

Confronting racial disparities

Children's embraces a data-driven approach to providing equitable care

THOMAS HELLMICH, M.D., medical director of emergency services at Children's Hospitals and Clinics of Minnesota, says that when he speaks with physician colleagues about health disparities, they assure him they treat all their patients the same, regardless of their ethnicity and background. In Hellmich's opinion, that's the problem.

Hellmich has come to the conclusion that physicians, despite their good intentions, don't recognize how their behaviors may contribute to disparities. He believes they need to see patient satisfaction and outcomes data stratified by race and ethnicity to know if they are truly delivering equitable care. Numbers don't lie, and he says they can reveal significant differences in such areas as patient satisfaction.

With that in mind, Hellmich is leading an effort to help Children's more consistently collect information about the race, language, and ethnicity of its patients. The data will be analyzed and paired with other data on patient outcomes and satisfaction to pinpoint disparities. For example, Children's will collect new information about patient comprehension and integrate it with race and ethnicity data to better identify root causes of poor outcomes. The ultimate goal is to develop evidence-based best practices



Photo by Steve Weverka

Thomas Hellmich, M.D., hopes that improved communication will reduce emergency department readmissions among non-English speaking patients.

aimed at providing equitable care.

The data collection effort is the first focus of Children's new Office of Health Care Equity, which was launched in September to reduce disparities in the care of children ▶▶

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Owner and Publisher

Minnesota Medical Association

Editor and Writer

Scott D. Smith

Manager, Quality Improvement

Rebecca Schierman

Graphic Designer

Joanna Kapke

Advisory Committee

Thomas J. Arneson, M.D.

Peter J. Dehnel, M.D.

Kurtis M. Hoppe, M.D.

David D. Luehr, M.D.

To Submit an Article, Idea or Comment

Contact Scott Smith at
ssmith@mnmed.org or 612/362-3726

MMA Address

1300 Godward Street, Ste 2500

Minneapolis, MN 55413

Phone: 612/378-1875 or

800/DIAL MMA (342-5662)

Fax: 612/378-3875

E-mail: mma@mnmed.org

Web site: www.MMAonline.net

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from diverse communities. The office is funded through a \$500,000 grant from the Robins, Kaplan, Miller, and Ciresi Foundation for Children. In addition to improving data collection at Children's, Hellmich and the director of the new office, Boris Kalanj, will participate in a disparities leadership program run by Massachusetts General Hospital and Harvard Medical School.

A spotty record collecting race data

Hospitals across the country have track records showing inconsistent collection of race, ethnicity, and language data. At Children's, admission forms have included questions about race and ethnicity for more than 10 years. But a lack of institutional will to make sure the data was collected led to only about half of patients having their race recorded in their records.

"We have had the problem of not asking the patient coming in, or sometimes our administrative staff would just guess instead of asking," Kalanj says.

Kalanj was aware of the mounting calls from researchers and policy leaders for providers to collect race data as a first step toward tackling the persistent problem of racial inequities in health care delivery. In response, Children's redoubled its efforts. It retrained registration staff and made it clear that race, ethnicity, and language data needed to be collected. Children's provided registration staff with scripted language for asking about race and made it clear that patients needed to identify their racial preference.

The effort paid off. By the end of 2007, Children's had improved its race and ethnicity identification rate from less than 50 percent to about 80 percent. It also was collecting language information on about 96 percent of its patients.

Putting the data to use

With more reliable data about patient

demographics in hand, Children's could start running reports to try to compare the quality of care provided to different groups. The process uncovered the troubling fact that minorities seemed less satisfied with their care, which will be one of the first problems that the Office of Equity will try to resolve.

"We know that overall, people who are nonwhite, on Medicaid, or are limited English speakers are less-satisfied with their care," Kalanj says.

But what hospital leaders don't know is why. One factor may be that these groups of patients are also more likely to use the emergency room for non-emergent issues. One possibility that

"We know that overall, people who are nonwhite, on Medicaid, or are limited English speakers are less-satisfied with their care."

Boris Kalanj

Director, Office of Health Care Equity

Hellmich and Kalanj want to explore is whether there is a link between the low satisfaction scores and the acuity of a patient's illness.

Hellmich wonders whether minority parents who bring a child with a minor illness to the emergency department feel they are being treated unfairly when they see another child, who came in later but is more critically ill, receiving attention first. "If you have one patient coming to the ED knowing it's for an emergency, and you have someone else who is coming because

of a lack of access, the ED staff is trained to respond to the former. So you can see how that sets up a whole set of issues,” Hellmich says.

The office also will try to ferret out whether a lack of understanding about how EDs triage patients is contributing to the lower scores. If so, Hellmich says, then it will be the staff’s responsibility to do a better job of managing expectations and educating patients about how emergency departments work.

