

MMA

QUALITY REVIEW

Physicians in pursuit of excellence

Staffing emergency

A southeastern Minnesota hospital uses an innovative approach for staffing its emergency department

WHEN WASECA MEDICAL CENTER lost its residency program, it confronted a problem common among Minnesota's rural hospitals: staffing its emergency department.

Leaders of this critical access hospital in a town of about 10,000 residents quickly realized emergency physicians were expensive and hard to come by in rural Minnesota. In 2007, 91 hospitals in Greater Minnesota reported an estimated 13 percent vacancy rate for emergency physicians—among the highest for specialties, according to a January 2008 report by the Rural Health Research Center at the University of Minnesota. In comparison, the overall vacancy rate for rural primary care physicians was 9.4 percent.

Three options quickly surfaced:

- Have local family physicians cover the ED shifts, as they had done before the resident program;
- Contract with an outside company to staff the ED, as the hospital had also done previously; or
- Use physician assistants and nurse practitioners with supervision and backup from local family physicians, a model a Waseca physician had read about in the medical literature.



Photo by Linda Malecha

Edward Wolske, M.D., medical director of Waseca's emergency department and trauma services (left), works closely with a team of midlevel practitioners, including physician assistant Mark Ross (right), to staff the town's emergency department.

All of the options seemed to have downsides.

Family physicians worried that assuming ED shifts would take away from their medical practices. Hiring contractors 24/7 would be expensive. As for hiring midlevels, it was unclear if the quality of care would suffer. Only one hospital in the region, Mayo's Luther Midelfort Hospital in Eau Claire, Wisconsin, had a track record with such a model.

In the end, the administration and physicians chose to hire certified physician assistants (PAs) and nurse practitioners specializing in emergency care and back them up with a healthy dose of physician support. ▶▶

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The new model

Staffing the ED with midlevel practitioners was a big change. For more than a decade, second- and third-year residents from the University of Minnesota staffed the ED at Waseca, while part of the training program for rural family physicians at Immanuel St. Joseph's Hospital (ISJ) in Mankato. However, in 2006, the university consolidated the residency program at the larger ISJ, which left a hole in Waseca's ED, says Michael Milbrath, executive vice president of the facility, part of Rochester-based Mayo Health System and the Mayo-ISJ regional health care delivery system.

“We know we don't know everything, but we'll find the people who do.”

Mark Ross, P.A.

Waseca Medical Center

Today the Waseca ED has four PAs and one nurse practitioner, all of whom have previous emergency experience. They handle a wide range of cases or direct patients elsewhere via ambulance or helicopter. “We're seeing the usual fare—everything from sore throats all the way to multi-system trauma,” says Mark Ross, a physician assistant and one of the original recruits.

To ensure the quality of the care they provide, family physicians would supervise the midlevels, and Waseca would engage emergency physicians from ISJ for support. Waseca's midlevels can call ISJ emergency physicians any time for consultations, and they work shifts at least once a month at ISJ, where they

can hone their skills. In addition, ISJ emergency physicians assist Waseca's medical staff to assess the performance of the program.

To ensure PAs meet state requirements for physician supervision, the midlevels follow strict protocols for when to contact the on-call physician or seek other consultation. For example, they must contact the on-call physician every time they see a critical patient, a fracture, or an obstetrics case, and every time a patient needs to be admitted to the hospital or transferred to another facility.

“We know we don't know everything, but we'll find the people who do,” Ross says.

He adds that because there's greater continuity of staff as compared with the rotating residents, ED staff members intimately learn hospital processes. They get to know patients who visit frequently for chronic conditions. And, because they're experienced in and focused on emergency care, the midlevels can complete more tests and nail down diagnoses faster than the residents who rotated through the ED.

Good results

Scot Peterson, a paramedic supervisor with North Memorial Ambulance in Waseca, thinks the change has been positive: “Things have changed for the better. The PAs are much quicker to make a decision on a critical patient that needs to get out of here. ... Our transport numbers have actually increased since this model has been in place. I think that's due to the fact that the PAs recognize that there are some patients who need to move to a higher level of care.”

