

MINNESOTA MEDICINE

APRIL 2013

PRICING PROBLEM

HOSPITALS AND CLINICS STRUGGLE TO TELL PATIENTS WHAT THINGS COST

PAGE 18

ALSO INSIDE:

PUBLIC PROGRAM snapshot PAGE 8

Troubles for **TEACHING PROGRAMS** PAGE 14

Talking to **VACCINE-HESITANT PARENTS** PAGE 49

PLUS:

Care of the **FRAIL ELDER** PAGE 39



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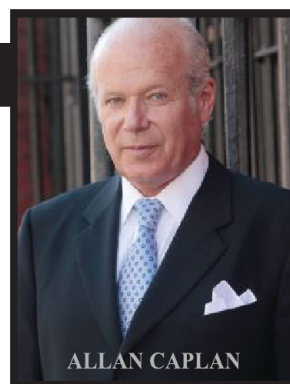
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CONTENTS

April 2013 | VOLUME 96 | ISSUE 4

FEATURES

ON THE COVER

18 Pricing problem

Hospitals and clinics struggle to tell patients what things cost.

BY SUZY FRISCH

FEATURE

8 Public program snapshot

How Minnesota's public health insurance programs are changing under the ACA.

BY KIM KISER

FEATURE

10 Finally, a policy on policies

After months of waiting to find out which health benefits are essential, insurers are now scrambling to comply with the fed's requirements.

BY CARMEN PEOTA

FEATURE

14 Troubles for teaching programs

Clinical training sites adapt to funding cuts they hope will be temporary.

BY HOWARD BELL

Clinical AND Health Affairs

39 Care of the Frail Elder:

The Nexus of Geriatrics and Palliative Care

BY ABDULLAH LADHA, M.B.B.S., SAURABH SHARMA, M.B.B.S., JOHN A. BATSIS, M.B.B.CH., GREGORY A. HANSON, M.D., AND KEITH M. SWETZ, M.D., M.A.

43 Value-Based Purchasing for Physician Services

BY BRYAN E. DOWD, PH.D., SHRIRAM PARASHURAM, M.S., TAMI SWENSON, M.S., ROBERT KANE, M.D., ROBERT COULAM, PH.D., AND DAVID KNUTSON, M.A.

46 Measuring Medical Productivity to Gauge the Value of Medicare

BY STEPHEN T. PARENTE, PH.D.

49 The C.A.S.E. Approach: Guidance for Talking with Vaccine-Hesitant Parents

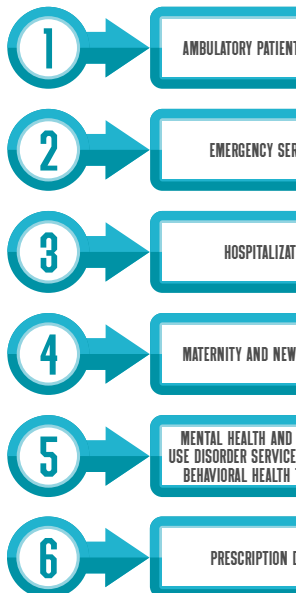
BY ROBERT M. JACOBSON, M.D., F.A.A.P., LINDA VAN ETTA, M.D., F.A.C.P., F.I.D.S.A., AND LYNN BAHTA, R.N.



8



10



14



DEPARTMENTS

4 EDITOR'S NOTE

5 PULSE

Cesareans and savings, U health programs rank highly, the value of the annual physical, payment reform manifesto

26 THE PHYSICIAN ADVOCATE

ClearWay's David Willoughby, MMA kicks off policy forums, MMA news briefs.

51 EMPLOYMENT OPPORTUNITIES

55 AD INDEX

PERSPECTIVE

24 Lost in translation

A simple lesson about our emergency system might have saved a life.

BY KRISTINA KROHN, M.D., AND PATRICIA WALKER, M.D., DTM&H

COMMENTARY

34 Beyond Obamacare

How a single-payer system could save health care in the United States.

BY DAVE DVORAK, M.D., M.P.H.

36 Paying for and delivering pregnancy care

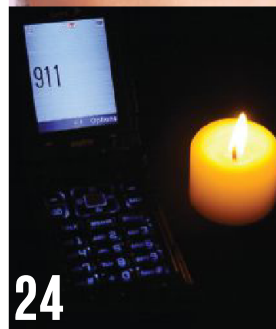
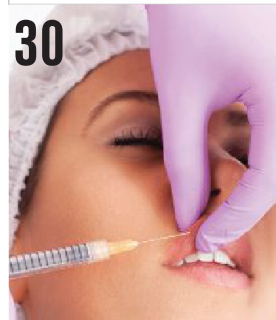
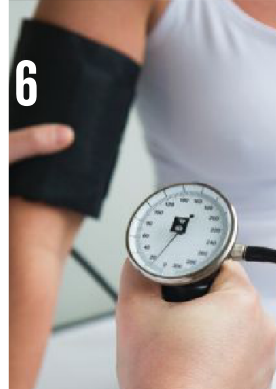
It's time to revamp the care delivery and payment model to improve the value of pregnancy care.

BY STEVE CALVIN, M.D., AND AMY ROMANO, C.N.M.

END NOTE

56 Rose

A POEM BY MICHAEL SHREVE, M.D.



MINNESOTA MEDICINE

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Annual subscription: \$45 (U.S.) and \$80 (all international)

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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

How do you gauge
what is useful and
what is wasteful
in caring for patients?

Measuring up

Like the inchworm measuring the marigolds in the song, health care payers continue their seemingly eternal quest to measure the unmeasurable. Whether it's health or marigolds, the baffling and the beautiful are hard to quantify, and that is one of the fundamental enigmas that face health care buyers, both public and private. How do you measure quality of care? How do you gauge what is useful and what is wasteful in caring for patients? What yardstick (or inchstick) do you use to assess health? The unfolding of the Affordable Care Act (ACA) has reinvigorated the search at all levels for a health care system that behaves more like a physics experiment than the messy thing we currently have. So far, the answer has been more elusive than the Higgs boson.

More than ever before, the actions of the public sector are driving the hunt. As the federal and state governments flesh out the health exchanges mandated by the ACA, perplexing details such as what should be included in a list of core health benefits to be covered and how to factor value into the price that is paid are challenging the best minds in Washington and St. Paul. In an age of fiscal cliffs and sequesters, those minds face a technology-addicted, aging, entitled population and a medical profession feeling embattled and even somewhat embittered. This mix of frugality, complexity and politics is dizzying to even the most well-intentioned public servant.

Those servants currently work in what can only be called a dysfunctional environment. Like drivers in the worst Manhattan traffic jam, senators and representatives honk loudly and call each other names,

generating heat and noise but little movement. Like much Internet communication today, public conversations between politicians are unidirectional assertions of partisan platitudes with little thought of dialogue. Perhaps constructive problem solving still happens behind closed committee doors—but for the bewildered public, the perception is that purposeless gridlock reigns.

The problems are daunting—the growing number of frail elders, the plight of the underinsured underclass, the shortage of primary care providers. Certainly measurers will help us wade through the mess and numbers will help answer some of the questions. But sometimes it seems we need dowsing rods rather than yardsticks to unearth a solution beyond the reach of calculations. Or perhaps we need mediators rather than actuaries to bring the shouters to the table and untangle the rat's nest in Congress. Only when conservatives start thinking like duly elected representatives instead of posturing revolutionaries and liberals realize that a compromise solution is better than no solution will we start fixing health care.

In his recent album, *Kisses on the Bottom*, that revisits old favorites, Paul McCartney simply and gently sings the inchworm song in his sweet tenor voice—“Inchworm, inchworm/Measuring the marigolds/You and your arithmetic/You'll probably go far.” Whether the planners of tomorrow's American health care system and the system they fashion will go far, remains to be seen. **MM**

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Nearly half of U.S. births are paid for by state Medicaid programs, and many of those births are cesarean sections.



Cesareans and savings

Childbirth is the most common and costly reason for hospitalizations in the United States. Nearly half of births are paid for by state Medicaid programs, and many of those births are cesarean sections. In 2009 alone, U.S. public health insurance programs paid more than \$3 billion for cesarean deliveries.