Children’s analysis of race data has also found that Spanish- and Somali-speaking patients have higher readmission rates to the emergency department than those whose primary language is English. There could be many reasons for this, because Children’s emergency department is a place where race, culture, language, health literacy, and socioeconomic status collide on a daily basis.

Is the rate higher because some of the minority patients didn’t have access to a clinic? Because they couldn’t afford medications? Or because they didn’t agree with or understand the follow-up plan?

Hellmich wants the office to explore this last area first, as he has seen examples of poor communication leading to readmissions. He recalls one instance in particular when a parent, after speaking to a physician through an interpreter, put an oral dose of amoxicillin in a child’s ear to cure an infection.

To isolate what effect communication breakdowns may be having, the Office of Health Care Equity plans to survey all emergency room patients for several weeks to find out how well they understood their diagnosis, instructions, and follow-up plan. The hope is that the data will suggest ways to reduce miscommunications between providers and patients. One idea that is being considered is to hire emergency department navigators to help the most vulnerable groups. Upon admission, families would be assigned a navigator who would guide them through admission, triage, and discharge. The navigators can also troubleshoot problems and make sure that patients have follow-up appointments or instructions before they leave.

In the end, Hellmich says he hopes the office will transform the way Children’s manages its data so that quality and patient satisfaction information can always be broken down by race and ethnicity. If that happens, he believes Children’s clinicians will be able to reduce disparities in care provided to certain groups.

“Right now, we aren’t getting enough data in front of our health care providers for them to react to. Until we do that, it is hard to ask for improvements,” Hellmich says. ▀

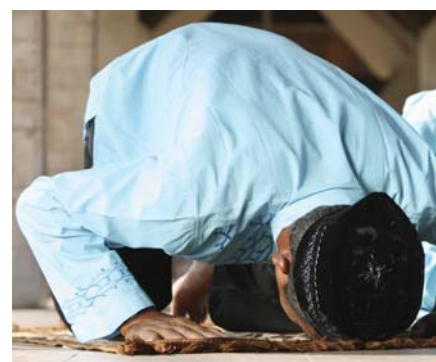
Snapshot

Know thy patient

FAIRVIEW HEALTH SERVICES started collecting information about patients’ race, ethnicity, language preference, and religion for its hospitals in 2004. In 2006, Fairview started pairing that data with quality benchmarks measuring patient outcomes, perceptions about the patient experience, and preventive care.

Loie Lenarz, M.D., Fairview’s chief clinical officer, says the addition of data on race took the guesswork out of the equation and allowed Fairview to better understand its patients and their needs.

“We really need to understand who the people are in our system if we are going to address their health care,” she says. When Fairview started



Race and religion data prompted Fairview to add Islamic prayer spaces in its hospitals.

comparing outcomes of racial groups, it found that minorities and whites had similar outcomes for an episode of care delivered in one of Fairview’s hospitals; however, Lenarz says she has little doubt they would rate their patient experience differently. To address that, Fairview has attempted to use what it knows about its patient populations to make care more culturally appropriate. Efforts range from adding prayer areas in hospitals used by Islamic patients to stocking culturally relevant magazines in lobbies used by patients of color.

Having the race data also has allowed Fairview to apply for more grants, as funders often request the information, and to make informed decisions about staffing interpreter services and creating printed materials such as hospital menus in languages other than English. It also started a doula program for East African women at the Riverside Campus of the University of Minnesota Medical Center, and educated nurses in birthing units with higher volumes of Latino patients about Latino naming conventions and common spellings in order to prevent misunderstandings that could result in errors on birth certificates and alienate new parents.

For Lenarz, the bottom line is that “knowing the race and preferred languages of your patients isn’t helpful if you aren’t also culturally competent.” ▀

What's your race?

Clinics are devising guidelines for asking about race, ethnicity, and language

MINNESOTA PROVIDERS TAKE PRIDE in the state's reputation as one of the healthiest in the nation. But that reputation belies part of the reality. Health statistics for Minnesota's people of color are, in some cases, grim.

The Commonwealth Fund, which studies racial and ethnic health disparities, ranks Minnesota 11th in the nation in terms of providing care overall, but 38th when it comes to providing equitable care. The foundation measures such indicators as how frequently minority patients visit a doctor or receive recommended care or preventive screenings.

Although Minnesota providers have been aware of the disparities for some time, there has not been a coordinated, state-wide response from clinics until now. As a first step toward eliminating disparities, a group of Minnesota provider organizations is creating guidelines for collecting data on patients' race, ethnicity, and preferred language. "You simply can't know where to start, until you have the data," says Sandra Eliason, M.D., an urgent care physician for Columbia Park Medical Group and Fairview, and a medical director for the Center for Cross Cultural Health in St. Paul. The guidelines are scheduled to be released in early 2009.