Edward Wolske, M.D., medical director of Waseca's ED and trauma services, who also directs the hospital's post acute care rehab unit, points to other measures that confirm the quality of emergency care. The average length of

Physician shortage tests rural clinics

FAMILY PHYSICIAN MARY SCHWIETERS, M.D., maintains that her clinic is providing quality care to the 3,000 residents of Melrose, Minnesota, and other nearby towns. But she says a physician shortage is wearing on her and her colleagues.

For two years, the clinic, which employs four full-time and two part-time physicians, has been trying to fill a vacancy left by a partner who retired.

Schwieters says there's enough work at CentraCare Clinic-Melrose for two more physicians, but "we can't even get anyone out here to look."

She attributes the lack of interest to the amount of work required in a rural practice. Schwieters sees patients in the clinic, visits them daily at the adjacent hospital, covers emergency department shifts, and is almost always on call to deliver babies. And that's not counting the care she provides outside the clinic, when she gets cornered in the grocery store by patients with questions or tends to fainting churchgoers. "The care really goes beyond the emergency room and the clinic," Schwieters says. "Someone going to a small town really has to want to be part of their patients' lives."

To address the staffing shortage, the clinic hired its first nurse practitioner in 2007 and may add another one.

Although the load is tough on the doctors, Schwieters says patients still receive high-level care. The Melrose clinic had



Photos courtesy CentraCare

Family physician Mary Schwieters, M.D., works hard to provide quality care at her clinic in Melrose, which is short-staffed.

the top score for diabetes care in the CentraCare system last year. According to MN Community Measurement, it provided optimal diabetes care to 23 percent of its diabetic patients, which was above the state average. Schwieters credits the clinic's success to an effective paper-based patient registry and the fact that doctors know their patients well.

But the current situation could deteriorate if the clinic continues to lose physicians. "At this point, I wouldn't say our quality is not directly affected by being short-staffed. But if we were to lose one or two more doctors, the ones who are left would not be able to manage the patient load because of sleep deprivation and burn out," she says. "So if you know of any family docs, please send them our way." ▀

stay, a key quality measure, has steadily improved to about 1.3 hours (the national average is more than three hours). And Waseca beats the 90-minute standard for transferring acute heart-attack patients to a cath lab after diagnosis—its average is under an hour, he says. Comparable data from before the staffing change aren't available.

The hospital measures the success of its use of midlevels in other ways as well. Visits to the ED have increased dramatically since the hospital adopted the new staffing model in 2006: from 4,477 in 2005 to 5,255 in 2007, up more than 17 percent. In addition, 88.4 percent of patients admitted to Waseca's ED reported overall satisfaction with the care they received, according to a Press Ganey survey. This patient-satisfaction rate put the ED in the 99th percentile of EDs surveyed by Press Ganey, according to Milbrath.

"Our volume continues to go up," says Wolske. "I believe a

lot of that is community confidence because with any small-town community, word gets around when care is good or bad. The fact that our visit numbers have continually gone up since the midlevels started shows that the community is comfortable with their care."

Although Wolske calls the staffing model successful, he worries it might fall victim to its own success as the demand for midlevels at a range of facilities has increased. A recent online search found 47 openings for PAs in southern Minnesota—from Winona to Worthington.

"The biggest hurdle we're having right now is getting PAs to fill slots because there's such a need within the state," Wolske says. ▀

By John Share

Freelance writer, St. Louis Park

Performance gap

Are rural clinic scores caused by demographics or quality of care?

CLINICS IN RURAL COUNTIES scored lower in providing optimal diabetes and vascular care than those in Minnesota's metropolitan areas, according to 2007 data from MN Community Measurement, a nonprofit that measures and publicly reports medical group and clinic performance.

Clinics were categorized by location: the 13-county Twin Cities metro area; the Fargo-Moorhead, Duluth, St. Cloud and Rochester areas; and greater Minnesota.

The analysis of data from more than 300 clinics showed that in the Twin Cities metro area, 17.6 percent of patients with diabetes received optimal care, compared with 13.8 percent in rural clinics. About fifteen percent of patients in the smaller metro areas received optimal care.

As for vascular patients, 35.2 percent of those in the participating Twin Cities clinics received optimal care, compared with 26.8 percent of those at the rural clinics. About thirty percent of patients in the smaller metro areas received optimal vascular care.