In order to learn more about birthing trends, University of Minnesota School of Public Health researcher Katy Kozhimannil, Ph.D., studied discharge data from 593 U.S. hospitals, each of which had at least 100 live births in 2009. She found the rate of c-section deliveries varied 10-fold—from 7.1 percent to 69.9 percent. Among women having low-risk pregnancies (those that were not preterm, breech or multiples and those who had not already had a cesarean delivery), the rate ranged from 2.4 percent to 36.5 percent.

Kozhimannil, who published her findings in the March issue of *Health Affairs*, noted that such variation was concerning and offered the following recommendations:

- Providing women having low-risk pregnancies access to care provided by midwives and trained doulas in licensed birthing centers
- Gathering more and better data on the quality of maternity care
- Rewarding hospitals and clinicians for consistently providing evidence-based care
- Making information about cesarean rates and other aspects of maternity care available to pregnant women.

In a separate study of Medicaid-funded births, Kozhimannil and her team found that women who received education and support from a doula had 40 percent fewer cesarean births than similar women who did not receive such support. Kozhimannil noted that this may be a case where “adding coverage on the front end could ultimately result in real dollars saved.”

Sources: Kozhimannil KB, Law MR, Virnig BA. *Health Affairs*. 2013; 2013 Mar;32(3):527-35. Kozhimannil KB, Hardeman RR, Attanasio LB, et al. *Am J Public Health*. 2013 February 14: e1-e9.

U programs make top 10

The University of Minnesota's health sciences schools fared well in the latest *U.S. News and World Report* ranking. A number of their programs made the top 10 in their category. Here's a listing of how they rated:

- The Medical School ranked fifth in rural medicine, seventh in primary care instruction and 10th in family medicine education
- The College of Pharmacy ranked third in the nation, with its masters of health care administration program ranking second
- The School of Public Health ranked fifth among public universities and eighth altogether
- The College of Veterinary Medicine maintained its ninth-place ranking
- The School of Nursing's graduate program in public health nursing ranked sixth and its midwifery program ranked eighth; the school ranked 25th overall.

U.S. News and World Report issued the rankings in March.



Annual physical not worth it?

A Cochrane Review published in October 2012 calls into question one of the mainstays of preventive medicine: the annual physical. Researchers looked at 16 randomized trials involving more than 180,000 people that compared groups who received general health checks with those who did not. The result: checks on healthy people did not reduce morbidity and mortality, including death from cardiovascular diseases and cancer.

The authors speculated that the results might be explained by the fact that primary care physicians identify and intervene when they suspect a patient is at risk of developing disease when they see them for other reasons and that those patients at highest risk of developing disease may not get health checks.

Source: Krogsboll LT, Jorgensen KJ, Larsen CG, Gotzsche PC. General health checks in adults for reducing morbidity and mortality from disease.



Payment reform manifesto

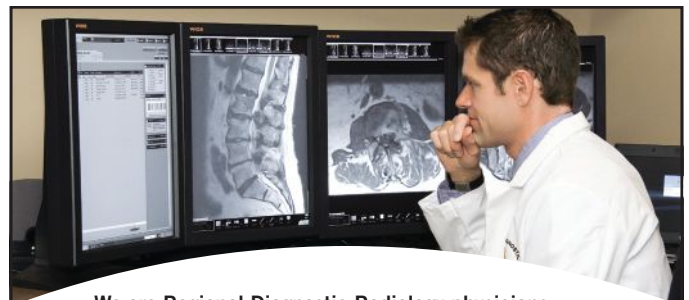
The National Commission on Physician Payment Reform, a group that was formed a year ago by the Society of General Internal Medicine, recently released a five-year blueprint for transforming physician payment. The group, which included health policy experts, researchers, health care organization leaders and physicians, issued 12 recommendations for changing the way doctors get paid.

Among them:

- Increase reimbursement for evaluation and management (E&M) services
- Pay equal rates for the same physician services regardless of specialty or setting
- Abolish Medicare's Sustainable Growth Rate payment system
- Eliminate stand-alone fee-for-service payment to medical practices over time.

The commission's co-chair Steven Schroeder, M.D., of the University of California, San Francisco, said in a statement, "The way we pay doctors is profoundly flawed. We need to move rapidly away from fee-for-service and embrace new ways of paying doctors that encourage cost-effective, high-quality care. The commission's recommendations put us on that path."

The full report is available online at http://physicianpayment-commission.org/wp-content/uploads/2012/02/physician_payment_report.pdf.



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Public program snapshot

BY KIM KISER



Health Insurance Exchange

Electronic marketplace for health insurance. The exchange will refer Minnesotans the public program for which they qualify. Minnesota's exchange is scheduled to



Medical Assistance/Medicaid

Minnesota's largest publicly funded health program, covering more than 600,000 people a month on average. Medical Assistance (MA) is funded with both state and federal dollars. Most beneficiaries are enrolled in managed care plans (the Prepaid Medical Assistance Program).

What's changed: Families with children and pregnant women who met certain income requirements have long been eligible for MA. Adults without children who have incomes below 75 percent of the federal poverty level (\$8,600) became eligible in March 2011. Those individuals had been enrolled in General Assistance Medical Care, which was discontinued. In 2012, people with disabilities who had been enrolled in fee-for-service MA were encouraged to move to a managed care plan.

On the docket: In February, Gov. Mark Dayton expanded MA eligibility to adults younger than 65 years of age who earn up to 138 percent of poverty (\$14,859 for a single adult) starting in 2014. This could bring an additional 87,000 people into the program, approximately 53,000 of whom would come from MinnesotaCare. The federal government will pay 100 percent of the cost for those additional enrollees during the first three years. The feds' contribution will gradually drop to 90 percent by 2020.



MinnesotaCare

A state-subsidized health insurance program for the working poor (families with incomes below 275 percent and childless adults with incomes up to 200 percent of poverty). It is funded through premiums, federal dollars and the 2 percent tax on Minnesota hospitals and health care providers. In 2012, it served an average of 129,000 people per month.

What's changed: 53,000 MinnesotaCare enrollees could be transferred to MA in 2014.

On the docket: Starting in 2014, current enrollees who are not transferred to MA will receive a federal subsidy to purchase coverage through the health insurance exchange, possibly eliminating the need for MinnesotaCare. The Commissioner of Human Services has been working with Minnesota's Congressional delegation to instead use the subsidy money to preserve the program as the state's Basic Health Plan, which will serve those who do not qualify for Medicaid or Medicare but who have incomes between 133 percent and 200 percent of poverty. Created by the ACA, Basic Health Plans are to be more affordable than private insurance.

With passage of the Affordable Care Act (ACA) came the promise of health insurance for more people who had previously gone without. That promise has led to changes in the public health

insurance programs operating in Minnesota. Here's a brief look at how both federal and state health care reform efforts are changing these programs.

BY PETE SOUZA/NOTWIST (PHOTO BY PETE SOUZA, MODIFIED BY UPLOADER) [CC-BY-3.0 (HTTP://CREATIVECOMMONS.ORG/LICENSES/BY/3.0)], VIA WIKIMEDIA COMMONS

ACA



to policies they can purchase or to be operational in October 2013.

Affordable Care Act

Referred to as "Obamacare," this 2010 law allows states to expand access to Medicaid and creates state and federally run health insurance exchanges, which serve as a marketplace for health insurance.



Healthy MN

Provides single adults with incomes up to 200 percent of poverty with vouchers from the state to buy health insurance. Started in July of 2012 to shift people from MinnesotaCare to the private market. Acceptance has been slow.



MCHA

Minnesota Comprehensive Health Association

Provides health insurance coverage to those who have been turned down because of a pre-existing condition. Also called Minnesota's high-risk pool, MCHA provides coverage to about 26,000 adults.

MCHA was created by the Minnesota Legislature in 1976; however, it is not a state program. It is funded by premiums paid by enrollees and an assessment on health plans.