The work group, brought together by MN Community Measurement, includes HealthPartners, Mayo Clinic, Children's Hospitals and Clinics of Minnesota, Community-University Health Care Center in Minneapolis, and Hennepin Faculty Associates.

Best practices

The guidelines will address key issues

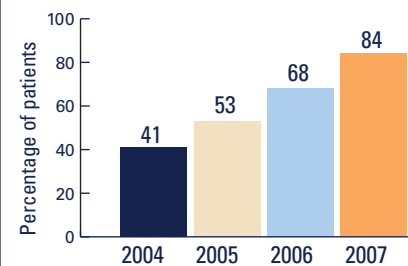
such as who in the clinic should collect the race, ethnicity, and language data, how that person should ask for such information, and how to define racial and ethnic categories. These are often cited as reasons why hospitals and clinics fail to collect this information in the first place. To address these issues, the group has been relying on the experience of members such as HealthPartners, which has information about language preference, race, and country of origin for about 90 percent of its patients.

HealthPartners' efforts to collect that information started in 2003, when the organization built language preference, race, and country of origin fields into its new electronic health record. Before widespread collection of the data, the organization worked with representatives from minority communities to get ideas about who should gather it and how, and it created the following script for asking about race:

We want to ask you about your race and country of origin. If you answer, you will help us provide the best care to all of our patients. We will use this information to help our doctors and nurses give you the best care. We will keep your information private and confidential.

Juan Linares, a Latino activist and director of the Prosperity Campaign in St. Paul, says providers need to explain why they want race data, otherwise patients may wonder what the interviewer wants and may avoid seeking care as a result. He says the key message from providers needs to be, "We want you to trust us, so we can serve your medical needs."

Collection Rate for HealthPartners Race Data



Source: HealthPartners

HealthPartners also decided that rooming staff, rather than registration staff, should ask the question. Most often, hospitals and clinics have the registration staff collect race data because they're seated behind a computer screen and can easily incorporate it into the patient's record. "We thought that question would be better asked face to face," says Beth Averbeck, M.D., HealthPartners' associate medical director for primary care, because the rooming nurse could answer questions and address concerns.

To date, only one patient has complained about the collection of race data, Averbeck says.

Another challenge for the work group has been defining ethnic and racial categories. There are no nationally agreed upon descriptions, according to Eliason. HealthPartners and Mayo Clinic use five categories that are derived from the ones used by the Federal Office of Budget Management: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, or White. HealthPartners also allows

patients to choose “some other race” or to not answer. In addition, HealthPartners asks patients to name their country of origin to learn more about their ethnicity. To get at similar information, Mayo Clinic is considering expanding its categories in 2009 and could create as many as 18 subcategories. These might include African American, African Born, or American-Born African.

Let the gathering begin

Once the guidelines are finished, members of the work group will start using them to collect data from within their organizations, which they will then submit to MN Community Measurement. MN Community Measurement will use the information to paint a more accurate picture of the type of care received by minority patients at a particular clinic compared with other patients seen at the facility. Those who are developing the guidelines hope other Minnesota clinics will voluntarily start collecting and submitting data as well.

“When providers run the data, sometimes their patients are not doing as well as they thought,” says Priscilla Flynn, Ph.D., coordinator of the Office of Women’s Health at Mayo Clinic, who also serves on the group’s steering committee, “and that is why we need to collect this data, because we are finding some surprises.” ▀

Online resource

The Health Research and Education Trust (affiliated with the American Hospital Association) has developed a comprehensive online toolkit for collecting race data. Go to [www.hretdisparities.org](http://www.hret disparities.org) to learn more.

Snapshot

Race data leads to improved care

HEALTHPARTNERS started collecting race data in 2004 and began tying it to quality measures in 2006.

In analyzing the data, organization leaders discovered gaps between the number of African-American patients and white patients who received optimal care for diabetes and screenings for breast and colon cancer.

Jennifer Hines, M.D., an internist at HealthPartners’ Midway Clinic in St. Paul, called the findings eye-opening. “It was very surprising for a lot of the providers. They saw that there were disparities. We said, ‘Wow, we are offering the same insurance, the same services, so why are they not accessing them?’”

This led the organization to undertake several projects to reduce disparities last year. One of those grew out of data that showed no disparities between African Americans and whites for same-day screenings such as cholesterol tests.

With that in mind, HealthPartners began offering same-day mammograms in one clinic in 2007 and was able to reduce the gap between African-American and white patients who received the screening from 16 percentage points to 2 percentage points.

