improve a patient's HbA1c score if it's above 6.9.

The strategies are working.

In 2006, 13 percent of the clinic's diabetic patients received optimum care, as defined by MN Community Measurement, compared with 2 percent in 2004, and 95 percent of its asthmatic patients had their condition documented as under control compared with 50 percent in 2004, Welsh says.

The EMR information is more complete. "I have all your immunizations and all your specialty visits, all your labs, and that makes a huge difference in being able to coordinate care," Welsh says.

Welsh also uses the EMR to consult with specialists. For example, she recently used the EMR to send a pulmonologist an abnormal chest X-ray that possibly indicated lung cancer and a CT scan that indicated a collapsed lung to determine whether a referral was necessary.

One-stop shop

This spring the clinic moved into a new facility along the Hiawatha Light Rail Line, which enabled the clinic to create a one-stop shop with services such as pharmacy, radiology, behavioral health, and pharmacy consultation. This has improved care coordination, Welsh says. For example, the clinic has a PharmD faculty member and onsite pharmacy.

"Now [the pharmacists] can walk . . .

History lesson

THE FIRST written reference to "medical home" appeared in an American Academy of Pediatrics (AAP) publication in 1967, which said a lack of a complete medical record and a "medical home" was a deterrent to the care of children with diseases or disabling conditions. In 2002, the term gained acceptance, when the AAP made it its standard of care for children with complex medical needs.



back to us in the exam room if they need to," Welsh says. "They can also spend 30 minutes talking to someone about how to [take their medication]. Most pharmacies don't have the time."

To help ensure that patients see familiar clinicians—a significant challenge for a residency clinic where residents change and faculty only see patients part time—the clinic created three teams of nurses and doctors that operate in a designated space in the clinic. If a patient can't see their doctor, staff tries to schedule them with a doctor on the same team so the nurse on that team can provide some continuity.

"A medical home should be a personal relationship with a physician who knows you and a team behind that physician who also knows you," Welsh says.

As for the future, the clinic's next step

MEDICAL HOME continued on p. 12

CORRECTION: The article "Learning from mistakes," *MMA Quality Review*, Spring 2007, incorrectly stated that one person died because of a medical device malfunction at Immanuel St. Joseph's Hospital in Mankato. Immanuel St. Joseph's did report such a medical error, however, it did not result in a patient death.

Through the patient's eyes

Minnesota providers increasingly use patient-satisfaction surveys to measure the quality of the care they provide.

BY SURVEYING surgery patients, staff at Fairview Northland Medical Center in Princeton learned patients wanted more follow-up when they leave the hospital.

Now patients get it. The medical-surgical unit supervisor calls patients at home to see whether they have questions or feedback about their stay.

The supervisor then shares that information with the unit's clinicians.

This is just one of the many changes that Fairview has made as a result of the patient surveys it conducts.

Although the surveys have been done for 18 years, the focus has shifted away from asking about such things as the tastiness of hospital food and toward discovering how well doctors explain conditions or medications, says Dick Burgeson, a quality research consultant for Fairview Health Services.

"It really goes after the communication and interaction with the caregivers much more than [the surveys of] 20 years ago," Burgeson says of the questionnaire. "A lot of people perceive it as being about the amenities—service quality—as opposed to clinical quality. I think when it [the survey] becomes more important is when we start looking at it as being part of quality of care."

Fairview now surveys patients served by its hospitals, clinics, surgery centers, and emergency departments. It also surveys patients served by its home care and hospice programs—the latter through a patient's family members.

Nearly 75 percent of providers who responded to a recent MN Community Measurement poll indicated they conduct surveys at the clinic level, and most indicated they use the information for improving the quality of care they provide, says Michelle Ferrari, project manager for the group's Robert Wood Johnson Foundation grant on Aligning Forces for Quality.

In 2006, the Mankato Clinic revamped its patient satisfaction survey program. Changes included distributing surveys in exam rooms rather than waiting areas, training employees on how to encourage patients to fill out the survey, and post-

Six ways to improve satisfaction scores

Research has shown these factors affect patient satisfaction.