On the docket: The ACA states that insurers can no longer turn away applicants because of pre-existing conditions. Starting in October 2013, all Minnesotans will be able to purchase individual health coverage through the state's health insurance exchange. This will provide those who have pre-existing conditions with alternatives to MCHA.



Pre-existing Condition Insurance Plan

A federally run program for those locked out of the health insurance market because of a pre-existing condition. It was designed to fill a need until 2014, when insurers are required to accept all comers. It does not replace state high-risk pools such as MCHA.

What's changed: The plan stopped accepting new enrollments in March 2013.

On the docket: Because insurers can no longer turn away applicants with pre-existing conditions, those who need coverage will be able to shop for it using the health insurance exchange.

Finally...

A POLICY ON POLICIES

After months of waiting to find out which health benefits are essential, Minnesota insurers are now scrambling to comply with the fed's requirements.

BY CARMEN PEOTA

On February 20, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius quietly announced a final rule related to one aspect of the Affordable Care Act (ACA): the provision that health insurance plans need to cover a set of essential health benefits.

Although the announcement caused only a ripple in the media, health insurers were paying close attention. They had been waiting for months to hear what they would need to include in the policies they would be offering through the health insurance exchanges starting in 2014.

The ACA itself requires that all insurance products need to cover services in 10 categories (see "The 10 Essentials"). But it doesn't deal in specifics and instead directs the Secretary of HHS to provide them.

Rather than bore into specifics in her final rule, however, Secretary Sibelius punted on the arduous and politically difficult task of naming an essential health benefit set for the nation. Instead, she noted that for the next two years each state must design health insurance products that mirror a typical plan in that state yet

also include services in the 10 required categories.

"What she said was, for the next two years, we're going to let the states figure this out," says Manny Munson-Regala, J.D., assistant to the Minnesota Commissioner of Health. "From my perspective, she kind of threw a curve ball at all of us."

Pragmatic move

Although it may have been a curve ball, the Secretary's ruling didn't come from left field. Months earlier, HHS had hinted at what it would do. In December 2011, the

agency announced its intention to take “a benchmark approach” and asked states to identify a plan in their markets that reflected a typical employer plan and could serve as a benchmark. They could select from the three largest (by enrollment) commercial small-group plans, the state or the federal employee plans, or they could pick the largest commercial HMO plan operating in the state. If they didn’t make a choice, their state’s largest small-group plan would become the benchmark.

Twenty-six states selected a benchmark plan. Munson-Regala says Minnesota policymakers did not have the authority to do so, so a HealthPartners plan became the benchmark. To insurers in Minnesota, the rule means that to comply with the ACA, they need to design insurance plans that look a lot like HealthPartners’ 500 25 Open Access plan and offer services in all 10 categories identified in the ACA. (Insurers can make decisions about the specific types and quantity of services covered as long as they don’t change the financial value of coverage.)

Munson-Regala sees the situation like this: “You tell restaurants that they need to have 10 courses and the courses can’t exceed the caloric value of X, but you don’t specify that the bread has to be sourdough or whole wheat or rye. So there’s some flexibility. I think the logic is that you want to have enough commonality so that consumers feel assured that in these 10 areas there will be some coverage while allowing the plans flexibility in figuring out how they want to meet those requirements... not to mention to provide a way so they can differentiate themselves from each other in the commercial market.”

Although there are some who want more clarity about what the essential benefit set is and eventually will be, Munson-Regala says he understands why HHS took the approach it did. “There obviously would have been folks objecting to that clarity, particularly if it resulted in a significant disruption in the marketplace.”

He says Secretary Sebelius was being pragmatic and true to her roots as a former insurance commissioner and governor of Kansas. “She’s a big believer



THE 10 ESSENTIALS

The Affordable Care Act didn’t identify exactly what needed to be included in an essential health benefit set. But it did say insurers need to include items and services within these 10 categories:

- 1 → AMBULATORY PATIENT SERVICES
- 2 → EMERGENCY SERVICES
- 3 → HOSPITALIZATION
- 4 → MATERNITY AND NEWBORN CARE
- 5 → MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT
- 6 → PRESCRIPTION DRUGS
- 7 → REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES*
- 8 → LABORATORY SERVICES
- 9 → PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT**
- 10 → 10. PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE**

*What is meant by “habilitative” was not clearly defined.

**Chronic disease management and pediatric oral and vision care have not typically been covered by insurance plans in Minnesota.

in giving states flexibility and control of their markets. I think that by doing it the way she did, it allowed for a transition to what she's going to have to do in 2016, when CMS revisits how it defines essential health benefits and determines whether it's time to set a national standard."

“EVERY INSURANCE COMPANY RIGHT NOW IS GOING THROUGH A MASSIVE OVERHAUL OF THEIR ENTIRE PORTFOLIO.”

– DANNETTE COLEMAN

A tough task

Whether the Secretary will say what benefits ought to be considered essential for all Americans by then remains to be seen. Clearly, managing a discussion where competing interests, differing values and changing science all must be considered is no easy task. When HHS asked for public comments on its intended approach to the essential benefit set, those from Minnesota alone included petitions for including coverage for visits with registered/licensed dietitians, smoking cessation, addiction treatment, mental health care, acupuncture, physical therapy services and habilitative treatments for autism.

“You’re balancing the very legitimate needs of individuals with the fact that there’s a price associated with the way coverage is provided,” Munson-Regala points out. “I don’t envy any decision maker having to figure out what the right balance is.”

In 2008, a Minnesota work group did engage in such a discussion. Following passage of the state’s health reform legislation, the then-Commissioner of Health convened the group to come up with an essential health benefit set for the state.

Roger Kathol, M.D., who was a member, says the majority of issues that came up were pretty noncontroversial—for example, there’s little debate about giving flu and pneumonia vaccines to the elderly. And people generally agreed that elective procedures such as cosmetic surgery shouldn’t be covered and that it probably

isn’t essential that people have private hospital rooms. But he recalls that the discussions about issues such as circumcision, for which the evidence shows only a small health benefit but where religious and personal feelings are strong, were difficult. And, he says, arguments for in-

cluding such clearly beneficial services as mental health care and care management for chronic conditions often ran up against those about cost.

The group did eventually submit their recommendations for an essential benefit set to the Department of Health. But those recommendations remained on a shelf. Shortly after they completed their work, Congress passed the ACA, and the issue moved to the national arena.

Rushing to be ready

Although all Minnesotans will one day benefit from having coverage for a comprehensive array of services, the ones most affected by the HHS final rule right now are those who are scrambling to help insurance companies comply with it. “Today, no products are compliant with the ACA,” says Dannette Coleman, vice president and general manager of Medica’s individual and family business.

She says some will need minor tweaks such as adding pediatric vision and dental and habilitative services now called for in the ACA. Individual plans are more likely to see changes than group plans, as individual plans have allowed people to opt out of coverage for things that are now required, such as maternity care, mental health care and substance abuse treatment. “In the future, they’ll just automatically be embedded in the product,” Coleman says. She also points out that policies can no longer have very large deductibles, as the new rule also spells out limits on out-of-pocket spending.

Because of these requirements, Coleman says “Every insurance company right now is going through a massive overhaul of their entire portfolio.” In addition, they are doing technical work so they can connect with exchanges and process premiums that might come partly from an individual and partly from the government.

“I don’t think anybody feels they have enough time, whether it’s the government or the health plans, but the deadlines are real, so we are certainly putting forth every effort,” she says.

Coleman says most consumers will notice few changes in their policies because Minnesota law already requires insurers to cover many services. They may see higher premiums, however. “If you think about the individual market, people are going to have less cost sharing, more services are going to be covered, and anybody regardless of their health status gets insurance. The combination of those things will make the average premium higher.” Coleman says she is concerned that higher premiums could cause some people to choose not to buy insurance.

Julie Brunner, executive director of the Minnesota Council of Health Plans, says the health plans have worked hard to manage the cost of premiums by designing products that have higher co-pays or deductibles, giving incentives for people to do preventive care, requiring prior authorization and offering chronic disease management programs. “What I think the plans will be trying to sort through now is which of those tools are still available.”