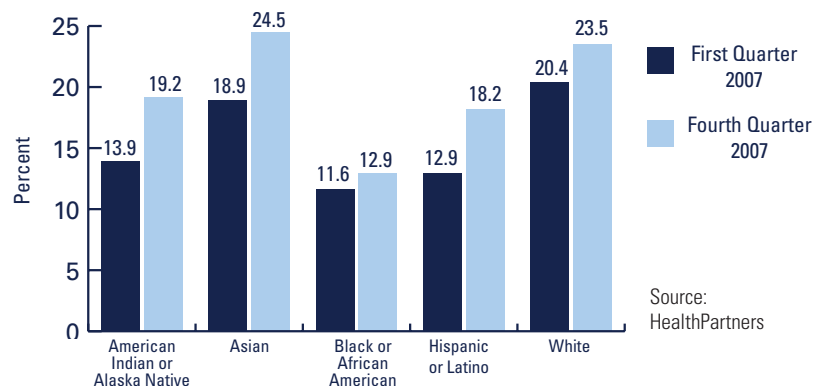
HealthPartners also developed customized scripts for talking with African-American patients about the importance of being screened for colon cancer, as they tend to be at greater risk of dying from the disease.

Hines, who works with patients who have recently arrived in the United States, says many immigrants are unfamiliar with the concept of preventive care and don’t understand its importance. HealthPartners is developing a video in which a Somali physician discusses the value of preventive screenings. Some of its clinics have also paired Somali women with female physicians with whom they feel more comfortable talking about issues such as cervical or breast cancer.

HealthPartners’ next systemwide initiative is to develop diabetes materials customized to fit the diets of various groups. For example, it has created a nutrition program for Asian patients in which rice is a staple, says Beth Averbeck, M.D., HealthPartners associate medical director for primary care. “Our challenge now is to reach out to our different communities and ask them, How can we do it differently? How can we do it better?” she says. ▀

Optimal Diabetes Care by Race

Percentage of HealthPartners’ patients who control their blood sugar, cholesterol, and blood pressure; regularly take aspirin; and don’t use tobacco.



NEWS

YOU CAN USE

Interpreter tips

MINNESOTA PHYSICIANS increasingly must work with interpreters during patient visits. Here are some tips for having a successful session.

- Make sure you are working with a qualified interpreter and not a family member or friend.
- Brief the interpreter on what to expect before the meeting.
- Plan enough time—it may take longer than an English-only appointment.
- Expect the interpreter to avoid spending time alone with the patient before the meeting.
- Ask the interpreter to interpret everything said in the room—curse words, side conversations—everything.
- Face the patient and talk to him or her directly.

Physician training

The MMA has helped develop a presentation to help doctors get the most out of the interpreters they work with. If you are interested in having this training at your clinic or hospital, contact Scott Smith at ssmith@mnmed.org or 612/362-3726.

- Don't speak too fast.
- Ask one question at a time. Don't “chain” your questions.
- Confirm understanding by asking the patient to repeat key information.

Source: Linking Voices, The Minnesota Language Services Initiative

Increasing cultural awareness in Minnesota

STRATIS HEALTH was awarded \$1 million by UCare to increase cultural awareness among health care providers across Minnesota. Stratis will create a state-wide cultural competency online resource and work directly with a number of clinics that UCare has contracts with that serve people of color and non-English-speaking patients. ▴

State awards EHR grants

THE MINNESOTA DEPARTMENT OF HEALTH has awarded 21 grants totaling \$3.5 million to rural hospitals, nursing homes, and clinics that wish to implement interoperable EHRs.

State law requires all Minnesota health care providers to use electronic health records by 2015.

In addition, the Department of Health is accepting applications for a low-interest electronic health record loan program. The state will provide \$1.5 million in six-year loans on a first-come, first-served basis to rural providers and community clinics. For more information, visit www.health.state.mn.us/divs/orhpc/funding/index.html. ▴

Online resources

Tools to promote cultural competency are available from the U.S. Department of Health and Human Services and Office of Minority Health.

www.thinkculturalhealth.org.



A web-based training program about cultural proficiency is available at the American Academy of Family Physicians' Quality Care for Diverse Populations. www.aafp.org

Materials about fighting MRSA

are available as part of a campaign by the Centers for Disease Control and Prevention to teach parents how to protect themselves and their families from MRSA skin infections. They include fact sheets, brochures, posters, and public service announcements. www.cdc.gov/MRSA

Guidelines for preventing deep



vein thrombosis were recently released by the Agency for Healthcare Research and Quality. www.ahrq.gov. ▴

Minnesota providers raise the bar

HERE IS A SAMPLING OF PROVIDERS recently recognized by Minnesota health plans for their efforts to improve care:

Access Psychiatric Home Health, Grand Rapids, instituted a program in which nurses provide follow-up home care to patients with bipolar disorder, schizophrenia, depression, and other mental illnesses. By providing the follow-up care, the nurses were able to keep these patients on their medications and reduce hospitalizations by 13.2 percent between 2006 and 2008. **Saint Mary's Duluth Clinic** set out to increase the percentage of children on Medical Assistance who were up to date with their well-child visits. The six clinics that took part started sending letters to parents in 2007 about the need for a visit, then made follow-up phone calls and sent reminder post cards. They

succeeded in improving the percentage of children who were up-to-date on their visits from 57 percent to more than 80 percent. These two providers won the Medica Raising the Bar Innovation Award. Learn about other award winners at www.medica.com.

