

MMA QUALITY REVIEW

Physicians in pursuit of excellence

2007 quality scores stall

Physicians wonder, is this as good as we get?

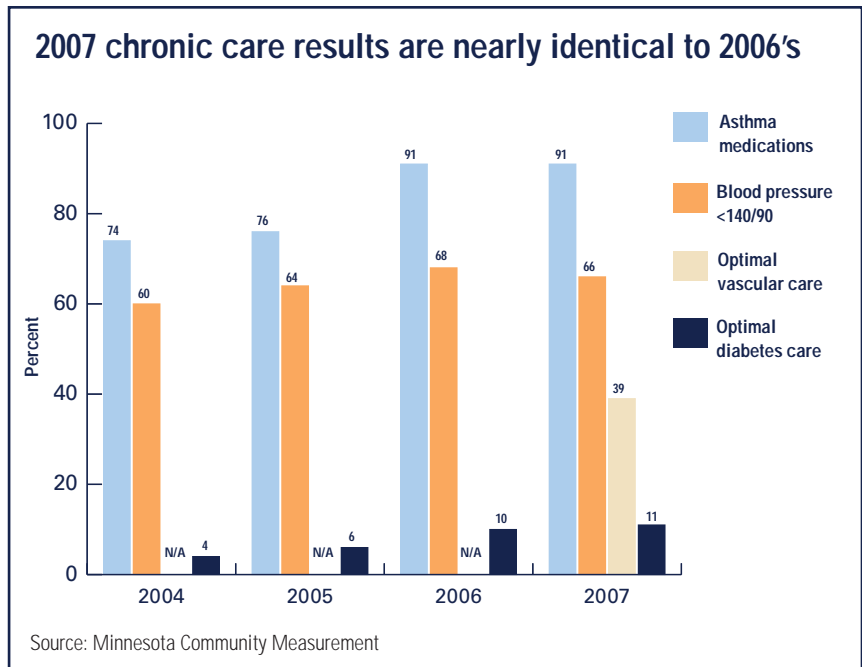
FOR THE FIRST TIME IN FOUR YEARS, Minnesota physicians failed to meaningfully improve their average scores on the state's most important quality report card from MN Community Measurement.

Although some individual clinics improved their scores, the overall lack of improvement caused physicians and quality experts to wonder if the community measurement performance plateau was a ceiling or just a base camp for a further ascent.

Most quality experts believe the lackluster results are temporary and that scores will climb in the future. But they also say the results show Minnesota needs to do a better job of adopting best practices, motivating patients to properly manage their diseases, and paying for quality outcomes.

Getting better gets harder

"Lots of groups have done the easy things to improve quality," says Nancy



Jarvis, M.D., medical director of Informatics at Park Nicollet Health Services. "Now we're starting to do harder things. Those take time." Physicians and quality experts explain the results as being a lull that may be caused by physicians lacking the resources to make beneficial changes, newly participating clinics dragging

scores down, and in some cases, the scores appearing unreliable.

Beth Averbeck, M.D., associate medical director for care improvement at HealthPartners Medical Group, says plateaus are a natural part of quality improvement. "You go through cycles of change. You make a change. Time passes. You measure the results of that

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change. Then you design the next level.”

Others suggested that because about 15 percent of the 128 clinics in the project participated for the first time, they didn't have time to make improvements.

Low scores can also be blamed on data flaws in a few instances, according to David Luehr, M.D., a Cloquet family physician who chairs the MMA Quality Committee.

“Sample sizes for some clinics are still inadequate to accurately reflect the improvement that's actually occurred,” Luehr says. He cites the network his own clinic belongs to, Northstar Physicians, headquartered in Duluth, as an example. According to MN Community Measurement, Northstar only provided optimal care to 1 percent of its diabetic patients. But that score was based on only a handful of patients. The clinic's internal analysis shows a 23 percent rate of optimal diabetes care, according to Bruce Penner, director of Northstar's clinic operations. “Our analysis uses a much larger sample that is statistically credible.”

MN Community Measurement has been striving to improve its methods. Patient data used to be collected only from health plan records. Now some groups can submit their data via links to their electronic health records (EHRs). “Direct data submission greatly increases the sample size,” which gives clinics more confidence in the scores, says Jim Chase, executive director of MN Community Measurement. Penner and Luehr agree that direct submission is the way to go, but Northstar and others don't have the resources to do it, since it is a labor intensive process, Penner says.