MN Community Measurement defines optimal diabetes care as control of blood sugar level, blood pressure, and cholesterol; and daily use of aspirin and not using tobacco. Optimal vascular care includes the same measures, except blood sugar.

Jim Chase, CEO of MN Community Measurement, says the differences between the urban and rural clinics are statistically significant and the numbers do indicate a gap in performance.

“While the percentage difference is small between the urban and rural regions, it represents a large number of people, since there are over 32,000 diabetics in treatment in those rural clinics,” he says. “If we could increase those results and make them similar to the metro region, 1,200 more patients a year would receive optimal care.”

elderly and poor residents.

A criticism of MN Community Measurement is that it doesn't risk-adjust for clinics that have sicker or poorer patients, placing them at a disadvantage.

“One thing that we know affects outcomes is socio-economic status, and nobody has developed a good risk-

“When we try to make it rural versus urban, that can lead to inaccurate comparisons. Poor versus not poor might be a little more relevant.”

Terence Cahill, M.D.

Family physician

United Hospital District Clinics of Faribault County, Blue Earth

Chase says the next step is to find out why there is a performance gap. He noted that possible causes could be the lack of electronic health record systems in rural Minnesota and the demographics of rural Minnesotans. Rural areas tend to have a disproportionate number of

adjustment tool that says your patients are more complicated because they are poor,” says Terence Cahill, M.D., a family physician at United Hospital District Clinics of Faribault County in Blue Earth who is also a member of the MN Community Measurement board.

Metro clinics score higher

Percent of patients receiving optimal care at Minnesota clinics

Region	Diabetes Rate	Vascular Care Rate
13-County Twin Cities Metro Area	17.6	35.2
Other Metro Areas	15.6	30.5
Rural Clinics	13.8	26.8

Source: MN Community Measurement

He explains that the assumption that a patient's poorly controlled diabetes is the clinic's fault ignores some of the challenges poorer patients face. For example, when a patient misses an appointment, the issue usually isn't on the clinic's end, he says, explaining that the patient probably couldn't get to the appointment because of long distances and no public transportation options.

"When we try to make it rural versus urban, that can lead to inaccurate comparisons. Poor versus not poor might be a little more relevant," Cahill says.

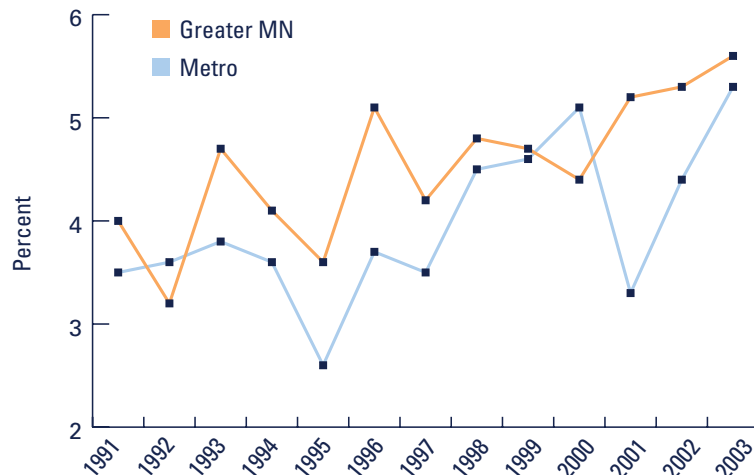
The results of the MN Community Measurement comparison don't surprise Clint MacKinney, M.D., an emergency room physician and quality consultant based in St. Joseph, Minnesota.

He says rural clinics often lack the resources to provide doctors with the real-time patient tracking and case-management support systems that can improve scores.

One solution, he says, might be to offer small practices more technical assistance through government-funded programs such as those offered by Stratis Health. But that's just part of the answer. "I remember being struck sometime ago by the depths of the quality-improvement staff at Park Nicollet Health Services, for example," MacKinney says. "Most rural clinics have zero full-time employees dedicated to quality improvement." ▀

By Scott D. Smith

Diabetes is on the rise in urban and rural areas



Source: Minnesota Department of Health Fact Sheet, Diabetes in Minnesota, March 15, 2005.