Physicians Neck and Back Clinic, which was able to prevent unnecessary back surgeries by implementing a 10-week out-patient exercise program. Employees of a local company who had originally been recommended for surgery participated in the program. Sixteen months after completing it, 92 percent of the patients did not require surgery. This clinic won the HealthPartners' Innovations in Healthcare Award. Learn about other award winners at www.healthpartners.com. ▀

E-prescribing

Guide available online

SIX NATIONAL ORGANIZATIONS have created a comprehensive guide for physicians making the transition from paper to electronic prescribing systems. A Clinician's Guide to Electronic Prescribing offers information for physicians about e-prescribing and a step-by-step guide for doctors wishing to make the transition.

The guide was created by the eHealth Initiative, whose members include the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the Medical Group Management Association, and the Center for Improving Medication Management. It is available at www.ehealthinitiative.org.

A 2008 Minnesota law requires that any person or organization involved in prescribing, filling or paying for prescriptions, or communicating or transmitting formulary or benefit information must do so electronically by January 1, 2011.

The specific transactions covered by the law are exchanges of eligibility information, formulary and benefit information, medication history information, and eligibility information, as well as electronic prescribing.

For more information about e-prescribing requirements and Minnesota's 2015 interoperable electronic health record system mandate, please visit www.health.state.mn.us/e-health. ▀



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Medicare offers e-prescribing bonus

DON'T MISS the opportunity to receive bonus payments from Medicare for e-prescribing.

In 2009 and 2010, physicians who successfully submit prescriptions electronically may receive a bonus payment of 2 percent of their overall Medicare reimbursement.

In 2011, the reward will begin to phase out, and physicians will be penalized for not using e-prescribing starting in 2012.

To participate in the program, you must register and report through the CMS Physician Quality Reporting Initiative.

To qualify, a provider's e-prescribing system must

- generate a complete active medication list,
- select medications,
- print prescriptions,
- transmit prescriptions,
- conduct safety checks,
- provide information about lower-cost alternatives and formulary medications, and
- include patient eligibility and authorization requirements.

For more information on the incentive programs go to www.cms.hhs.gov/pqri/. ▀

Q&A

What really works?



Photo courtesy Dr. Chin

Marshall Chin, M.D.

Marshall Chin, M.D., has been hunting for practical things doctors can do to reduce poor outcomes for their minority patients. An internist and associate professor of medicine at the University of Chicago, Chin heads Finding Answers: Disparities Research for Change, a \$6 million program launched by the Robert Wood Johnson Foundation in 2005. Chin and colleagues also authored a literature review about efforts to reduce disparities that was published in *Medical Care Research and Review* in October 2007. We spoke with him about his findings and what he sees happening in medical practices today.

Q: Are physicians aware of disparities in care?

A: When you survey physicians, about 80 percent will say that they believe disparities exist in the country. However, if you ask them whether disparities exist in their practice, the number decreases to about 40 percent. So we are at a point where people have been exposed to the idea of disparities, but there is still a reluctance to think they exist in their own practice.

Q: Why do you think that is?

A: Physicians are well-intentioned and well-meaning and, by and large, very ethical and principled people. They probably think they are providing equitable care, but study after study has shown disparities in most practices.

Q: What patient groups receive lower quality care?

A: National studies demonstrate that patients of certain racial and ethnic backgrounds, those with lower socioeconomic backgrounds, those without insurance, and those who don't speak English do worse in terms of quality and outcomes.

Q: Can you give me an example of how language, race, ethnicity, or income can affect care?

A: When we are thinking about a patient with depression, the

bottom line is to try to improve their quality of life. To have the best outcome possible, the patient needs to have access to care. Once they see the doctor, the doctor needs to prescribe the right medications, counseling, and treatments. There needs to be adequate follow-up, and the patient needs to come back for more visits. If there are problems anywhere along that pathway, then the patient will do worse. So lack of insurance could affect access to care or their ability to afford medications. Some racial or ethnic groups might have stigmas about mental illness. Language, of course, is a huge issue in terms of collecting information to make a diagnosis and developing a relationship that leads to adherence and adequate follow up.

Q: What are some examples from your practice of how race is relevant?