Expectations—Physicians should take the time to elicit patients' expectations. Satisfaction is higher when expectations are met.

Communication—Satisfaction rates are higher when physicians listen seriously to patients' problems and explain their condition clearly.

Control—Less dominance and allowing patients to express their ideas, concerns, and expectations boosts scores.

Decision-making—Patients expressed a preference for physicians who recognized the importance of their social and mental functioning as much as their physical functioning.

Time—Longer visits and chatting improve satisfaction rates.

Appearance—Patients like "semiformal" attire and a smile. They like to hear a formal title and see a name badge. They're less comfortable with facial piercings, short tops, or earrings on men. They prefer being called by their first name.

Source: Thiedke CC, What do we really know about patient satisfaction? Family Practice Management. January 2007;14(1):33.

ing signs as part of the "Our Services. Your Voice" marketing campaign. It also rewarded departments with high scores and high survey-return rates.

The efforts paid off immediately, as the clinic identified several areas in which it could improve its service, including shortening patient wait times and communicating test results more quickly. To reduce the amount of time patients waited >>>

▶▶▶ for primary care openings, clinic staff created a new central scheduling program that gives patients the choice of getting an appointment at one of eight primary care departments in four nearby communities.

“As a service organization, it’s imperative that we understand what the consumer wants and how they want it delivered,” says Bryan Nermoe, the clinic’s chief operating officer. “Our survey process provides us with some of that information.”

Mayo Clinic collects some 55,000 surveys annually and finds the results worthwhile for both marketing and quality-improvement reasons.

An outside firm, Omaha-based Professional Research Consultants Inc., conducts the surveys over the phone using a combination of generic questions and questions specific to Mayo. Once the results are tabulated, they are made available to Mayo employees.

Laurie Wilshusen, a director of marketing at Mayo’s Scottsdale, Arizona, facility, is in charge of analyzing the survey data. She spends hours helping physicians, nurses, and administrators interpret the data.

Wilshusen says surveys pay off from a marketing perspective. Based on Mayo’s internal studies, a dissatisfied patient tells 13 others about their experience, while a satisfied patient tells 46 people. She says if every patient admitted to Mayo had a positive experience, it would translate to about 23 million favorable mentions.

“It would cost an awful lot of money to advertise to 23 million people,” she says. “So it’s incredibly worth it for us to keep our patients happy.”

The surveys also point out ways to improve care and provide a feedback loop that can identify problems.

“When there is anything remotely remiss we have to find out what is going on, and we have to fix it. People really jump on the results,” Wilshusen says.

For example, in early 2007, a surgical department was seeing low marks for communication with patients who doctors determined could not be helped with surgery.

In response, Mayo created a team of nurses, doctors, and administrators to develop a method for communicating that surgery was not recommended, while also informing them about other options for coping with their condition.

Wilshusen says departments aren’t penalized, but the clinic does use the surveys to try to improve group performance.

“We don’t come down on groups who are not performing,” she says. “We want to help them.” ▴

By Andrew Tellijohn

MMA Quality Review Correspondent

National patient satisfaction survey available

Experts say this survey is likely to be part of your future.



© istockphoto.com/jmphoto

A PROMINENT NATIONAL quality organization has developed a patient satisfaction survey experts say will become the standard for comparing doctors and medical groups.

The Agency for Healthcare Research and Quality (AHRQ) put the survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey, on its website (www.cahps.ahrq.gov/default.asp) in May.

The survey and the information needed to administer it are free.

Experts say that physicians should consider using the CAHPS survey in anticipation of its likely acceptance by health plans, certifying bodies, and Medicare.

Medicare has not gone on record as saying it will eventually link payment to patient-satisfaction reporting, “But, in my opinion, it’s just a matter of time until that happens,” says Dale Shaller, a health care consultant in Stillwater and managing director of the national CAHPS benchmarking database. Shaller is also part of the Harvard and Yale universities research team that helped develop the survey.

Currently, hospitals that do not submit patient-satisfaction measures do not receive an annual pay increase from Medicare.