Spread too thin

Physician resistance to quality goals is probably not the reason some clinics score low, experts say. “Most physicians agree setting these goals is something we need to do,” says Chase. “We may quibble over specific parameters in the goals, but the discussion isn't should we be doing this,

“Lots of groups have done the easy things to improve quality ... Now we're starting to do harder things. Those take time.”

Nancy Jarvis, M.D.,
medical director of informatics at
Park Nicollet Health Services

but how should we be doing this.”

Instead, some groups simply may not have the time, resources, or organizational willpower to make changes, according to Chase. “They're faced with so many other challenges in their practice. They're just struggling to keep up with the day-to-day of practicing medicine.”

Another possibility is that some clinics may be spreading themselves too thin with regard to quality improvement efforts to achieve significant results in any one area, according to Jarvis. “Improving quality is a time-consuming process that requires changing many things at once,” she says. “Sometimes our efforts get diluted. No one is going to improve everything every year.”

Recipe for improvement

Quality experts agree the ingredients for success include motivating physicians to practice evidence-based medicine, motivating patients to take care of themselves, and changing the reimbursement structure.

Neighborhood Health Care Network's (NHCN) community clinics in the Twin Cities have invested greatly in motivating patients. That investment has paid off in a diabetes care score that jumped from 1 percent in 2005 to 19 percent in 2007, a jump that defies the assertion that clinics serving low-income populations can't make rapid improvement (see story on p. 8).

HealthPartners uses disease-management specialists who periodically call patients who are having a particularly hard time managing their chronic condition. They're piloting scheduled telephone visits with patients as an alternative to office visits for managing their chronic conditions.

Clinics are also using health educators to increase patient motivation. At Park Nicollet, diabetes educators improved outcomes so dramatically, the organization found a way to continue them after funding for the pilot program was gone. Fairview is piloting a grant-funded initiative to fully cover salaries for nutrition, pharmacy, and diabetes educators, according to Barry Bershaw, M.D., medical director for quality at Fairview Health Services. "We hope to show that reimbursing these services saves health care dollars so that health plans will start adequately reimbursing them."

Motivating physicians

Pay for performance combined with EHRs has helped quality scores rise at HealthPartners and Fairview Health Services. Fairview's diabetes scores jumped from 9 percent in 2005 to 20 percent in 2007. "Physicians practice medicine the way they are paid to practice medicine," Bershaw says. "Pay for performance attempts to shift practice style from 'see more patients' to 'improve outcomes.'"

Since insurers usually pay for office visits, not outcomes, Fairview set up a pool of money to reward primary care physicians who meet outcome goals. Bonuses are given to every physician in a department, not just the individuals who met goals. "Peer pressure and collaboration on best practices is at work here," Bershaw says. "When we apply pay for performance to a chronic condition, quality always improves."

Park Nicollet, Fairview, HealthPartners and others use EHRs to provide physicians with decision support such as computer prompts tied to practice guidelines for a particular condition. Screen pop-ups show when a patient is due for a test and remind physi-

cians what to ask, check for, or schedule.

Reimbursement changes are needed

All clinics, no matter how much they've improved quality, face the same reimbursement barrier, sources say.

For maximum improvement to occur, clinics must be reimbursed for doing the things that increase quality. "It's the tyranny of the office visit," Jarvis says. "We get paid for seeing patients in the office, not for outcomes. We need to reimburse what improves quality."

Physicians are overwhelmed with an extraordinary number of daily tasks and may not have the time to fully manage a patient's disease.

Many clinics with improving scores have learned to delegate patient management. "There are not enough hours in the day for physicians to do it all," Jarvis

says. So some clinics are learning to delegate patient management.

"A nurse can order a mammogram. Case managers can schedule a test or appointment. Use the skills your allied professionals have." The problem is getting reimbursed for this team approach to medicine. Jarvis calls the reimbursement structure "a huge barrier to quality."

As it stands now, reimbursement rewards a factory-like piecemeal approach to practicing medicine, according to Bershaw. "Seeing lots of patients makes you more money than putting in the extra time needed to provide high-quality care," he says. But payment issues aren't an excuse for not trying. This 2007 plateau, as Chase says, "is a message that we have to redesign how chronic care is treated and paid for." ▀

Electronic health records— nice but not necessary

IT'S TRUE that the better-performing clinics tend to use electronic health records (EHRs) that build patient registries, prompt providers, and track quality improvements. But EHRs are not a prerequisite for improving quality. Dakota Clinic, based in Fargo and serving northwestern Minnesota, increased its diabetes scores from 1 percent to 8 percent of patients receiving optimal care in two years—without electronic records.