A: I'm on the south side of Chicago and treat a number of African-American patients. There is a fair amount of historical mistrust of the health care system among them, so trust is an issue that often must be addressed. There can also be racial and ethnic traditions about food and exercise. Many of the African Americans in Chicago migrated from the South and eat a traditional southern diet that is high in fat. So any type of dietary counseling plan that doesn't take that into account will be doomed to failure. You have

Online resource

The Finding Answers: Research for Change website includes a searchable database of summaries of 206 journal articles about racial and ethnic health disparities interventions. www.solvingdisparities.org

to help the patient think through how they will adapt their current diet.

Q: Should doctors track the race of their patients?

A: Yes. Physicians don't think they have disparities in their own practice. But when people see their own data, they become motivated and take action.

Q: What is the goal of collecting race data?

A: Ideally you could stratify your patients by race, by insurance status, by language, and by socioeconomic status. Then you could document problems, target populations, and come up with interventions.

Q: Is this happening in practice?

A: Awareness has been raised, but there is still a long way to go. To date, most of the focus has been on documenting differences in care. We know from hundreds of studies that differences in care exist. But there is a crying need right now for more solutions and interventions that work.

Q: Why worry about race and ethnicity? Isn't it better to focus on improving quality for all patients?

A: One problem with a lot of current quality efforts is that they don't take race and culture into account. Some people believe that a rising tide will lift all boats, but the evidence seems pretty clear to us that some cultural tailoring provides additional benefits.

Q: Can physicians really make a difference? Aren't these gaps caused by greater forces in society?

A: There are some broader societal issues such as poverty and other more fundamental root causes; but there is plenty of evidence that physicians can play a major role in reducing some of the health care disparities we see. As I mentioned, we reviewed the literature and found more than 200 interventions. Many of them were successful. We know right now that there are plenty of things that we could be working on to reduce disparities.

When we did our review, we came up with three umbrella concepts:

- multifactorial interventions that target the multiple levers that affect the patient's pathway through the system,
- culturally tailored interventions seem to be more effective than

general interventions, and

- and nurse-led interventions can be especially useful. Nurse case management combined with community health workers providing patient education and social support to patients improved diabetes care in one urban clinic.

Q: How could these ideas work in clinics?

A: I think in the future we will see teams that closely track patients and interventions. These teams will include a physician, a nurse case manager, and a community health worker who will help the patient bridge what happens at home and what happens in the health care system because to improve outcomes you need to work on both.

Q: What would you tell physicians to do now?

A: Collect and look at your own data and make disparities reduction a specific part of your quality improvement efforts. You should enroll in a state-of-the-art disparities training program. These programs can help clinicians be more aware of their own biases. They also teach specific communication techniques—a common one being the teach-back method.

Q: Can racial and ethnic disparities in health care be eliminated?

A: I'm optimistic we will see a reduction in gaps in the upcoming years. But first we need to find more interventions that work in the real world. We also need to create the incentives and funding streams that help people do the right things. ▀

Carolina providers reduce amputations

ONE SUCCESSFUL EFFORT Marshall Chin points to is the Centers for Disease Control and Prevention's REACH 2010 initiative, which began in 1999. The CDC funded efforts to reduce disparities in about 40 communities. For example, in South Carolina, the REACH Charleston and Georgetown Diabetes Coalition focused on improving care for more than 12,000 African Americans with diabetes in two counties. By 2005, it had nearly eliminated a 21 percent gap in yearly blood-sugar testing rates between whites and African Americans. During a seven-year period, it reduced amputations among hospitalized African Americans with diabetes by more than 50 percent. The key was bringing clinics and community organizations together. For example, the Medical University of South Carolina School of Nursing used students to train African-American volunteers who served as diabetes educators. One program matched recently hospitalized African Americans with diabetes with volunteers from local churches who provided them with social and educational support. To learn more, visit www.cdc.gov/reach. ▀

MINNESOTA & NATIONAL ROUNDUP

State awards first health care reform contracts

THE STATE HAS TAPPED a group of Minnesota organizations to standardize Minnesota's health care quality measures—a mandate of the 2008 health care reform legislation.

The Minnesota Department of Health awarded the contract for the Quality Measurement and Incentive Payment System to St. Paul-based MN Community Measurement, which will work with the Minnesota Hospital Association, Stratis Health, the Minnesota Medical Association, and the University of Minnesota School of Public Health to lay the groundwork

for a uniform system of reporting on health care quality in Minnesota. The measures will be used in standardized payment-incentive programs.

The first phase of the contract involves creating an inventory of existing health care quality measures and recommending to the commissioner of health a set of measures for public reporting by January 30. The next phase will focus on creating an inventory of pay-for-performance programs operating in Minnesota and selecting a set of measures for pay-for-performance programs by February 2009. ▀

Price listings draw patients



AN ONLINE LISTING of prices for 83 procedures at primary care clinics and radiology facilities in the Twin Cities metro area is the most popular component of HealthPartners' website, drawing more than 107,000

search requests per month from members.