In Minnesota, the MN Community Measurement proj-

ect already intends to use it to collect patient-satisfaction data in the next few years.

Health plans, many of which already collect this information, are also likely to embrace the CAHPS survey as it will produce scores that can be compared with regional and national benchmarks, he says.

Finally, the American Board of Medical Specialties, an umbrella group for 24 specialty organizations, is looking at building patient survey components into their certification processes.

For example, the American Board of Internal Medicine has a module in which physicians survey patients with a revised CAHPS survey and analyze the information. ▀

How CAHPS works

THE SURVEY is mailed to patients or conducted over the phone after a visit. Experts say surveys conducted at the doctor's office provide less reliable data. The survey measures the physician's ability to explain concepts, listen, and respect the patient. It also measures wait times and the amount of time the physician spends with patients. At least 45 completed surveys are needed to assess a doctor. As a rule, a sample of 113 is needed to generate 45 completed surveys. The estimated cost per

CAHPS Clinician & Group Survey

13. Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this doctor within 15 minutes of your appointment time?

- 1 Never
- 2 Almost Never
- 3 Sometimes
- 4 Usually
- 5 Almost Always
- 6 Always

completed mail survey is \$8.

To get the CAHPS materials, visit www.cahps.ahrq.gov/default.asp

Project could spark revolution in depression care

MORE THAN 20 Minnesota provider groups and the state's largest health plans will participate in a three-year project to identify a best-practice model for treating depression and a way to pay for the care.

The project, coordinated by the Institute for Clinical Systems Improvement (ICSI), is called Depression Improvement Across Minnesota Offering a New Direction (DIAMOND).

Starting in the first quarter of 2008, provider groups will treat patients with depression using the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model. This treatment strategy was pioneered by Jürgen Unützer, M.D., a psychiatrist and professor at the University of Washington School of Medicine.

The model uses a personalized team

approach in the primary care setting. A depression care specialist (usually a nurse or psychologist) works closely with the patient's primary care doctor to treat the patient's depression with medication, psychotherapy, and frequent follow-up and tracking.

The model was twice as effective as usual care in reducing depression when it was tested in 18 primary care clinics, according to a 2002 article in *The Journal of the American Medical Association*, "Collaborative Care Management of Late-Life Depression in the Primary Care Setting: a Randomized Controlled Trial."

Nancy Jaeckels, director of education and resources for the Institute for Clinical Systems Improvement (ICSI), says providers throughout the country have imple-

mented IMPACT, but this pilot project is the first to involve payers and include a reimbursement strategy.

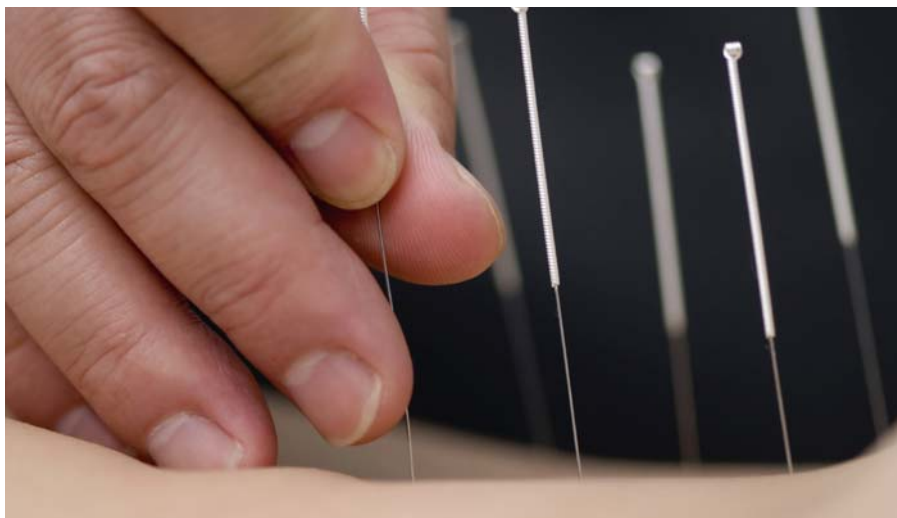
The state's six largest health plans and the Minnesota Department of Human Services have agreed to create systems for reimbursing the care manager and pay for the extra services offered in the model. The DIAMOND project will last about three years, which is enough time to implement the program and evaluate its effectiveness. The HealthPartners Research Foundation is seeking funds from the National Institutes of Health to study the results.