Bonuses go to 22 groups

BRIDGES TO EXCELLENCE, an employer-led pay-for-performance program, gave bonuses this summer to clinics based on their MN Community Measurement scores for providing optimal care for diabetes and heart disease patients.

Minnesota physician groups that met certain benchmarks could earn \$150 for each coronary artery disease patient and \$100 for each diabetic patient covered by the employers who participate in Bridges to Excellence.

The following organizations received bonuses:

- AALFA Family Clinic
- Allina Medical Clinic
- Camden Physicians
- Fairview Health Services
- Family Health Services
- Family Practice Medical Center
- France Avenue Family Physicians
- HealthEast Care System
- HealthPartners
- Innovis Health
- Mankato Clinic
- MeritCare
- Park Nicollet Health Services
- Quello Clinic
- Richfield Medical Group
- Riverside Family Physicians
- Southdale Internal Medicine
- St. Cloud Medical Group P.A.
- St. Paul Heart Clinic
- U of M Physicians
- Western Wisc. Medical Assoc.
- Winona Clinic

EHRs appear to boost clinic scores

CLINICS WITH ELECTRONIC HEALTH RECORDS provided better diabetes care in 2007 than those that relied on paper records, according to MN Community Measurement, a Minneapolis-based nonprofit that measures the performance of clinics and medical groups.

The organization released diabetes and vascular care scores on June 30, 2008 for the more than 300 clinics.

Clinics with electronic health records (EHRs) scored seven percentage points higher in providing optimal diabetes care than clinics with paper-based systems.

In addition to having EHRs that tracked patients and prompt physicians about missing care items, clinics that tended to score higher also employed care managers and dietitians, and met regularly to analyze their performance data. ▀

NEWS

YOU CAN USE

Efforts needed to improve women's preventive screening

Rural Hispanics talk about barriers to care



Issue: Providing culturally competent care in a rural setting

Research says: Researchers from the University of Illinois Chicago conducted 19 focus groups with 181 Hispanic residents from three rural communities in the Upper Midwest. The participants said the main barriers to their accessing care

were a lack of or limited health insurance, the high costs of services, difficulty communicating with providers, their legal status, and a lack of transportation.

Fast fact: Unqualified interpreters were the leading problem.

Put it in practice: Physicians can address the barriers rural Hispanic patients face by employing bilingual staff and qualified medical interpreters, increasing staff knowledge of cultural differences, and considering alternate transportation services. ▀

Source: Cristancho, S. Listening to rural Hispanic immigrants in the Midwest: a community-based participatory assessment of major barriers to health care access and use. *Qualitative Health Research*. 2008; 18: 633-46.



Issue: Little is known about the quality of preventive services received by women in rural clinics.

Research says: Researchers from East Tennessee State University did a chart review of 12 randomly selected clinics in the United States and found that in rural health clinics rates were lower than Centers for Disease Control targets for counseling at-risk patients about the need for Pap tests (66 percent versus the CDC goal of 85 percent) and administration of mammograms within the two previous years for women over age 40 (55 percent versus the CDC goal of 70 percent).

Fast fact: Screening rates for insured and uninsured female patients were not significantly different.

Put it in practice: Efforts to improve Pap and mammogram screening rates are needed in rural areas. Interventions should address the cost of screening, lack of insurance, transportation problems, fear, embarrassment, and privacy issues. ▀

Source: Edwards, J.B. Women's Preventive Screening in Rural Health Clinics. *Women's Health Issues*. 2008;18(3):155-66.

Medicare to pay bonuses for e-prescribing

A LAW PASSED THIS SUMMER offers significant incentives for e-prescribing. The law provides Medicare payment incentives of up to 2 percent for practitioners who use qualified e-prescribing systems in 2009 through 2013, and a reduction in payments of up to 2 percent to providers who fail to e-prescribe by 2012. The law allows hardship exceptions. Learn more at www.cms.hhs.gov. ▀

Carrots, then sticks

	Bonus	Penalty
2009	2%	None
2010	2%	None
2011	1%	None
2012	1%	1%
2013	0.5%	1.5%
Beyond	None	2%

Source: The Medicare Improvements for Patients and Providers Act of 2008

Nearly 100 benchmarks added

IN AUGUST, the National Quality Forum endorsed nearly 100 clinician-level consensus standards in areas including cancer care, infectious disease management, perioperative care, surgery and anesthesia, prevention and management of stroke, and influenza and pneumococcal immunizations. To learn more visit, www.qualityforum.org. ▀

Would your patients be more satisfied at another clinic?