HealthPartners recently began offering the service, which lists specific prices at clinics in HealthPartners' open-access network.

The prices are for services in five high-volume categories: office visits, immunizations/vaccines, common lab services, X-rays, and CTs/MRIs.

In December, HealthPartners plans to expand the site's capability so members can compare prices for 100 services or procedures at up to three locations. ▀

Physicians agree on new measures

AT ITS SEPTEMBER 2008 meeting, the AMA's Physician Consortium for Performance Improvement voted on and approved new or updated measures in the following areas:

- child and adolescent major depressive disorder (new),
- preventive care and screening (updated), and
- obstructive sleep apnea (new).

To access the measures and supporting tools, please visit www.physicianconsortium.org

Recent ICSI guidelines

- Initial Management of Abnormal Cervical Cytology (Pap Smear) and HPV Testing (October)
- Menopause and Hormone Therapy: Collaborative Decision Making and Management (October)
- Immunizations (October)
- Preventive Services for Adults (October)
- Preventive Services for Children and Adolescents (October)
- Diagnosis and Treatment of Osteoporosis (September)
- Routine Prenatal Care (August)

Minneapolis internist wins quality award

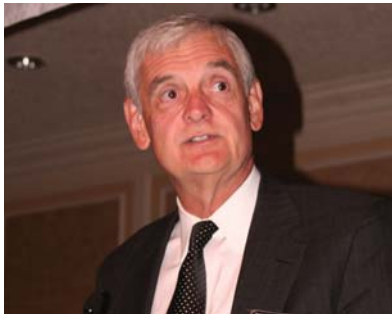


Photo by Scott D. Smith

Brian Anderson, M.D., accepts his award at the MMA's Annual Meeting in September.

BRIAN J. ANDERSON, M.D., received the MMA Physician Leadership in Quality Award in September for his work in quality improvement, his passion for teaching health care executives about quality improvement, his efforts to improve quality and safety at rural hospitals, and his support of measurement and transparency in health care.

A Minneapolis internist and cardiologist in private practice, Anderson worked with Stratis Health to help rural hospitals improve their care of heart failure and stroke patients.

He was a key contributor to the development of the Hospital Quality Report, a joint project by the Minnesota Hospital Association and Stratis Health that was launched in 2005. Anderson also serves on the board of MN Community Measurement. ▀

Post-heart attack deaths linked to income and education

IN THE JUNE ISSUE of *Mayo Clinic Proceedings*, Mayo Clinic researchers reported the results of a study that found residents of Olmsted County who had lower incomes and education levels were more likely to die after a heart attack than those who were more affluent and educated.

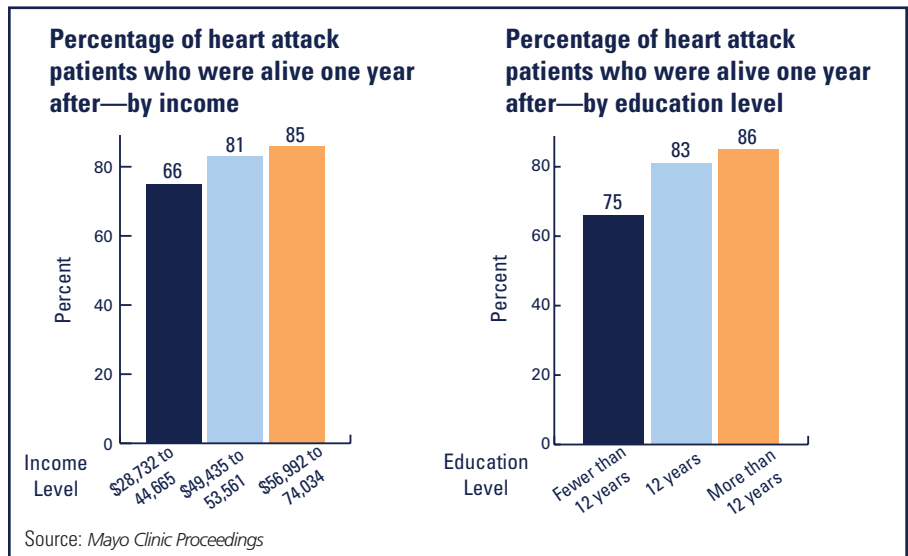
The authors examined medical records from 705 patients in the county who were treated for heart attack between November 1, 2002, and May 31, 2006.

Researchers recorded the years of schooling completed (self-reported by the patients on a questionnaire) and neighborhood income (obtained by linking the participant's address to 2000 U.S. Census Bureau data) for each participant. Participants were divided into

three groups by income and three by level of education. Researchers analyzed survival data across these groups.