"This is completely unique compared with anything in the country, and it could result in a new payment system and care design for treating depression in Minnesota," Jaeckels says. ▀

NEWS

YOU CAN USE

Patients and alternative therapies



© istockphoto.com/zillil

Asking about use of alternative therapies can improve patient satisfaction.

Issue: Can asking Asian-American patients about their use of traditional therapies increase trust?

Research says: Asian-American patients report greater satisfaction when asked about their use of and preference for traditional therapies (for example herbal medicine, acupuncture, and tai chi). Patients were more likely to perceive an exam as being thorough, have more confidence and trust in the doctor, feel as if they were treated with courtesy and respect, and recommend a medical facility to a family member or friend if they were asked about alternative therapies.

Fast fact: Two-thirds of survey respondents reported using some form of alternative therapy; fewer than 8 percent discuss these therapies with their care providers.

Put it into practice: Ask patients about their practices and preferences regarding traditional medicines. Discussions should be nonjudgmental so patients don't feel criticized. ▴

Source: Ahn AC, Ngo-Metzger Q, Legedza ATR, et al. Complementary and alternative medical therapy use among Chinese and Vietnamese Americans. *Am J Public Health*. 2006; 96(4):647-53.

Tips to try

Help patients be active consumers

Patients can improve their outcomes by taking an active role in their medical appointments and health care decisions.

The Agency for Healthcare Research and Quality's "Be Prepared for Medical Appointments" list walks a patient through questions about medications, medical tests, and diagnoses. The list is available at www.ahrq.gov/qual/beprepared.pdf.

Ask Me 3

The Partnership for Clear Health Communication launched Ask Me 3 to help ensure patients always understand the answers to the following questions:

- 1) What is my main problem?
- 2) What do I need to do?
- 3) Why is it important for me to do this?

For more information, go to www.askme3.org.



Deciphering MedSpeak

An online tool, developed by the Medical Library Association helps doctors and patients translate medical terms. For example:

ZYGOMATIC - the cheekbones

www.mlanet.org/resources/med-speak/

Patients need more than numbers

Issue: Are programs that encourage patients to “know their numbers” (for example, HbA1c or lipid profiles) effective?

Research says: Patients who are engaged in their care have better health outcomes. However, simply knowing current and target HbA1c levels is not enough to produce greater understanding of how to better manage diabetes.

Fast fact: More than two-thirds of

diabetic patients surveyed did not know their most recent HbA1c value. Latino respondents were less than half as likely to know their numbers as patients from other ethnic groups.

Put it into practice:

Providers can encourage patients to record and track their HbA1c scores but should also discuss with them the meaning of those numbers. ▴

Source: Heisler M, Piette JD, Spencer M, Kieffer E, Vlian S. *Diabetes Care*. 2005;28:816–22.

Glossary



© istockphoto.com/teendpack

Patient activation—Building the knowledge, skills, beliefs, and behaviors that a patient needs to manage a chronic illness. Activated patients are able to manage their own symptoms and problems, maintain function, and slow declines in their health. They are involved in their treatment and treatment decisions. And they collaborate with providers and select those providers and provider organizations based on performance or quality.

Source: Hibbard J, et al. Does increasing patient activation result in improved self-management behaviors? A further validation of the patient activation measure (PAM). *Health Services Research*, 2005;40(6p1):1918-30.

© istockphoto.com/PeterJubst



Patients need doctors to help them understand blood sugar scores.

Chronic care model gets results

Issue: Does providing chronic care coordination improve outcomes?

Research says: The chronic care model incorporates decision-support tools such as patient tracking systems, care teams, disease-management programs, and support for patient self-management.