She doesn’t think even a federal mandate for an essential health benefit set will squelch competition in the insurance market. “I think the plans will continue to work hard to distinguish themselves in product design and in cost,” she says. “We’re in a period of transition, and it will be very interesting to observe what the marketplace looks like in three or four years.” MM

Carmen Peota is managing editor of *Minnesota Medicine*.

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Troubles for teaching programs

Clinical training sites adapt to
funding cuts
they hope will be temporary.

by **Howard Bell**



In 2011, Minnesota's Legislature cut by half an important source of funding for training the state's future health care workforce. Support for the Medical Education and Research Costs (MERC) trust fund went from \$63 million to \$31 million as part of a larger effort to eliminate the state's budget deficit. Since then, clinical training sites have scrambled to bridge that funding gap without sacrificing the quality or amount of training they do.

The Minnesota Legislature established MERC in 1997 to compensate hospitals and clinics for a portion of the cost of training medical students, residents, fellows, advanced practice nurses, physician assistants, pharmacists, chiropractors and dentists. Every two years, it appropriates money to the fund from the state's cigarette tax; Medical Assistance, the state's Medicaid program, which accounts for 75 percent of the funding; and a federal match. The Minnesota Department of Health administers and disperses the dollars.

MERC is a relatively small source of funding for clinical training, but it's an important one. Other dollars come from the state's appropriation to the University of Minnesota. That amount has been cut by 20 percent since 2008, according to Barbara Brandt, Ph.D., the University of Minnesota Academic Health Center's (AHC) vice president of education. The bulk of the funding comes from teaching hospitals' and clinics' general revenues, and Medicare pays for some through its Direct and Indirect Graduate Medical Education Payments. But the Medicare dollars can only be used for training residents, not medical students and other health professionals.

In 2011, the most recent funding cycle, 21 teaching programs received MERC money. Those programs distributed the dollars to 621 clinical training sites across the state. Those sites provided training to more than 3,100 full-time equivalent trainees.

Weathering the cuts

A number of factors contribute to the cost of providing clinical training, including the fact that teaching students can slow down clinicians (some estimate by as much as 20 to 25 percent). Because of that, training sites can lose patient care revenue when they take on students. In addition, they incur expenses such as those for administrative support, office supplies, conferences and even lab coats.

Teaching programs and their training sites have been weathering the cuts mostly by diverting money from general operating funds and in some cases eliminating clinical rotations, all while hoping that this May the Legislature will restore MERC money to near 2010 levels—\$57 million per year for fiscal years 2014 and 2015.

"Because Governor Dayton's budget calls for MERC funding to increase in 2013, we did not feel it was prudent to make radical changes to our training programs, especially given the state's health care workforce shortage," says Michael Belzer, M.D., chief medical officer and medical director at Hennepin County Medical Center (HCMC) and assistant dean of the University of Minnesota Medical School. Belzer is also on the MERC Advisory Committee, which helps the Department of Health fine-tune MERC disbursement policies. Before the 2011 cuts, MERC covered 20 percent of medical education costs at HCMC. In 2011, it paid 10 percent or \$4 million.

HCMC has used \$11 million in general operating funds to keep its programs whole for two years—almost whole that is. "We eliminated many rotations to underserved rural and inner-city clinics," Belzer says. Rotations at those sites aren't eligible for Medicare training money. So when MERC was cut, Belzer explains, "We tried to consolidate rotations to where we get reimbursed." HCMC also curtailed or eliminated some research projects and

had to divert money from other areas to support its Simulation Center, where high-tech manikins are used to train students in such procedures as putting in central lines and IVs and intubation.

Delayed reaction

MERC money is paid out one year after clinical training takes place, so the effect of cuts is delayed, says Brandt, who is also on the MERC Advisory Committee. "I'm hearing that sites and health systems are just now realizing the full effects."

At the AHC, the effects are sizable because it receives 64 percent of all MERC money. The cuts will amount to \$16 million this year and another \$10 million next year if funding is not restored. "It put a serious strain on the university's ability to find and retain clinical training sites," says Terry Bock, the AHC's associate vice president and chief of staff.

For example, several of the AHC's pediatrics and OB/GYN training sites have made significant reductions in the number of residents and medical students they are willing or able to train. Bock says it has been especially hard to find placements for first- and second-year medical students because they primarily observe, which affects physicians' productivity, and even to some extent third- and fourth-year students who help provide care.

The 2011 Legislature also completely eliminated the \$5 million MERC appropriation to the AHC for innovative training programs. Although the university has patched together some temporary funding, it has had to reduce its support of clinical training at dental clinics for the underserved in the Twin Cities, Willmar and Hibbing, and for medical, dental, nursing and resident rotations at the Community University Health Care Clinic in Minneapolis' Phillips neighborhood. It also reduced resident rotations at University of Minnesota Physicians' clinics and at

the University of Minnesota Medical Center, Fairview. Gone, too, is the MERC support for a palliative care training program in Staples as well as other programs that expose students to rural practices.

Brandt says the AHC had seen an increase in the number of students interested in practicing in rural, underserved areas because of those training programs.

A crucial pipeline

Duluth's Family Medicine Residency Program is so crucial to maintaining the region's supply of primary care doctors

managed by the Duluth Graduate Medical Education Council, a collaborate partnership of the University of Minnesota and the two hospitals.

MERC used to cover 16 percent of all of the residency program's operating costs. Now it covers 7 percent—a half million dollars less. Residency program operations would have been seriously hobbled had St. Luke's and Essentia not stepped in, making up for the lost money mostly by using Direct and Indirect Medical Education Payments from Medicare that would have been used elsewhere at the hospitals.

for medical students enrolled in the Rural Physician Associate Program (RPAP), a University of Minnesota program in which third-year medical students spend nine months working at a rural clinic alongside a family medicine preceptor. "Our commitment to training students interested in rural medicine hasn't changed," says Gateway's administrator Eric Nielsen. "We're just having to subsidize more of the cost of doing it."

Cuts on top of cuts

Mayo Clinic saw its MERC funding disappear back in 2007, when the Legislature changed how MERC money gets handed out. Until then, 67 percent of what a facility received was based on how many trainees it has and 33 percent was based on the facility's volume of Medicaid patients. Since 2007, that allocation has been based entirely on Medicaid volume. "We went from receiving 28 percent of the state's MERC funds to 4 percent," says Steven Rose, M.D., dean of Mayo's School of Graduate Medical Education. "We've had to divert money from patient care funds to cover the cost of clinical training. It's forced us to limit growth in other areas."

Mayo rolls its MERC money into its sizeable education budget to help pay salaries, administrative costs and stipends for its residents and fellows. Some of the money is passed on to Critical Access Hospitals and public health clinics that sponsor Mayo trainees, including pharmacy students.

The Medicaid-weighted formula for distributing MERC money means that a pharmacy student worth \$186,000 in MERC money at a facility with a high volume of Medicaid patients is worth only a few thousand dollars at a facility with a low Medicaid volume, even though training costs and quality are similar at both places. It's a case of the tail wagging the dog, according to Kathleen Meyerle, J.D., Mayo's legal counsel for MERC matters. "We need to decide if MERC is going to be a way to pay for clinical training or a secondary way to distribute entitlement payments."

"We need to avoid a domino effect,
where fewer preceptors provide fewer
clinical experiences for students, which
makes the workforce pipeline smaller."

—Katherine Dean

that both of the city's hospitals—Essentia Health and St. Luke's—give 100 percent of their MERC money to the program. "Hospitals aren't required to do this," says Katherine Dean, director for health science and medical education at Essentia's Institute for Rural Health. "Most keep some of the money to pay some of their own clinical training costs; but the residency program is so important to the region's primary care workforce that the hospitals give the program all of their MERC money."

Essentia Health has managed the residency program and its training clinic—the Family Medicine Clinic—since July partly because the MERC cuts were the final fiscal straw for the nationally acclaimed program that was already on shaky financial footing. Before that, the program was

"Without their increased support, the residency program would not have been able to meet its operational budget," Dean says.