Among the 155 deaths recorded during the study period, one-year survival estimates were lowest for people in the lowest income group.

"Higher levels of education also could directly affect health through greater knowledge acquired during schooling and greater empowerment and self-efficacy," wrote Yariv Gerber, Ph.D., the study's lead author. "Education is strongly associated with health literacy, which in turn affects one's ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions." ▀



Physicians, insurers seek common P4P measures

IN OCTOBER, the Minnesota Medical Association and the Minnesota Council of Health Plans brought together employers and other health care stakeholders to identify a common set of measures payers could use for incentive programs. Right now, the variety of measures being

used in pay-for-performance programs increases administrative costs and burdens. As a result of the collaboration, physicians, health plans, and employers recommended that MN Community Measurement measures be used for pay-for-performance initiatives, when pos-

sible. The group also recommended MN Community Measurement be involved in the development of future measures. The recommendations are nonbinding, and payers will still be free to choose their own measures. ▀

Exposing a gap

Patients with public insurance are less likely to receive optimal care

THE NATION'S FIRST LARGE-SCALE look at the quality of care clinics provided patients with public insurance versus those with private insurance reveals a gap. Patients enrolled in public insurance programs received preventive screenings and optimal care for conditions such as diabetes less often than those who had private insurance.

The study, which was conducted by MN Community Measurement at the request of the Minnesota Department of Human Services, looked at the quality of care received by patients with private insurance and those who were enrolled in Medical Assistance, MinnesotaCare, and General Assistance Medical Care. Using health plan claims and medical records data, MN Community Measurement looked at care delivered by clinics in 2006 for asthma, diabetes, pharyngitis, upper respiratory infections, childhood immunizations, and screenings for chlamydia, and breast and cervical cancer.

“As a whole, Minnesota medical groups are significantly less successful at achieving quality-of-care outcomes for people on public programs. We found this to be the case in seven of eight measures,” says Jim Chase, executive director of MN Community Measurement, which released the results of the study in September. The difference was most striking for breast cancer screening, with about one-fifth fewer public program patients ages 52 to 69 having a mammogram during the past two years than privately insured patients. The difference in care of children with public and private coverage was also marked in the areas of appropriate testing for pharyngitis and immunizations. Testing for chlamydia was the only category in which public enrollees were screened at a higher rate.

The study did not try to uncover causes, but Chase says language barriers, misunderstandings, or access to care may have played a role. Public programs include enrollees with low socioeconomic status, as well as a disproportionate share of persons of color, American Indians, and persons with disabilities, compared with Minnesota’s general population, he says. “Medical groups have told us that people on public programs are not being offered different care, but have different challenges, and that may be what is driving the gap,” he says.

Some clinics shine

Not all clinics saw such disparities, however. Fairview Health Services achieved comparable rates for providing optimal care to publicly and commercially insured patients with diabetes, with

2007 Summary of Differences in Rates of Patients Receiving Optimal Care with Private and Public Insurance

Quality Measure (ages)	Public Insurance Average (%)	Private Insurance Average (%)
Asthma Care (5-56)	88.1	92.6
Optimal Diabetes Care (18-75)	6.5	11.4
Appropriate Treatment for Children with URI (3 mos.-18 yrs.)	83.8	85.0
Appropriate Testing for Children with Pharyngitis (2-18)	73.0	85.9
Breast Cancer Screening (52-69)	57.6	77.1
Cervical Cancer Screening (21-64)	71.9	79.0
Chlamydia Screening (16-25)	47.9	37.7
Childhood Immunizations (2)	68.2	78.3

nearly 20 percent of public and private patients receiving optimal care. This was higher than the state average of 7 percent. Optimal diabetes care includes control of blood sugar, blood pressure, cholesterol; daily use of aspirin, and abstaining from tobacco use. Columbia Park Medical Group and Allina Hospitals and Clinics also received comparable results for public and private patients.

Fairview credits the achievement to its team approach and use of care plans tailored to the needs of each individual patient with diabetes. “We are not looking at the income levels, we’re looking at what does this individual need to be successful,” says Carla Screeden, vice president for employed physician services. For example, nurses try to get subsidized medicines for patients who are financially strapped. If transportation is an issue, Fairview schedulers try to group services such as lab work, a doctor visit, and counseling with a nutritionist into one visit, thus reducing copays and transportation problems.

Similarly, HealthPartners found that same-day mammograms improved breast cancer screening rates by eliminating the chance that patients might go home, reconsider, and not follow through.

“If I spend time really talking to them and convincing them that this would be a great screening, and add in that we can do it today, then that gives them a little more confidence to go ahead, and get it done,” says Jennifer Hines, M.D., an internist at HealthPartners Midway clinic. ▀