The more elements of the model physicians incorporate, the more significant the decrease in patient HbA1c scores and lipid values.

Fast fact: For every element of the chronic care model used in clinical practice, there was a corresponding reduction in HbA1c and lipid ratios.

Put it into practice: Even small practices can implement elements of the model by using diabetes patient tracking systems and registries, instituting patient reminders, setting goals with patients, and educating them about their condition. ▴

Source: Nutting PA, Dickinson WP, Dickinson LM, Nelson CC, King DK, Crabtree BF, Glasgow RE. Use of Chronic care model elements is associated with higher-quality care for diabetes. *Ann Fam Med*. 2007;5:14-20.

Q&A

Putting patients at the center



Photo courtesy Allina Hospitals and Clinics

Steven C. Bergeson, M.D.

Steven C. Bergeson, M.D., medical director for quality for Allina Hospitals and Clinics, was the lead author of “A Systems Approach to Patient-Centered Care,” which appeared in the December 20, 2006, issue of *The Journal of the American Medical Association*. Bergeson believes we need a patient-centered health care system that encourages continuity, addresses patient concerns, supports their efforts to stay healthy, and improves information flow between specialties.

Q: What is patient-centered care?

A: The Institute of Medicine’s 2001 report “Crossing the Quality Chasm” defined it as not only being courteous, communicating well, and respecting patients’ values but also coordinating and integrating care across boundaries of specialties and facilities, being upfront with them about possible side effects of a medication, and letting them know who to call if they have a problem.

Q: How did we get away from this idea in the first place?

A: Our system of care does not support long-term relationships. Only 37 percent of physicians in the United States have five-year relationships with patients, compared with 63 percent in the United Kingdom. That’s a huge difference, especially when continuity of care predicts so many good things.

Q: A Commonwealth Fund study found that only 22 percent of physicians practice patient-centered care. What do you think about that?

A: It isn’t a product of intent. Clinicians are working extremely hard. Part of what makes delivering patient-centered care difficult is how care is paid for and part is how we’ve designed visits. Many things are being looked at to improve that, such as thinking of doctor visits in broader terms and allowing visits to happen over the phone or by e-mail.

Q: How does Minnesota compare with other states in terms of providing patient-centered care?

A: There is no good comparative data yet. However, Minnesota has strong primary care, excellent outcomes of care, and lower costs, according to the Dartmouth Atlas, and many feel these are related to patient-centered care.

Q: For the patient, what makes care patient-centered?

A: A Massachusetts study found two factors that predict patient satisfaction. One was the doctor’s knowledge of them as a whole person; the other was trust. Patients who said

their doctor was in the 95th percentile on whole-person knowledge were 2.6 times more likely to take their medicine as directed than doctors in the 5th percentile.

Q: What are your suggestions for a clinic or hospital that wants to provide patient-centered care?

A: Allina's experimenting with a lot of things. One idea is informing patients of treatments they should be receiving to make sure nothing falls through the cracks. For example, giving parents an immunization list or giving patients or caregivers lists of medications. Clinics can also provide patients with ways they can easily contact the practice and when they should do so. Continuity of information between providers and settings is also really important. The whole transition from the hospital to home is a pretty big cliff

patients jump off when they leave the hospital.

Q: Are there characteristics of a patient-centered clinic?