Nurses and educators do monthly paper audits by pulling charts, according to Jane Skalsky, Dakota's quality improvement manager. Individual physician results are shared internally with administrators, physicians, and nurses. This results in friendly competition among their approximately 100 primary care physicians in 21 clinics, Skalsky says.

"We identify those physicians

whose patients routinely meet the five diabetes measures, find out how they're doing it, and share that networkwide." Several of Dakota's clinics say sending out patient reminders about tests and proper condition management helps patients buy into the process. ▀



Top performers

Medical groups with the five highest percentage scores in MN Community Measurement categories

The MMA Quality Review provides this list with the caveat that rankings based on MN Community Measurement data scores are far from ironclad because the margin of error for each clinic's score might be greater than the performance difference between it and another clinic. However, the Quality Review still thinks it's worthwhile to give a nod to those groups that scored at the top of the charts in 2007.

Combined cancer screening

The percentage of adults ages 50 to 80 years who received appropriate cancer screening services (breast, cervical, colorectal). A patient must be up-to-date for all three components to be considered up-to-date for this measure.

HealthPartners Central Minnesota Clinics **69%**
Park Nicollet Health Services **65%**
Camden Physicians **64%**
HealthPartners Medical Group **61%**
Hennepin Faculty Associates **60%**
Statewide average 54%



Treatment for colds

The percentage of children, ages three months to 18 years, who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode date.

St. Paul Family Medical Center **100%**
Grand Itasca Clinic **97%**

Gundersen Clinic **96%**
University of Minnesota Physicians **95%**
Neighborhood Health Care Network **95%**
Statewide average 84%

Diabetes composite

The percentage of patients with diabetes (type 1 and type 2), ages 18 to 75 years, who reached all of the following five treatment goals to reduce the risk of cardiovascular diseases: hemoglobin A1c (HbA1c) level less than 7%; blood pressure less than 130/80 mmHg; LDL-C control less than 100 mg/dL; daily aspirin use for diabetes patients ages 41 to 75, and being documented as tobacco-free in medical record.



Fairview Health Services **20%**
Neighborhood Health Care Network **19%**
Park Nicollet Health Services **17%**
Family HealthServices Minnesota **15%**
HealthPartners Medical Group **14%**
Statewide average 13.5%

Blood pressure management

The percentage of patients, ages 18 to 85, with a diagnosis of hypertension whose blood pressure was less than 140/90.

Mayo Clinic **84%**
Altru Health System **82%**
Winona Clinic **80%**
Quello Clinic, **76%**

Fairview Health Services **74%**
 Park Nicollet Health Services **74%**
 Statewide average **66%**

Vascular composite

The percentage of patients ages 18 to 75 who have vascular disease and reached all of the following four treatment goals to reduce risk of cardiovascular diseases: blood pressure less than 140/90 mmHg (if the patient also has diabetes, BP must be <130/80); LDL-C less than 100 mg/dL; daily aspirin use; and being documented as tobacco free in medical record.

Quello Clinic, LTD **61%**
 HealthPartners Medical Group **53%**
 St. Paul Heart Clinic, **52%**
 Metropolitan Cardiology Consultants **50%**
 Fairview Health Services **49%**
 Statewide average **39%**



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Childhood immunizations

The percentage of children two years of age who had the following vaccines by their second birthday: four DTaP/DT, three IPV, one MMR, three H influenza type B, three Hepatitis B, one VZV and four pneumococcal conjugate.

Stillwater Medical Group **91%**
 Aspen Medical Group **91%**
 Park Nicollet Health Services **88%**
 Mankato Clinic, LTD **88%**
 CentraCare Health System **87%**
 HealthPartners Medical Group **87%**
 Statewide average **76%**

Asthma

The percentage of patients ages 5 to 56 identified as having persistent asthma who were appropriately prescribed medication.