NINE MINNESOTA MEDICAL GROUPS, representing 123 clinics, are currently piloting a new project to try and allow providers to answer such a question. The clinics are working with MN Community Measurement to create a report comparing clinic patient satisfaction rates. Patients will take the Clinician and Group CAHPS

survey, developed by the Agency for Healthcare Research and Quality (www.cahps.ahrq.gov), between September and November of this year. A public report will follow in early 2009. Medical groups and clinics interested in participating should contact Michelle Ferrari at ferrari@mnhealthcare.org. ▀

Online resources

To help rural primary care providers and others treat underserved populations, the American Psychiatric Association has developed an online clearinghouse of resources that includes information about telepsychiatry, www.psych.org/SpecialGroups/Clearinghouse.aspx.

State and federal Offices of Rural Health have grants available to rural communities to implement health information technologies. For more information, visit www.ruralhealth.hrsa.gov.



The Minnesota Alliance for Patient Safety statewide informed consent form is now available in Russian and Spanish. The form replaces the assorted consent forms in use by clinics, hospitals, and surgical centers, and is written at a lower literacy level. For more information visit www.mnpatient-safety.org.

A new ICSI guideline addresses primary prevention of chronic disease risk factors. The guideline includes health risk assessments, strategies to help patients lead a healthy lifestyle, and other useful tools. For more information, visit www.icsi.org.



The 2008 Minnesota Alliance for Patient Safety conference will be held November 13-14. Topics will include care transitions, health care transparency and disclosure, just culture, and patient safety in ambulatory care. For more information, visit www.mnpatient-safety.org.

Physicians must register to receive their 2007 Physician Quality Reporting Initiative final feedback report. Reports are available on a secure CMS website, but an online account is needed to access them. For more information, visit www.cms.hhs.gov/PQRI.

Minnesota's 2008 Health Care Reform legislation addressed quality care, including provisions for care coordination, a set of standardized P4P measures for use by payers, and an annual quality report for the public, and requirements that e-prescribing be implemented by 2011. Learn more at www.mmaonline.net.

A government program is giving eligible rural health care providers discounts on telecommunication and Internet services. Learn more at www.universalservice.org/rhc/.

Cultural competence is an increasingly relevant skill in rural Minnesota. The Office of Minority Health at the U.S. Department of Health and Human Services has created a free online accredited educational program. A Physician's Practical Guide to Culturally Competent Care is available at www.cccm.thinkculturalhealth.org/



Q&A

Rating rural health care



Photo courtesy of the University of Minnesota

Ira Moscovice, Ph.D., director of the University of Minnesota Rural Health Research Center, has been at the forefront of efforts to develop quality and patient safety measures for rural clinics and hospitals. Here are his views on the quality of health care in greater Minnesota.

Ira Moscovice, Ph.D.

Q: How do you define rural Minnesota?

A: One of the easiest ways is to look at counties. All counties are designated as metro or nonmetro. In Minnesota, the Metropolitan Statistical Areas include the areas around the cities of Minneapolis and St. Paul, St. Cloud, Rochester, Duluth, Fargo, Grand Forks, and La Crosse.

Q: What do we know about the quality of health care in rural Minnesota?

A: The data we have is on the inpatient side from Hospital Compare, which is based on Medicare data. What we've seen over the past three years nationally and in Minnesota is that rural hospitals are lagging on almost all of the heart attack quality measures and most of the congestive heart failure quality measures. However, rural hospitals do better on some of the pneumonia and surgical-infection prevention measures. So there is work to be done in rural hospitals.

Q: Have rural hospitals been closing the quality gap between them and urban hospitals?

A: Quality has been improving for both urban and rural hospitals, but the relative gap has stayed the same.