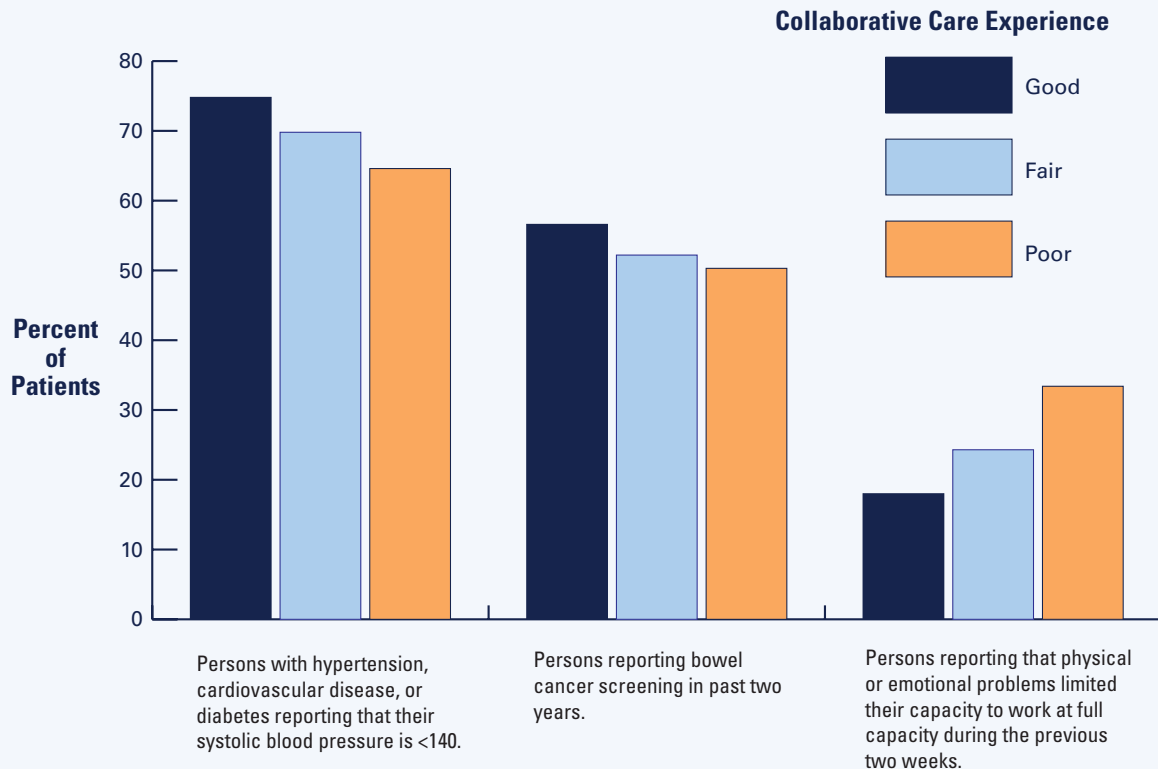
A: One is this whole idea of seeing the same clinician over time. If they see the same doctor over time, not only are patients happier, but they get better care for their chronic illnesses. They are more likely to be screened with a colonoscopy or a mammogram. Clinicians are also more satisfied when they see their own patients.

Q: What is something physicians could do better?

A: A lot of patients leave an exam without getting their questions answered. How can we design the visit to actually ensure their participation? It might be as simple as helping them make a list of concerns. ▲

Collaborating with patients results in better outcomes

Collaborative care happens when health care providers and patients work together to manage a disease. Dartmouth Medical School researchers conducted an Internet survey of about 25,000 people in the United States with chronic disease between 2003 and 2005. Respondents categorized their care as good, fair, or poor based on whether they had received useful information from their providers and whether they felt confident in their ability to manage their disease. Only 21 percent of respondents experienced good collaborative care.



Source: Wasson, J.H. et al., "Patients report positive impacts of collaborative care," Journal of Ambulatory Care Management, July-Sept. 2006 29(3): 199-206.

MINNESOTA & NATIONAL ROUNDUP

MMA Board adopts pay-for-performance principles

THE MMA BOARD OF TRUSTEES approved a set of principles that they say should be the basis for pay-for-performance programs. “We recognize that there are differences of opinion as to the value and efficacy of pay for performance,” says David Luehr, M.D., chair of the MMA’s Quality Committee. “What we’ve provided is a tool that can be used to help ensure that pay-for-performance programs are applied ethically and in a way that will benefit patients.”

To view the detailed document, visit featured links at www.mmaonline.net ▀

The MMA’s Principles

Pay for performance programs should:

- Drive improvements in health care quality and the systems in which quality care is delivered;
- Promote and strengthen the partnership between patients and physicians;
- Support and facilitate broad participation and minimize barriers to participation;
- Be credible, reliable, transparent, scientifically valid, administratively streamlined, and useful to patients and physicians; and
- Reward those physicians and clinics that
 - a) show measurable improvements to the process of providing quality care, b) show measurable improvements in patients’ clinical outcomes, c) meet or exceed stated clinical goals, d) make efforts to improve the systems in which they practice, or e) work to successfully coordinate patients’ care among providers.