Edina Family Physicians, **100%**
 Children's Physician Network **98%**
 St. Cloud Medical Group, PA **97%**
 Alexandria Clinic, P.A. **97%**
 Family Medical Center, PA **97%**
 Gundersen Clinic **97%**
 Statewide average **92%**



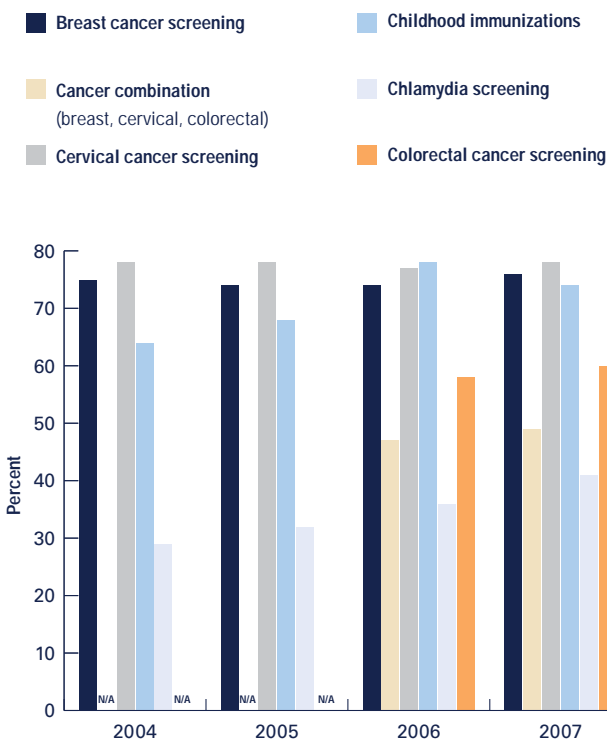
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Sore throats

The percentage of children ages 2 to 18 who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode.

MinuteClinic **99%**
 Parkview Medical Clinic **99%**
 HealthPartners Medical Group **97%**
 Family Practice Medical Center of Willmar, **97%**
 Gundersen Clinic **97%**
 Maple Grove Urgent Care **97%**
 Statewide average **81%**

Results for preventive care measures



Source: Minnesota Community Measurement

NEWS

YOU CAN USE

Improve diabetes care by treating depression



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Depression treatment is often a missing piece of diabetes treatment.

Issue: Improving diabetes care.

Research says:

Harvard researchers surveyed 879 diabetic patients in Massachusetts and found that about 20 percent of patients suffered from major depression and about two-thirds reported some depressive symptoms. The researchers

found that major depression is significantly associated with poorer diabetes self-care, which includes adhering to a healthy diet, spacing carbohydrates, exercising, monitoring glucose lev-

els, and taking medications. Even mild depression can be associated with poorer adherence to diet, exercise, and medication.

Fast fact: Less than 60 percent of the patients identified by the study as suffering major depression had the disease noted in their chart.

Put it in practice: Treatments and therapies to address depressive symptoms could improve diabetes self-care significantly. Physicians should screen for depression and recognize the impact that milder symptoms of depression can have on diabetes self-care. ▴

Source: Gonzalez, JS. Depression, self-care, and medication adherence in type 2 diabetes: relationships across the full range of symptom severity. *Diabetes Care*. 2007;30:2222-7.

Prevent bloodstream infections

Issue: More than half of the catheter-related bloodstream infections (CR-BSIs) that affect more than 200,000 patients per year may be preventable.

Research says: Mayo Clinic researchers surveyed 516 private and Veterans Administration (VA) hospitals and found that fewer than half of the private hospitals were using a widely accepted approach to preventing catheter-related bloodstream infection, which includes maximal sterile barrier precautions, chlorhexidine gluconate, and avoidance of routine central line changes.

Fast fact: Health care-associated infections affect more than 2 million hospitalized patients annually and cost the U.S. more than \$6 billion in excess charges.

Put it in practice: To improve adoption of key CR-BSI prevention practices, hospitals can begin by fostering a culture of safety, encouraging infection control professional



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Visit the 5 Million Lives campaign at www.ihl.org/IHI/Programs/Campaign/CentralLineInfection.htm to get information about preventing bloodstream infections.

certification, and participating in an infection-prevention collaborative such as the National Nosocomial Infections Surveillance System or the Institute for Healthcare Improvement 5 Million Lives campaign. ▴

Source: Krein SL. Use of central venous catheter-related bloodstream infection prevention practices by US hospitals. *Mayo Clinic Proceedings*. 2007;82(6):672-8.

What Somali women consider good care

Issue: Providing culturally competent care to Somali women.