The residency program uses the MERC money it does receive for everything from resident and staff salaries to keeping the lights on at the clinic. Before the cuts, MERC funding almost covered the stipends paid to Essentia physicians who teach residents and medical students. Now it pays for roughly one-third, according to Dean. "It doesn't come close to covering the full cost of their time," she says. "But it's a way for us to say 'Thank you for teaching. We know we slowed you down.' If MERC went away, we would likely not be able to pay the stipends."

Rural clinics such as Gateway in Moose Lake receive \$4,000 in MERC money to help cover the stipend and lodging costs

A scarce human resource

Clinical training is on thin ice for more reasons than the cuts to the MERC fund, according to Raymond Christensen, M.D., associate dean for rural health at the University of Minnesota Medical School in Duluth. "It's getting harder to find preceptors, especially in rural areas," he says. One reason is production expectations. "The way it works now," he says, "you see a patient, turn the crank and get paid. When you teach, the crank doesn't turn as often and you don't get paid as much. Teaching takes time." And that's something physicians at rural clinics with small staffs don't have much of. "Our physicians these days also want time for a life outside of medicine."

Christensen says MERC might help attract and retain preceptors if some of that money went directly to them in the form of stipends, like it does at Essentia, instead of going to the preceptor's employer. "Most preceptors aren't even aware of MERC or that their teaching efforts are one reason their clinic or hospital gets that money," he says. "Even if the money doesn't go directly into their pocket, they should at least receive a note now and then thanking them for their contributions to the future of medicine."

Belzer agrees that preceptors are a "scarce resource." Teaching time has always been considered voluntary; but as operating budgets tighten and reimbursements keep decreasing, he says, "clinicians are pushed to their limit to produce patient care revenue. They don't have time to teach."

"We need to avoid a domino effect, where fewer preceptors provide fewer clinical experiences for students, which makes the workforce pipeline smaller and worsens the already serious shortage of providers, especially in rural primary care," Dean says.

She is concerned that a perfect storm of funding cuts looms on the horizon that could further eviscerate clinical training. Aside from cuts to the MERC fund, the state's appropriation to the University of Minnesota now stands at its 1999 level, and there's talk at the federal level of cutting Direct and Indirect Graduate Medical Education Payments to hospitals.

Cuts to those funding sources, Dean says, would be devastating to Essentia and the region it serves. "Medicare cuts would affect our ability to train primary care physicians, which rural Minnesota is in greatest need of, because Duluth's hospitals would no longer be in a position to support the residency program to the extent they do now."

For now, clinical training sites will continue playing the hands they're being dealt. But that approach can only work for so long. As Dean points out, "There's only so much we can do. We cannot maintain our base of primary care physicians, advanced practice nurses, pharmacists and other members of the health care team if we are unable to place students in the clinical rotations required for them to graduate." MM

Howard Bell is a frequent contributor to *Minnesota Medicine*.

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PRICING PROBLEM

**HOSPITALS AND
CLINICS STRUGGLE
TO TELL PATIENTS
WHAT THINGS COST**

BY SUZY FRISCH

In the past, when patients asked customer service staff at Lakewood Health System in Staples how much a planned test or procedure at its hospital would cost, they couldn't ever say with much certainty. Even if they pulled data from past procedures—a time-consuming exercise—each case was so unique, it was impossible to come up with a fair estimate.

Bills that arrived long after the procedure was done were often a rude awakening for patients, especially those with high-deductible health insurance or none at all. And Lakewood wasn't happy when patients couldn't pay them.

Something had to change.

In June 2011, CFO Jim Dregney and his co-worker Lisa Bjerga attended a conference that sparked an idea: provide patients with price estimates. Dregney took what he learned at the conference and convinced other executives and Lakewood's board that opening up about pricing was the way to go. It would give customers better service, cement Lakewood's commitment to innovation both in medical care and operations, and reduce the amount of patient debt it was writing off.

"We were trying to be more proactive instead of reactive with patients," says Bjerga, Lakewood's revenue cycle director at Lakewood, which serves four central Minnesota counties with a 25-bed Critical Access Hospital, five primary care clinics and a 100-bed nursing home. "When you focus your efforts on the front end, you can move issues from the back end with more success."

Too many variables

Although providing price estimates is expected in most industries, it's still not common in health care. In fact, finding out about the cost of medical services and procedures can be down-right difficult. Researchers from the University of Iowa who studied the extent to which consumers can find out about the price of common surgical procedures wrote in an article in the February *Journal of the American Medical Association Internal Medicine* that it is arduous to learn about the price of a procedure ahead of time.

To conduct the study, they randomly called two hospitals in each state along with the top 20 orthopedic surgery hospitals named by *U.S. News and World Report* and asked about prices. After contacting each institution up to five times, 19 of the hospitals still did not provide pricing information. More than 25 percent didn't provide it until the third call. And many hospitals couldn't provide information about the cost of physician services, requiring the research team to place even more calls. And when they did find the information they were looking for, they discovered huge fluctuations in prices. For instance, the price of a hip replacement varied across the country by more than \$110,000.

Hospitals and clinics often say the reason for the lack of transparency about price is because there are too many variables per patient for them to provide accurate estimates. Price depends on what kind of insurance patients have, what deductible they pay, their out-of-pocket maximums, what medical care they require, and whether there are complications or additional services needed in the moment. For example, a patient scheduled for a single-plane MRI may end up needing a second plane. Or a patient hospitalized for a surgery may need to stay longer than is routine because of an infection.

Another reason why hospitals and clinics don't readily share price information "is there has been no demand for it, so there is no supply of it," says Roger Feldman, a health economist and Blue Cross professor of health insurance at the University of Minnesota. He explains that because most patients are insured and 90 percent of their medical costs get paid by a third party, they've had no reason to be concerned about price. "Once you pass your deductible, there is very little cost-sharing," he says. "Even with a high-deductible plan, just setting foot in the hospital will send you through that deductible. That takes away an incentive to shop on the basis of price."

That is starting to change. "Many states and the federal government are trying to put out quality and price information, and other private payers like UnitedHealth Group have put in pricing systems," he says. In addition, some clinics are switching to a cash-only business model, which requires them to figure out and post their prices.



Transparency tipping point

Driving these changes is the fact that industry has slowly been giving consumers more control over their health care spending, a movement that started in the early 1990s with the publication of *Patient Power*, a book from the Cato Institute that proposed the creation of health savings accounts and high-deductible plans. The premise was that if consumers knew how

Pre-encounter teamwork

Lakewood started paving the way for providing patients with personalized cost estimates for procedures and services such as hip replacement, childbirth and CT scans in late 2011. It was no small undertaking, Dregney says.

Lakewood implemented software that enabled staff to build profiles of 200 common procedures using past claims. Em-

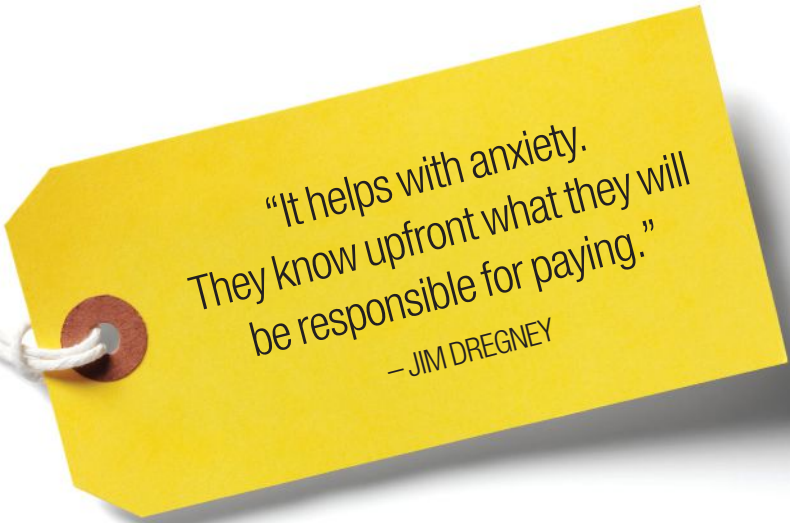
Lakewood also gives them a discount if they commit to paying on or before the date of their service. The health system, which has averaged 420 estimates a month since October 2012, has vastly improved its collections as a result, notes Dregney. It has also drastically reduced claim denials for lack of pre-authorization, and it has steered more patients without insurance or with low incomes to assistance programs ahead of time, when they are more likely to get financial help.