Turning anger into action

MORE AND MORE patients or families of patients who have suffered devastating medical errors are creating patient-safety organizations, according to a *May Wall Street Journal* article.

For example, Sorrel King, whose 18-month-old daughter Josie died after a series of mistakes at Johns Hopkins Children’s Center in Baltimore, started a website where patients can share medical error experiences. King also used settlement money to fund a safety program at Johns Hopkins and to start the Josie King Foundation, which funds safety initiatives at other hospitals, according to the May 30 edition of the paper.

The foundation funded a pilot project at the University of Pittsburgh Medical Center called “Condition Help,” a hotline families can use to summon a rapid response team when they believe something is amiss. Since July 2005, patients called 62 times, and data suggest that 69 percent of those incidents otherwise could have led to potentially harmful situations. ▀



Eighteen-month-old Josie King died after a nurse mistakenly injected her with methadone.

Patient-safety groups launched by victims of medical errors

The Josie King Foundation
(www.josieking.org)

Consumers Advancing Patient Safety
(www.patientsafety.org)

Persons United Limiting Substandards and Errors in Health Care
(www.pulseamerica.org)

Medically Induced Trauma Support Services
(www.MITSS.org)

Medical home project saves \$120 million

NORTH CAROLINA'S medical home program for Medicaid beneficiaries has gained the atten-

tion of national policymakers because it has saved money and improved outcomes.

The central philosophy of the program, Community Care of North Carolina, is to develop local networks of primary care providers to coordinate preventive care.

The program, started in 1998, includes about 740,000 Medicaid recipients.

Among its goals is keeping patients with diabetes and asthma out of the hospital through preventive care.

North Carolina saved \$60 million in Medicaid costs in 2003 and about \$120 million in 2004 as a result of the program, according to Mercer Human Resources Consulting Group.

For more information, visit www.communitycarenc.com. ▀



Photo illustration by Joanna Kapke

Lawmakers pass quality initiatives

THIS MAY MINNESOTA LEGISLATORS approved money for payment reform, health information technology grants, and medical home pilot projects.

Pay for performance

The Legislature approved an expansion of Gov. Tim Pawlenty's Quality Care and Rewarding Excellence (QCare) program.

It approved \$679,000 for bonus payments to physicians and medical groups in 2008-09 who provide optimal care for patients in state health programs with diabetes or heart disease, says Vicki Kunerth, director of performance measurement and quality improvement for the Minnesota Human Services Department. The QCare program previously only included diabetics.

The bonus for an individual physician with a patient covered through a fee-for-service plan is \$125 up to twice a year if the patient meets certain benchmarks, including control of blood sugar and blood pressure and aspirin use.

"What this does is measure performance not on the service provided but on the actual results for the patient," Kunerth says.

However, about 70 percent of enrollees in state programs are covered by

managed care plans. The bonuses tied to these patients will go to medical groups or clinics where a certain percentage of all patients meet optimal care measures. The managed care rewards come through the Bridges to Excellence program.

Rewarding healthy patients

Kunerth also says she is excited because the department will partner with MN Community Measurement to compare data on patients on public programs with that on privately insured patients. She expects those numbers to be available in 2008. The department also received the go-ahead to reward patients for meeting wellness goals. It plans to implement that reward program in 2008.

Going paperless

The recently passed state budget includes \$14 million to help health care providers upgrade to electronic medical records. Scott Leitz, assistant commissioner of health, says about half the money will be used for grants and the rest for setting up a revolving loan fund. The health department expects to publicize guidelines for the program later this summer. ▀

State to test medical homes

IN MAY the Minnesota Legislature jumped on the medical home bandwagon by funding four initiatives related to medical homes.