Research says: Researchers from the University of Rochester Medical School surveyed Somali refugee women in Rochester, N.Y., and found that they correlated physicians

providing female interpreters and privacy during exams with a favorable health care experience. Respondents also said they believed adequate transportation and health literacy programs should be basic elements of any respectful health care system.

Put it in practice: Availability of female physicians and interpreters is important to many Somali women, especially for gynecological appointments. ▀

Source: Epstein CJ. Caring for Somali women: implications for clinician-patient communication. *Patient Education and Counseling*. 2007; 66:3.337-45.

Resources and tools

Diabetes campaign offers free materials

THE NATIONAL DIABETES EDUCATION PROGRAM has launched a national campaign—Control Your Diabetes For Life that emphasizes the link between diabetes and cardiovascular disease.

It includes educational materials tailored to at-risk groups, including Hmong patients, and brochures, tip sheets, and a pocket guide with a list of current recommendations for diagnosing and managing diabetes.

The National Diabetes Education Program is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations. For more information, visit http://ndep.nih.gov/campaigns/ControlForLife/ControlForLife_index.htm. ▀



Safely discharge patients

THE SOCIETY OF HOSPITAL MEDICINE has developed a discharge patient-education tool to help ease the transition from hospital to outpatient care by ensuring that patients understand their discharge instructions. The tool includes details about the hospital stay, treatments, test results, follow-up appointments, symptoms to be concerned about, and medications. For more information, visit www.hospitalmedicine.org ▀

Glossary

PLAN-DO-STUDY-ACT (PDSA) CYCLE

The PDSA cycle is shorthand for testing a change by planning it, trying it, observing the results, and acting on what is learned. It is the scientific method used for action-oriented learning. Once a team has set an objective, established measures, and identified changes that should result, the next step is to test the change. For more information visit www.ihl.org. ▀

New toolkits help doctors implement safe practices

THE AGENCY FOR HEALTHCARE

RESEARCH AND QUALITY has several new toolkits designed to help doctors, nurses, hospital managers, patients, and others reduce medical errors. The toolkits, developed through AHRQ's Partnerships in Implementing Patient Safety program, are free and can be adapted to most health care settings. For a complete listing of the 17 toolkits, visit www.ahrq.gov/qual/pips. ▀

Toolkit topics include

- Preventing deep vein thrombosis
- Patient-centered care
- Infections
- Handoffs

Community clinics shine

Clinic group racks up outstanding results in diabetes care

THE NEIGHBORHOOD HEALTH CARE NETWORK (NHCN) has defied conventional wisdom by getting better results for its diabetes care than those of clinics with more affluent patients.

The NHCN, a group of 14 clinics primarily in St. Paul and Minneapolis, had the second-highest percentage of patients receiving optimal diabetes care in the state during 2006, according to the 2007 MN Community Measurement report.

Research on health disparities would suggest that a group of clinics, like NHCN, with one-third of patients having limited English skills and about half being uninsured, would have a hard time scoring well on diabetes measures that include outcomes.

But since 2004, the clinics have taken a team approach involving community health workers that has paid off with results.

A quick turnaround

During the past few years, NHCN has significantly improved its ability to motivate diabetic patients to quit smoking, take aspirin, and manage cholesterol, blood pressure, and blood sugar levels—the five criteria that MN Community Measurement uses to measure optimal diabetes care.

The clinics dramatically improved their percentage of patients with diabetes receiving optimal care to 19 percent in 2006, up from 1 percent in 2004.

It was in 2004 that the clinics, prompted by federal requirements tied to funding, started implementing strategies to better manage chronic diseases, says Walt Cooney, NHCN executive director.

What has worked in general, Cooney says, has been a medical home approach that pairs patients with culturally similar case managers and having a networkwide disease registry that tracks at-risk patients.

“There’s a lot of talk about medical home now. I think the community clinics really are the epitome of the medical home and have been for a long time,” says Betty Hanna, director of clinical quality and disease management for the NHCN.

Team approach pays off

NorthPoint Health and Wellness Center, one of the NHCN clinics in North Minneapolis, exemplifies the approach that the clinic-network strives for.

NorthPoint has a diabetes team that includes an endocrinolo-



Diabetes educators, such as Michele Kimber, left, play a key role in helping patients such as Chloe Doty manage their diabetes at NorthPoint Health and Wellness in north Minneapolis.

gist, a registered dietician, a diabetes nurse educator, optometrist, community health workers, and several physicians.