Three levels of service

As part of a shift to a new business model, Southdale Internal Medicine, P.A., an independent five-physician practice in Edina is now posting its prices.

Instead of billing insurance companies, the practice now requires patients to pay for each office visit, lab test, injection or procedure. Prices, which are posted on its website, vary depending on the length of the visit: from \$40 for 10 minutes to up to \$160 for 40 minutes or \$40 for a 10-minute phone consultation. Patients also can select limited concierge services for \$300 annually, which include phone consultations, online care and regular emails; they are charged the aforementioned fees for office visits and other services. Full concierge services run \$2,500 annually and include all face-to-face office visits, labs, phone consultations, online care, and email or text messages.

Merlin Brown, M.D., one of the physician owners, says they were able to come up with their prices because they knew roughly what insurers pay for doctor visits (\$60 to \$100), and they knew their costs. With that information, they could figure out how much time they spend making phone calls, answering emails and text messages from patients, and filling out forms—tasks insurers don't pay for—and price their services accordingly. Patients can file claims with their insurers for visits, tests and procedures (those services will likely be considered out-of-network).



"It helps with anxiety.
They know upfront what they will
be responsible for paying."
— JIM DREGNEY

much care and services cost, they could make better decisions about how to spend their health care dollars.

The idea of high-deductible health plans took off. According to Mercer's national survey of employer-sponsored health plans, 59 percent of organizations with more than 20,000 employees offered high-deductible plans in 2012. This year for the first time, for example, Target Corporation is only offering its employees account-based plans.

With the Affordable Care Act kicking in, there's additional pressure for health care providers to show value, which can't be done without dealing with cost. For all of these reasons, we may be reaching the transparency tipping point.

Employees spent months tallying every line item that went into those services and calculated an average price, as well as a minimum and maximum price per procedure. It also reassigned several employees to create a six-member pre-encounter team that could develop personalized estimates. Now, when patients know they need a medical service, they work with the pre-encounter team, who can tell them what a procedure or service costs on average. In addition, the team looks at the patient's insurance coverage, how much of their deductible they have met and their out-of-pocket maximums, and then provides an estimate of what it will ultimately cost that patient.

"It helps with anxiety," Dregney says. "This way they know upfront within some reasonable expectation what they will be responsible for paying."

Thus far, both the hospital and patients have been pleased with this effort. When patients know their share of the cost, they can plan financially for the procedure.

Brown says they decided last fall to stop accepting insurance but wanted to give patients plenty of notice. "It's been a long time coming," he says. "It gives us a lot more freedom to give the care our patients want without asking the insurance company if we can." They can also be compensated for care that insurers won't pay for.

For example, Brown recently saw a patient who was diagnosed with diabetes and needed to learn how to use insulin. Insurance wouldn't cover time spent educating him, but Brown and his team worked with him anyway. As he was learning how to monitor his blood glucose, the patient would text Brown with his sugar readings, and Brown would text back his insulin dosage. "This is medical care, but there is no billing code," he says. Now, when Brown goes the extra mile for a patient, he'll get paid for his time.

Facing the prospect of either trying a new financial model, going bankrupt or joining a larger health care system, the owners decided to try this approach knowing they might lose some patients, says Brown, who co-wrote the book *Where Doesn't It Hurt?*, about outpatient health care structures and costs.

Since announcing the change, the clinic has lost fewer patients than Brown anticipated. He says many like coming to Southdale because it is so patient-focused, and that they are willing pay a bit more for that. He thinks the clinic also will attract more uninsured patients.

As he sees it, everyone wins: Patients know what they will spend to see the doctor, and the physicians will be more fairly compensated for the time they spend caring for patients. The partners don't expect to make more money from this new setup, Brown says, but it definitely will boost their job satisfaction because they can concentrate on patient care rather than on playing by insurers' rules.



COMMERCIAL VENTURES

Opening the door for people to compare health care costs is no longer just the purview of nonprofits and industry players. Several new companies are helping consumers find the most affordable provider, facility or prescription.

One such company is GoodRx, launched this fall in Santa Monica, California. On the GoodRx website, consumers can type in the prescription they need and their zip code. The website then lists all of the nearby pharmacies and the prices they charge for that medication. Surprisingly, prices vary widely from one pharmacy to another. So far, GoodRx covers 6,000 brand-name and generic medications.

Castlight Health from San Francisco targets the employees of self-insured companies, helping them compare prices for medical procedures and tests. Castlight offers consumers a personalized tool to help them find unbiased information about pricing and quality, whether they will be using the services of a provider, facility or lab. Minnetonka-based Carlson is providing Castlight's technology to its 10,000 employees.

Another company trying to increase transparency is New Choice Health in Pensacola Beach, Florida. It helps consumers compare costs of procedures at providers in about 25 cities. New Choice Health provides pricing information on 18 procedures and tests including gallbladder removal, X-ray, ultrasound and colonoscopy. —S.F.

Upfront posting

James Eelkema, M.D., a family physician, took a similar path almost four years ago. As founder of TimeWise Medical in Burnsville, Eelkema decided to quit accepting insurance and open a cash-only practice. He, too, was frustrated by many of the insurance rules and regulations that he believed impeded his ability to provide patient-centered care.

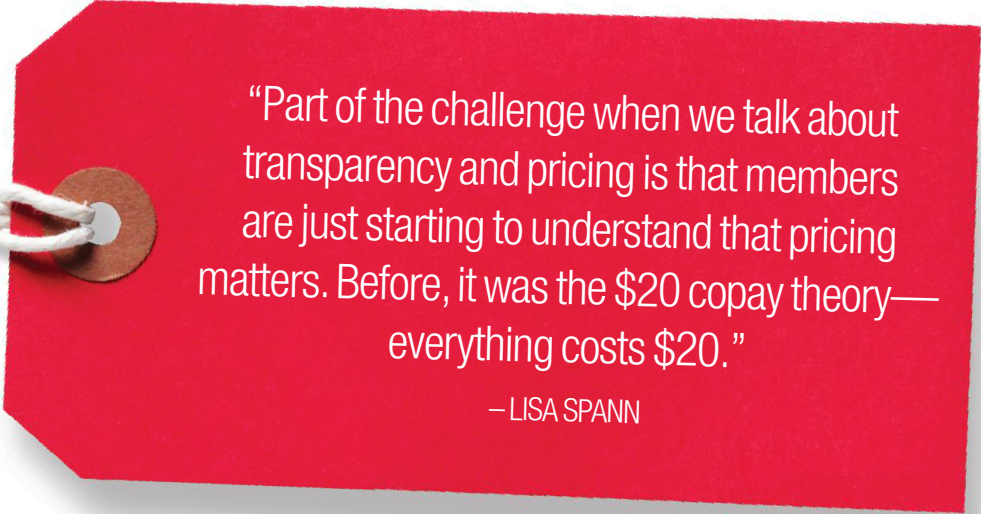
He also was troubled by the time needed for insurance administration and the imbedded unfairness to patients paying out-of-pocket, who often don't receive the same discounts large clinics give insurance companies.

one employee, rents a small clinic and out-sources many professional services. "I can keep my costs down, and then the charge to the patient is relatively low," he says. (Eelkema did raise prices from \$36 for a one-concern visit in 2011.) He says he sees a number of uninsured patients as well as those with high-deductible and other health plans.

Eelkema says he sees fewer patients than when he worked for a large clinic, but he gets paid the same amount. "If the visit takes X amount of time, that's what I spend. If it takes longer, I can spend that, too. I used to be under time pressure to see X number of patients."

data. The site also indicates with color whether providers charge lower, medium or higher prices.