Q: Why is there a gap?

A: It could be due to a variety of issues: staffing levels, organizational culture with respect to quality improvement, a lack of specialists and technology, a lack of connections with external entities and partners, and not using clinical guidelines and protocols. It could also be a volume issue, poor documentation. It is still an open question.

Q: Could the difference be caused by the characteristics of rural patients?

A: The rural population is a bit older, sicker, and has less health insurance coverage. So that could explain a portion of the results.

Q: Do rural hospitals do better in some areas?

A: Centers for Medicare and Medicaid Services (CMS) has just released its first set of patient satisfaction data, and guess what? Smaller hospitals had the highest rating, which is not surprising because the patient-provider relationship is different in the rural environment. Rural hospitals have also performed well on the pneumonia measures.

Q: Do rural hospitals have any other advantages?

A: Systems theory indicates that smaller size and scale should better facilitate the implementation of quality-improvement strategies. Rural hospitals are less complex and should be able to address quality and safety issues much more directly.

Q: Are there any measures for rural ambulatory care?

A: Almost half of the revenue of smaller rural hospitals is on the outpatient side. So the ambulatory side is really important. CMS has just started some demonstrations to look at the quality of ambulatory care provided by physicians and is also starting to look at outpatient hospital measures. Where I really see things evolving is toward collecting information on quality of episodes of inpatient and outpatient care over time.

Q: Part of your work has been to develop rural-specific measures. What did you come up with?

A: Two of the core functions of a rural hospital are emergency care and transferring patients. So we developed a set of quality measures for the timeliness of care for heart attack patients and a set of measures for patient transfers that start with whether the appropriate information was communicated between health providers.

Q: Tell me more.

A: For instance, what was the median time for a heart attack patient to get an aspirin, an EKG, and other appropriate tests? As for transfers, we monitor whether vital information such as demographic information, information about medications, vital signs, and so forth was communicated from the rural hospital out to the receiving hospital.

Q: Are these measures being used by CMS?

A: Larger hospitals started using the timeliness measures in July, and rural hospitals are scheduled to start using them by January 1, 2009. The National Quality Forum has endorsed the transfer measures, and we are hoping that CMS will start using them next year.

Q: Is there a measure for whether the hospital made the right decision about transferring the patient?

A: No, but that is where our work is heading. Another obvious question is, How did the patient do? What was their outcome? But that also gets much more complicated.

Q: Should rural providers have different measures than urban providers?

A: I don't think we want to develop measures just for rural hospitals. The kinds of issues at the core of how a rural hospital performs are also relevant for other hospitals. On the other hand, I think it is very important to have that rural-specific information at the local level and to understand the differences across settings, because if we need improvement in both rural and urban hospitals, the solutions may be different.

Q: Have we been too lax about measuring the quality of rural hospitals?

A: Historically, rural hospitals were allowed to be exempt from these efforts because they didn't have the volume. However in recent years, there has been a real push from Health Resources and Services Administration to provide states resources to work with critical access hospitals on their quality improvement. Today, about three-fourths of the critical access hospitals nationally and in Minnesota participate in quality reporting, even though they don't have a financial incentive to do so.

Q: Should their participation be mandated?

A: I believe Stratis Health has been real successful in Minnesota in increasing critical access hospital participation at a rate of about 10 percent a year for the last few years. Hopefully, we can approach 100 percent participation with a voluntary program.

Q: What needs to be done to help rural providers improve their quality?

A: At the macro level, we need to build a rural health information technology infrastructure. We also need to make sure that rural hospitals participate in quality initiatives and that relevant measures are being used. The Joint Commission, National Quality Forum, and CMS have all become much more sensitive about the rural aspects of quality. We are moving in the right direction.

Another challenge is just the sheer financial stability of smaller institutions.

As for individual hospitals, the most important thing is to collect and report quality data and outcomes on a regular basis both within your institution and to the public. ▀

MINNESOTA & NATIONAL ROUNDUP

Minnesota to start palliative care project

STRATIS HEALTH is launching the Rural Palliative Care Initiative, a learning collaborative that will bring together health care providers from as many as 10 rural communities in the fall of 2008 to start or strengthen palliative care programs in their communities.