The team tries to identify high-risk diabetic patients, such as those with A1c readings over 8.5 or those who lack health insurance, and crafts individualized care plans for them.

Pam White, a nurse practitioner and director of community health outreach at NorthPoint, says the use of community health workers who share the cultural background and language of patients is extremely valuable in helping patients with extra needs.

“The community health workers help patients navigate the system, provide them with resources, and they can help patients understand why it is important to take care of their diabetes,” she says. They also offer resources ranging from educational materials to securing a ride to the next appointment.

The workers try to overcome factors, such as mental illness or a lack of money, that might cause a patient to miss an appoint-

© Star Tribune/Minneapolis-St. Paul 2008

ment. They also contact patients to remind them a few days before upcoming visits.

Physicians focus on the acute care of the patients, “whereas the nurse and the community health workers can focus on taking care of some of the psychosocial issues,” White says.

The clinic also tries to make a patient’s visit as efficient as possible. For example, if the clinic’s optometrist sees that a patient needs a diabetic retinopathy test, he will try to do the test during that visit, instead of scheduling a separate appointment.

Although the NHCN has defied the odds by outscoring other clinics, Chris Reisdorf, manager of policy development for the Minnesota Department of Human Services, says she’s not surprised.

“I think it’s an example of what putting together best practices can do,” she says. “You can see their passion and commitment to serving the people that come through their door.” ▾

By Andrew Tellijohn

MMA Quality Review Correspondent

State to pay for community health workers

FINANCING COMMUNITY CLINICS has always been challenging and complex, says Walt Cooney, NHCN executive director. In the past, clinics mostly funded community health workers through federal subsidies or grants.

In 2007, the Minnesota Legislature passed a measure providing reimbursement for services provided by community health workers to patients with public benefits.

Cooney says the state’s funding decision might save it money in the long run.

“One lesson we’ve learned is that if these patients are engaged at the preventive level, we can save a lot of costs downstream.” ▾

From the malpractice files

Medication error

SADLY, MISTAKES ARE OFTEN THE BEST TEACHERS. Here’s a case from the files of the Midwest Medical Insurance Company that illustrates how a medication error can occur. Some of the details have been changed to protect the identity of those involved.

Facts

A 69-year-old woman with chronic low back pain needed a lumbar CT myelogram. The radiology technician grabbed a bottle of contrast that had a charge label used for billing purposes over the manufacturer’s label. He filled a syringe with the solution and placed it on the treatment tray. The radiologist came into the room, discussed the procedure with the patient, then injected approximately 1,300 ml of contrast without checking the contents of the syringe.

Outcome

After the radiologist left the room, the patient complained of generalized pain and discomfort and then lost consciousness. She exhibited tonic and clonic neck movements, her eyes twitched, and her feet jerked. Staff treated her for the seizures, then transferred her to a tertiary care center.

Later, the radiology technician found the empty bottle of contrast material and realized he had mistakenly grabbed a bottle of the contrast solution used for MRI instead of for CT scans. The patient suffered permanent cognitive impairment and loss of motor control. She will require life-long nursing care. The case settled for \$200,000 against the hospital and \$460,000 against the radiologist.

Process fixes

The following procedures could have reduced the chances of this event:

- The charge label should not have been placed over the manufacturer’s label.
- The physician and technician should have both verified the medication before it was administered.
- The person administering the medication should have prepared the syringe.
- The clinic should create a system that verifies these “rights”: right patient, right medication, right dose, right route.

Learn more about preventing medication errors at the Institute for Safe Medication Practices (ISMP) website, www.ismp.org. ▾

MINNESOTA & NATIONAL ROUNDUP

Error-related deaths decline

DEATHS FROM REPORTABLE MEDICAL ERRORS fell by more than 50 percent, with a reduction in deaths related to falls accounting for much of the improvement, according to the adverse health events report released in January by the Minnesota Department of Health (MDH).

“It’s encouraging that we’re making headway,” said MMA president James J. Dehen Jr., M.D. “It’s also a testament to the impact that good quality reporting and tracking can have on the ability of providers to find and fix problems.”

Between October 7, 2006, and October 6, 2007, there were 125 reportable errors and 13 reported deaths. Four deaths were due to falls, three were the result of suicide, five were related to a product or device, and one was related to care management. Another 10 people suffered a serious disability because of an error.