Medica created the service to make members more aware of what procedures cost, says Lisa Spann, director of commercial product strategy and development. Witnessing the move toward consumer-driven health care, the company also wanted to help people make informed decisions when choosing providers and obtaining services. "Part of the challenge when we talk about transparency and pricing is that members are just starting to understand that pricing matters. Before, it was the \$20 copay theory—everything costs \$20," she says. "They are starting to



"Part of the challenge when we talk about transparency and pricing is that members are just starting to understand that pricing matters. Before, it was the \$20 copay theory—everything costs \$20."

—LISA SPANN

Eelkema posts his fees on the TimeWise website. When patients visit him for one concern, they pay \$55. If they have two concerns it's \$80. Physicals cost \$140. A urinalysis costs \$15 and an EKG is \$30. Unlike the Southdale physicians, who did research before setting up their fee schedule, Eelkema says he pulled his pricing "out of thin air" when he opened his clinic in 2009.

He says he has been able to keep prices down with low overhead. In addition to not having to file insurance claims and deal with preauthorizations, he also has only

Insurance insights

Insurers themselves began providing price information a number of years ago. Since 2007, Medica has publicized price ranges for hundreds of office visits, treatments, tests and procedures at hospitals and clinics across the state.

When consumers go to the Main Street Medica website (www.mainstreetmedica.com), they can enter the type of care they need and the type of provider they seek: clinic, hospital inpatient or outpatient, imaging services or chiropractic care. Then they see a list of providers that offer the service, as well as a range of prices for each provider. Those prices are based on the average allowed amount from Medica claims

understand how much procedures and services actually cost."

So far, Medica has received positive feedback about the site, and the number views from both members and the public has steadily increased. Spann notes that when they get inquiries from individuals, they do tend to be from people with high-deductible plans.

Another resource on prices of health services is Minnesota HealthScores, created by the nonprofit MN Community Measurement. Its website contains searchable information about health care quality

and cost, compiled from data from health plans and 600 medical clinics statewide. HealthScores offers average costs for about 100 procedures completed at clinics, hospitals and medical groups, says Jim Chase, president of MN Community Measurement.

Chase says gathering the information wasn't easy, as neither providers nor payers were keen on sharing it. "As with our quality measures, we are going to have to show that the information is useful before people will want to share more data," he says.

Last year, HealthScores saw more than 53,000 visitors, and Chase says they are staying on the site longer and looking at multiple pages. The most popular pages are the ones containing patient experience and cost information, and users are asking for more robust information in those areas. "Reviews are mixed. Many of our measures have been developed by clinicians for use in improving care, and they aren't always easily understood by the public," he says. "Consumers are more interested in information that they can use to make decisions or change their own care."

Chase notes that cost shouldn't be the only factor in helping patients evaluate providers. He believes providing information about price along with that about quality is where the transparency movement is heading.

Often people associate high-quality care with high-cost care—the more it costs the better it is, says the University of Minnesota's Feldman. And that's not always the case. Feldman has teamed with Stephen Parente, a professor of health finance in the Carlson School of Management, and Lewis Sandy, M.D., senior vice president of clinical advancement at UnitedHealth, to evaluate the impact of price transparency. They are examining UnitedHealth's system, which provides consumers with quality and cost information about providers. Using patient claims data, Feldman and his team gave participants scores based on whether they saw high-quality, low-cost providers. One year later, they found those individuals who improved their scores (meaning they were more likely to see a high-quality/low-cost provider) managed to simultaneously lower their costs. Those same patients also tended to be the ones who were sicker.

"It was encouraging to me that people who had the most reason to go looking for better information were improving their scores by a significant amount. And patients who improve their scores can improve their cost outcomes," Feldman says. "There is evidence out there that provider transparency systems could work." And that might be just the incentive clinics and hospitals need to become more open about what they charge. **MM**

Suzy Frisch is an Apple Valley freelance writer and frequent contributor to *Minnesota Medicine*.



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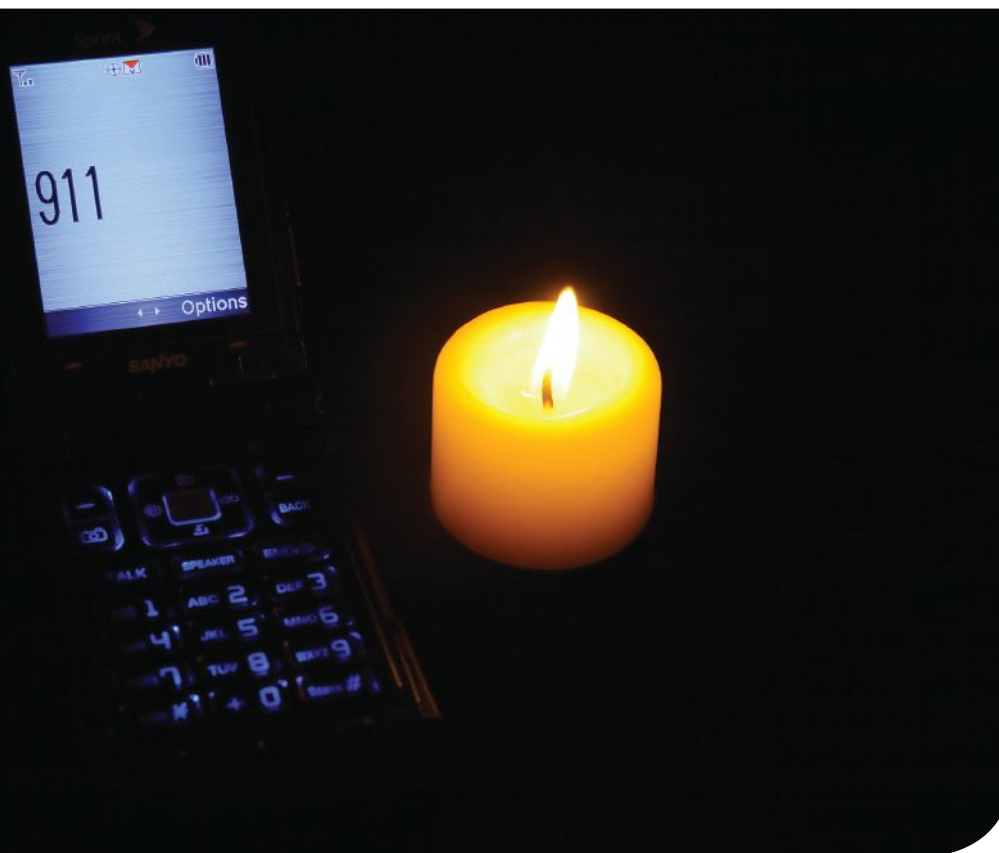
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Lost in translation

A simple lesson about our emergency system might have saved a life.

BY KRISTINA KROHN, M.D., AND PATRICIA WALKER, M.D., DTM&H

Kou and Hay* were healthy when they arrived in the United States. There was no reason to think one of them would die shortly after settling in Minnesota.

The couple, Karen† refugees from Burma, had come to the United States at Kou's urging. He had some education, and he thought they could have a better life here than in the Thai refugee camp where they lived. Hay was hesitant, as she had only completed the third grade before her parents died and she and her siblings escaped into the Burmese jungle, fleeing the junta's army. She remembers nights walking single file, stretching to hold the hand

of the sibling behind her. One night she saw a bullet tear through her sister's skirt, missing her sister's knee by centimeters. After her cousin was killed, she and three of her siblings headed for Thailand. She was 10 years old. Five other siblings stayed in Burma.

Kou and Hay, along with many other Karen, grew up in refugee camps in Thailand. Fighting between Burmese government forces and those of ethnic minorities that began during colonial times and has continued for decades has displaced at least 450,000 people.^{1,2} More than 140,000 of them, mostly Karen, currently live in refugee camps in Thailand.²

Hay smiled as she talked about meeting her husband. "I was so young. I did not know how to fall in love," she said. "But my husband was older. He saw me, then he talked to my older sister to try to arrange the marriage." Typically, parents arrange marriages, but Kou, then 27, convinced Hay's sister and an aunt to arrange the marriage through his older brother. She became pregnant soon after the wedding.