1. A provider-directed care coordination pilot program for Medical Assistance patients with serious conditions. Primary care clinics will serve as medical homes for these and receive an average payment of \$50 per month per patient for being a medical home.
2. Approved \$1.76 million to fund four
3. Approved \$1 million to expand the Medical Home Learning Collaborative, initiated by the American Academy of Pediatrics and others, to provide a medical home for children with special needs.
4. Payment reform that would reward preventive, cost-effective, and evi-

pilot projects to coordinate care for children and adults with complex health care needs. Two of the projects must focus on children with autism.



Rep. Thomas Huntley, DFL-Duluth, was so impressed with St. Mary's Duluth Clinic Heart Center's Heart Failure Program that he successfully pushed for the state to fund medical home pilot projects.

Photo by Janna Netland Lover

dence-based care. The commissioner of health must produce a proposal for such reform by December of this year. ▀

A specialized medical home

This heart failure program's medical home approach gets results.

SINCE 1999, St. Mary's Duluth Clinic Heart Center, part of the the SMDC Health System, has had a medical home program for heart-failure patients in which a team of care providers focuses on knowing a patient's case and coordinating his or her care to prevent hospitalizations.

It has helped patients such as Gary Fenice, 52, of Moose Lake, who was told last summer that if he didn't change his lifestyle, he'd likely die of congestive heart failure. Fenice was 50 pounds overweight and a lover of cigarettes, prime rib, crab, and Scotch.

Providers gave him a telemonitoring scale and told him who he could call with questions. Each day, he weighs himself and answers questions about his symptoms, such as shortness of breath. If he displays troubling symptoms, a nurse calls him. With the team's help, Fenice lost more than 20 pounds, improved his diet, cut down on his smoking, and stayed out of the hospital.

Patients such as Fenice aren't the only ones seeing results. Ninety-eight percent of the program's heart failure patients undergo guideline-directed therapy that has resulted in a 3 percent six-month readmission rate compared with the national average of between 30 percent and 50 percent, says Linda Wick, R.N.,



Nurse practitioner Linda Wick checks Timothy Juhl's blood pressure during a routine Heart Failure Program check up at the St. Mary's Duluth Clinic Heart Center.

Photo courtesy SMDC Health System, Jim Formis

C.N.P., a nurse practitioner and manager of the Heart Failure Program.

"The program itself ... yes, it definitely makes a difference," Fenice says. "They're pretty passionate about what they do—they scared the hell out of me is what they did." ▀

MEDICAL HOME continued from p. 2

is to help patients take charge of their own health. The clinic will focus on incorporating techniques designed to engage patients in their health care, such as motivational interviewing.

"We want each visit with the patient to be focused on 'How are you going to help yourself?'" she says.

Harder to finance than a real home

A LACK of reimbursement for coordinating care is the top barrier to providing medical homes, providers say. For example, Medicare would pay about \$7,000 for a heart failure patient's hospital stay but wouldn't cover the \$75 cost of renting a weight-monitoring scale that could prevent hospitalization. National specialty societies are urging Congress to adopt a Medicare physician payment system that reimburses doctors for managing diseases and coordinating care. In 2006, the CMS made a move in this direction by picking eight health care organizations to run three-year medical home pilot programs in different states.

A home for children

Minnesota Children with Special Health Needs is a Minnesota Department of Health program that has helped about 20 pediatric clinics create medical home teams composed of a physician, staff member, and parents who work together to coordinate care for children with special health needs. The program started in March 2004 to help coordinate care for children with complex medical conditions, according to John Hurley, manager of the Minnesota Children with Special Health Needs Program.

Hurley's staff review a clinic's practices to see if they support or impede patient-centered relationships. They convene meetings among staff from various clinics three times a year to discuss topics such as communication among providers. They also share best practices for children with conditions such as autism and diabetes.

All the practices taking part in the program have enrolled patients in a registry of children with special needs and created care plans for those kids.

"It sounds pretty basic," Hurley concedes. "Yet it is something that wasn't there before." ▀

By Andrew Tellijohn

MMA Quality Review Correspondent