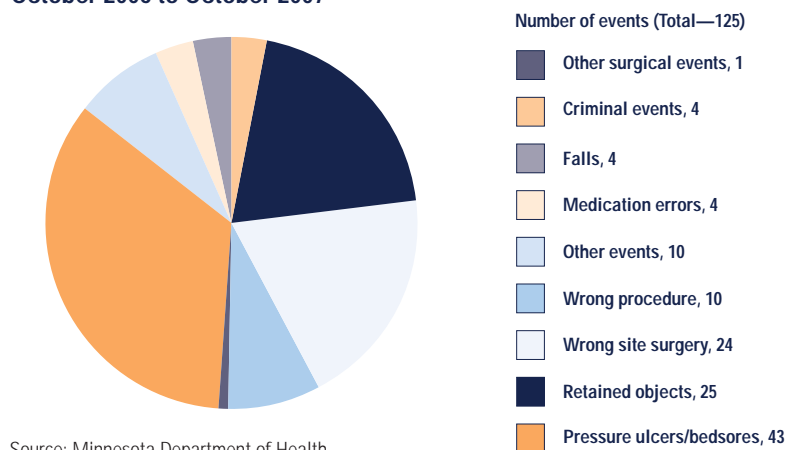
During a comparable time period from 2004 to 2005, the state saw 154 reportable errors, 24 deaths, and 7 serious disabilities. There were 12 deaths due to falls.

Of the 197 facilities covered by the law, 21 percent reported adverse events during this reporting period.

As in previous years, stage three or four pressure ulcers were the most commonly reported events, followed by retained foreign objects and wrong-site surgeries. For the first time, the number of reported pressure ulcers and

Reported adverse health events by category

October 2006 to October 2007



Source: Minnesota Department of Health

retained objects decreased.

Of the reports submitted during the reporting period, 17 percent resulted in no harm to patients, while 19 percent led to either death or serious disabil-

ity. A majority of events, 62 percent, resulted in a need for additional treatment or monitoring, but not a longer hospital stay. ▲

State offers interest-free loans for EHR systems

IN EARLY JANUARY, the Minnesota Office of Rural Health and Primary Care had \$3.15 million available to fund six-year, no-interest loans to help physicians and clinics purchase interoperable electronic health record systems. Recipients have two years to start making payments. The loans are available to rural and community clinics.

These loans are available to eligible applicants during fiscal year 2007-2008. For more information or to access the application materials go to www.health.state.mn.us/divs/orhpc/funding/index.html or contact Karen Welle at 651/201-3865 or Karen.Welle@health.state.mn.us. ▲

White House hopes to tie pay to EHRs

IN DECEMBER DURING THE DEBATE ABOUT MEDICARE REIMBURSEMENT, the Bush administration said physicians should have to adopt electronic health records (EHRs) or suffer a 10 percent pay cut. Health and Human Services Secretary Mike Leavitt said in news reports, "In my view, any new [Medicare reimbursement] bill should require physicians to implement health information technology that meets department standards in order to be eligible for higher payments from Medicare."

The administration believes the link could speed up adoption of EHRs.

Organized medicine, including the American Medical Association (AMA) and state and specialty societies, is concerned that a federal mandate tied to payment would punish groups that already need financial assistance to acquire new health information systems. ▀



Photo courtesy U.S. Department of Health and Human Services

HHS Secretary Michael Leavitt will have another opportunity to push the Bush administration's agenda of tying quality measures to Medicare payments during the first half of 2008. Congress passed a measure averting a 10 percent cut in physician reimbursements. But since that measure expires in July, Congress is expected to address the issue again in the next few months.

2008 Minnesota e-Health Summit

THE 2008 MINNESOTA e-HEALTH SUMMIT will be held on Thursday, June 26, at the Northland Inn, in Brooklyn Park.

The Minnesota e-Health Summit provides relevant and timely information about emerging national and state e-Health initiatives. Attendees hear from nationally recognized health information technology experts and learn about the progress of innovative projects underway in Minnesota. For more information about the summit, visit www.health.state.mn.us/e-health/. ▀



New York develops model for ranking doctors

MANY OF THE NATION'S LARGEST INSURERS have agreed to adopt a doctor-ranking model developed by New York Attorney General Andrew Cuomo, the AMA, the Medical Society of New York, and patient and consumer groups, according to a press release from Cuomo's office.

The ranking guidelines were developed after Cuomo's office discovered that many major insurers ranked doctors solely on cost instead of quality.