To date, palliative care programs have developed primarily in large urban hospitals but lagged behind in long-term care facilities and rural hospitals.

The initiative will involve hospitals with fewer than 150 licensed beds. Participants are expected to be announced in September. UCare is funding the initiative, while Stratis Health, in partnership with the palliative care program of Fairview Health Services, leads the effort. For more information, contact Janelle Shearer, program manager, at 952/853-8553 or jshearer@stratishealth.org. ▀



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Surgical errors cost nearly \$1.5 billion



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POTENTIALLY PREVENTABLE MEDICAL ERRORS that occur during or after surgery cost employers nearly \$1.5 billion a year, according to an estimate by the Health and Human Services Agency for Healthcare Research and Quality (AHRQ).

A study published in the July 28 issue of the *Health Services Research*, found that insurers paid an additional

\$28,218 for surgery patients who experienced acute respiratory failure and an additional \$19,480 for surgery patients who experienced postoperative infections. This was 54 percent and 48 percent, respectively, more than was paid out for patients who were not subjected to errors.

The study also found that one of every 10 patients who died within 90 days of surgery did so because of a preventable error and that one-third of those deaths occurred after the initial hospital discharge. The study was based on a nationwide sample of more than 161,000 patients ages 18 to 64 in employer-based health plans who underwent surgery between 2001 and 2002. ▀

Urgent care goals

THE JOINT COMMISSION AND THE URGENT CARE ASSOCIATION OF AMERICA have joined together to provide quality oversight for the estimated 8,000 urgent care clinics in the United States.

Both organizations currently provide accreditation for urgent care clinics but will now develop joint quality standards specific to urgent care and introduce them in 2010.

For more information, please contact Michael Kulczycki, executive director, Ambulatory Care Accreditation at mkulczycki@jointcommission.org. ▀

Seeking quality transports

Ambulance measures could help level the playing field for rural responders

MEASURING AMBULANCE QUALITY should be easy, right? Just start your stopwatch and wait for the patient to arrive at the hospital.

Not so, says Gary Wingrove, former Minnesota State EMS director and director of government relations and strategic affairs for Gold Cross, Mayo Clinic's air and ground transportation company.

"People like to focus on response times, but there are some major issues with that because it is often outside of the responder's control," Wingrove says.

As important as the response time is it is also important that patients get appropriate care on the way to the hospital, he says. For that reason, he believes ambulance services need to develop quality measures to improve care.

Since 2005, Wingrove has been part of a work group at the North Central EMS Institute, a St. Cloud-based non-profit that has been testing six measures by applying them to EMS data from Minnesota, North Dakota, and Nebraska. The data come from the National EMS Information System (NEMSIS), a national registry of EMS calls. The group's goal is to generate baseline information on EMS performance.

The measures include the time from symptom onset to the time of the 911 call; the time between dispatch and arrival at the patient's location; the percentage of patients who require respiratory support and receive it; the accuracy of the patient care report; the percentage of patients whose condition indicated a need for advanced life support who actually received it, and the time to defibrillation.

The group's first look at results earlier this year was disappointing, because the findings didn't appear reliable. For example, only 15 percent of patients needing oxygen received it, according to the analysis. Wingrove blames this low result on the unreliability of the NEMSIS data. He's confident nearly all the patients actually got the oxygen but that crews skipped documenting that to save time. Other results, such as the average time people wait to call 911, which was about 8 minutes, seemed more reliable. Wingrove believes stronger reporting requirements will likely be needed to improve the NEMSIS data.

He hopes the kinks can be ironed out in the reporting system in the next couple of years, so ambulance services will have reliable data, that can be used for quality improvement efforts.

Need for speed

Still, response time is an important measure, and coming up with a fair transport time benchmark for ambulance services—professional or volunteer, in rural and urban settings is a challenge.

"If Medicare evaluates responders just on how fast they get to the patient, rural ambulance services will never win," Wingrove says.

Rural emergency responders are at a time disadvantage because they cover greater distances. Also, 80 percent of Minnesota's emergency responders are volunteers who need time to get to the ambulance when called.