At the end of 2007, Minnetonka-based UnitedHealth Group, Aetna, Cigna, and other insurers agreed to follow the code, according to the press release. Also, New York legislative leaders also said in news reports that they intend to pass a law requiring insurers to follow the code.

According to the press release from Cuomo, the national insurers will now:

- Use more than cost data when ranking physicians,
- Share all details on how they rank doctors with both consumers and physicians,
- Use national standards to measure quality and cost efficiency, and use statistically valid methods,
- Risk-adjust,
- Hire an external monitor to check methods, and
- Institute a patient and physician appeals process.

If New York passes comprehensive legislation, it would be a first of its kind. ▀

Lessons lost

Patients may lose when doctors turn to peers instead of safety experts

PHYSICIANS WERE MORE LIKELY to discuss errors with their colleagues than to report them to their organization's risk managers or patient safety experts, according to a study done by researchers at several universities.

The study authors surveyed a group of 1,082 physicians at hospitals, clinics, and surgery centers in Missouri and Washington. Nearly all of the physicians believed they should report errors and that knowledge about errors was necessary to improve patient safety, according to the study, published in the January/February 2008 issue of *Health Affairs*.

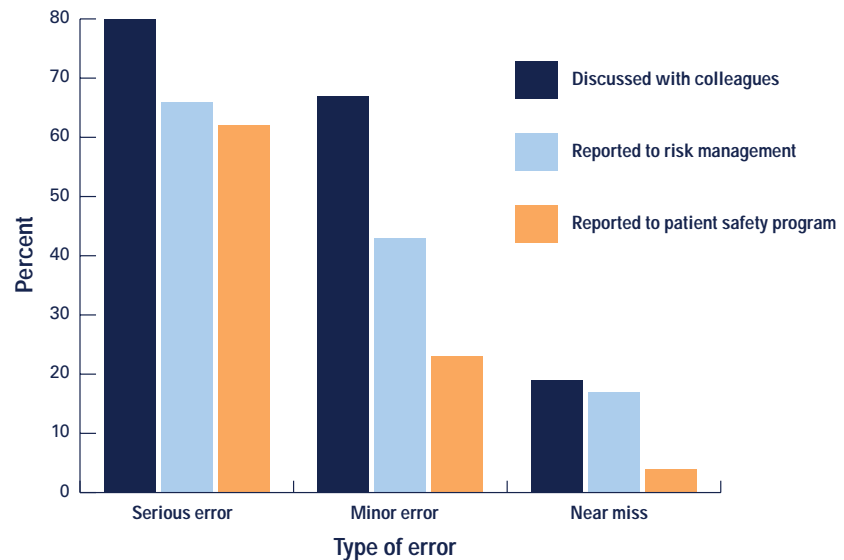
However, the findings suggest that valuable insights about errors get lost because many physicians don't feed error information into a formal tracking system, as they perceive such systems to be inadequate.

Only about 30 percent of physicians said reporting systems are adequate, and only 19 percent said current systems to disseminate lessons learned were adequate. Many of the physicians said error-reporting systems geared to improve quality weren't even available to them.

"Physicians say they want to learn from errors that take place in their institution to improve patient safety," Agency of Health Care Quality director Carolyn M. Clancy, M.D., said in a press release. "We need to build on that willingness with error-reporting programs that encourage their participation."

The U.S. Department of Health and Human Services has been trying to improve the nation's ability to report and track errors since 2005. It's in the

Who physicians talk to after making errors



Source: January/February 2008, *Health Affairs*

process of drafting regulations for creating patient safety organizations that will collect, aggregate, and analyze information that won't be discoverable by attorneys. These organizations were called for in the Patient Safety and Quality

Improvement Act of 2005.

Slightly more than half, 56 percent, of the surveyed physicians reported prior involvement in a serious error, and 74 percent reported being involved in a minor error. ▴

Tips for improving error-reporting systems

- Reassure physicians that reports are confidential and nondiscoverable.
- Actually use the information to improve quality.
- Standardize the process so it takes less than two minutes.
- Link mortality and morbidity conferences to quality improvement programs.
- Encourage physicians to report near misses.
- Create an error-reporting system involving specialists from different hospitals. In one study, neonatal intensivists made safety improvements after participated in an multi-hospital error listserv.

Source: Lost Opportunities: How Physicians Communicate About Errors. *Health Affairs*. January/February 2008.