Wingrove says for transport times to actually indicate quality, a time per distance measure that adjusts for such fac-



A fair transport measure will need to factor in time, distance, and unique care circumstances.

tors will have to be developed. If this can be achieved, Wingrove believes it could benefit rural services in particular.

"Right now, we do have a disparity in the level of care, as more resources are concentrated in the urban centers," he says. However, rural responders often must provide more care for a longer period than their urban counterparts. Rural responders have to travel longer distances, up to 60 minutes, to reach the hospital, whereas urban responders are usually 10 minutes from a hospital, Wingrove says.

Good measures might shed light on quality disparities and result in increased funding for rural services, he says.

"A lot of places in rural Minnesota can't afford to have paramedics at all, but logic would say we potentially have the best-trained responders in the wrong places." ▴

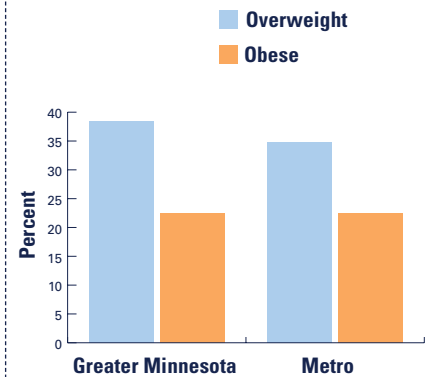
By Scott D. Smith

Rural health by the numbers

Aging rural population

30% of the state's total population lives in rural Minnesota,
41% of those 65 and older reside there.

Adults overweight or obese



Uninsured rates in 2004

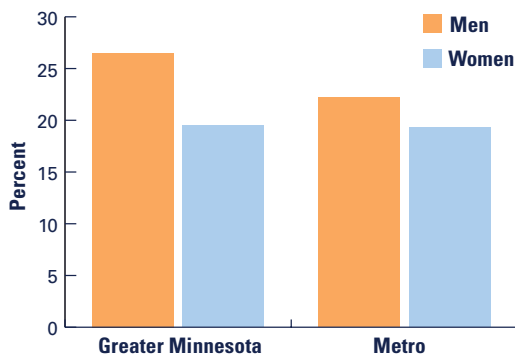
Minnesota nonelderly **7.4%**

Rural nonelderly **9.7%**

Income

Rural counties comprise
81.6% of those with a household income of less than \$50,000. The state median income was \$51,202 in 2004.

Smokers by region and gender



Health care worker shortage

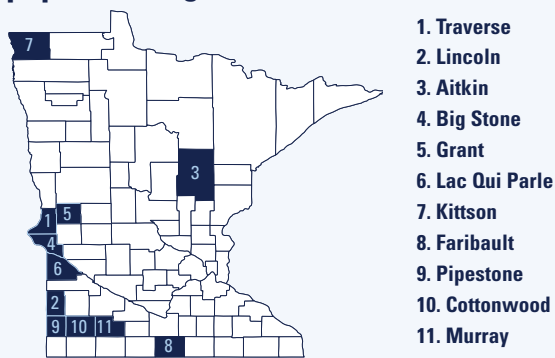
37% of Minnesota's rural population lives in a health professional shortage area

46% of the most rural counties have

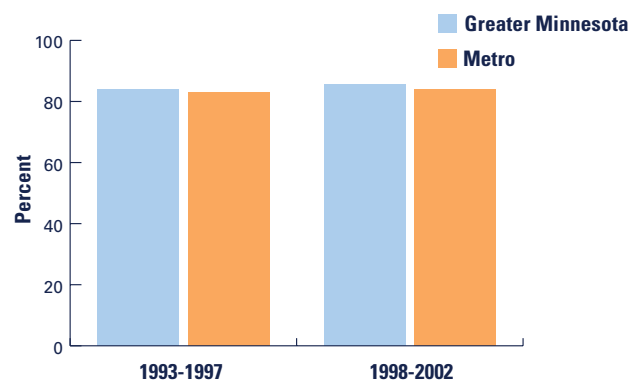
13% of the state's population but only

5% of the state's practicing physicians

Counties with more than 20% of their population age 65 and older



Prenatal care initiated in the first trimester



Source: Health and Well Being of Rural Minnesotans: A Minnesota Rural Health Status Report