It was for her children and Kou that Hay finally agreed to move to the United States. After their application as refugees was accepted, they went through cultural orientation classes in the camp; all she remembered from the classes was being told that someone would meet her family at the airport and recognize them because of their bag. Each

refugee is given a blue-and-white plastic bag emblazoned with the logo of the International Organization for Migration that is filled with important medical and resettlement documents. Many refugees remember these bags as a requirement for traveling to America. Hay remembers meeting a woman at the airport, who, after seeing the bags, said "Welcome! Come here! I will show you the way!"

The family moved into public housing. Hay was five months pregnant with their fifth child. She worked to get her 8-, 7- and 5-year-old children into school and took care of the 2-year-old at home while Kou studied English so he could find a job. They were struggling but happy. After a few short months, they learned how to shop at the grocery store, set up a bank account and pay bills. Hay saw an obstetrician and delivered her baby. They were determined to move ahead with a new life.

When her son was 1 month old, something woke Hay one night at midnight—maybe it was the baby, maybe Kou had moved, Hay does not remember. But she

*Names have been changed.

†Pronounced ka-REN. The Karen are one of the largest ethnic groups in Burma.

knew something was wrong as soon as she looked over at her husband. “He was gasping. His head was arched back.”

Before rushing out of the apartment, Hay woke her four older children and instructed them to stay with their father. Then she ran into the hallway to get help. She had learned about calling 911, but because she did not speak English she worried that she would not be able to tell the operator what was happening. Instead of placing the call, she ran to get help from her neighbors, most of whom were also Karen.

She knocked on the first door, through which she could hear people moving around in the apartment. Someone came up to the peephole but turned away. She continued down the hall. “I knocked on many doors,” she recalled.

Finally, someone opened a door. They too did not speak English, so they got out their phone and called around the apartment building until they found a neighbor who did. This neighbor then called 911.

While Hay was running from neighbor to neighbor, Kou was dying. When the paramedics arrived they could not resuscitate him. At 3 a.m. the paramedics pronounced Kou dead. As far as Hay knows, her children were with their father when he died.

A week after her husband's death, Hay visited her primary care doctor for grief counseling. She could not explain how Kou had died. If she had received the medical examiner's report, she did not know what it was or what it said. The doctor saw Hay every other week for months, helping her work through her grief and referring her to a therapist. The clinic's social worker helped her move to a new apartment, where she hoped she wouldn't feel haunted by images of her dying husband. Finally, knowing that Hay needed closure, a resident physician working at the clinic called the medical examiner. The doctor was stunned by what she heard: Kou had died of asthma.

Kou's medical record showed no indication of asthma. In talking with Hay, doctors only learned that he sometimes had a cough or “breathing trouble.” When Hay returned for her next visit, her doctor had her slowly describe what had happened that night. After hearing the story, her doctor returned to the workroom discouraged. “She didn't know how to call 911. We failed her.”

The residents at our immigrant clinic spend a lot of time doing well-child checks. At each check-up, they go over the most common health problems that the child might face before the next visit. They also ask if parents know how to use a car seat and encourage kids to wear a helmet when biking. Before they heard Hay's story, they would sometimes ask if their patients knew about our 911 system; but they did not explain how it works. They did not realize that immigrants like Hay need to understand that they do not have to speak English to use the system, that emergency personnel can pinpoint the location of a call and send someone to check on a caller in distress. They need to know that officials wearing uniforms may show up—but that they are there to help. (Refugees may not have good memories of people in uniforms arriving at their doorstep.) Now, they try to tell patients, “If it is an emergency, just call. Talk in your own language. They will come. You can show them what's wrong and they will help.”

Younger immigrants are generally healthy. Accidents cause most of the morbidity and mortality in this age group. They need to hear simple public health messages: Wear your seatbelt. Look both ways before crossing the street. Wear your bike helmet. Call 911 when there is an emergency. After we talked about the case of Hay and Kou in our clinic, we changed our practice. We now include 911 education during our patients' new-arrival immigrant screenings.

We will never know if calling 911 three hours earlier would have saved Kou's life. He might have died anyway. But next time, we don't want to have this lingering doubt

in our minds. We want to know that our patients know how to access help and that stories like Hay's will never have to be told again. **MM**

Kristina Krohn is in the medicine-pediatrics residency and Global Health Pathway program at the University of Minnesota. She is also a recipient of the Stanford-NBC News Global Health and Media Fellowship, Center for Innovation in Global Health, Stanford University. Patricia Walker is director of the Global Health Pathway program and medical director of HealthPartners Travel and Tropical Medicine Center.

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Calling 911

ECHO (Emergency and Community Health Outreach) Minnesota, an organization that provides health and safety information to people who speak limited English, has a number of resources on calling 911 during an emergency. A video, brochures and fact sheets are available in multiple languages and can be accessed online at www.echominnesota.org or by calling 651-789-4342 or emailing info@echominnesota.org.



Clearing the air

What's next for Minnesota's most visible anti-smoking organization?

BY MELISSA MRACHEK

Smoking on commercial airline flights seems preposterous to anyone born in the last 25 years, but David Willoughby, chief executive officer of ClearWay Minnesota, remembers well the days when people used to light up on airplanes. “My parents were missionaries in South America,” he says. “We would take flights from the United States to Colombia, and smoking was allowed on the plane.” He remembers walking off the plane with a headache and feeling sick even though he had been sitting in the nonsmoking section. At a young age, Willoughby was already learning about the health effects of cigarette smoke.

Little did he know then that he would go on to be a leader in Minnesota's efforts to reduce the harmful effects of tobacco. ClearWay Minnesota is an independent nonprofit organization that strives to improve the health of Minnesotans by reducing tobacco use and exposure to

secondhand smoke. Along with the MMA, ClearWay is also a strategic partner in the Raise it for Health Coalition, a group of 34 Minnesota health and nonprofit organizations dedicated to reducing tobacco use. The coalition is working to raise the price of tobacco products in order to prevent children from starting to use them and encourage existing users to quit. Raising the tobacco tax is one of the MMA's priorities for the 2013 legislative session.

Coming to Minnesota

ClearWay was established in 1998 with money from the state's historic tobacco settlement. The organization was given enough funding to support its anti-smoking initiatives for 25 years. That funding will run out in 2023.

Willoughby has been at the reins since 2000, having come from Arizona where he was a leader with the Southwest Division

of the American Cancer Society. He became interested in Minnesota, despite the cold winters, because of its progressive approach to public health issues. “Minnesota has a great way of looking at things proactively,” he says. “The public health sector in Minnesota is much more robust than in other areas of the country. Minnesota health plans and physicians were thinking about population health and prevention even back in the '90s. I didn't see or experience that in Arizona at that time.”

In addition, Willoughby liked the idea of working on a narrow, but important, issue. “When I saw the opportunity with the settlement dollars to have 25 years to really change things for the better and influence policy, I was inspired,” he says.

Although ClearWay has a decade left to continue making its mark on population health in Minnesota, it already has an impressive list of accomplishments including: establishing a statewide helpline for people trying to quit smoking; passing a law banning smoking in bars and restaurants; and achieving a tax on cigarettes that is used for health care purposes. But Willoughby says ClearWay's work is far from finished.

Consider this: 77,000 Minnesota kids smoke, more than 600,000 adults smoke and 5,000 people die each year in Minnesota from tobacco-related illnesses. In addition, health care costs related to tobacco use add up to almost \$3 billion annually.

“Our three legacy goals for ClearWay are to reduce adult tobacco prevalence to below 9 percent, make sure less than 5 percent of adults are exposed to secondhand smoke and ensure smoking cessation support is covered by insurance or in benefit packages,” he says. “When we close our doors, we want to ensure the safety net that we provide to thousands of Minnesotans who want to quit smoking is in place and available through other organizations.”

Tobacco tax fight

ClearWay is using a number of tactics to achieve its goals. Topping the list this year is increasing the tobacco tax. National research has shown that raising the price



“A \$1.50 increase on the cost of a pack of cigarettes will keep 41,000 kids from ever picking up a cigarette.”

— DAVID WILLOUGHBY, CEO, CLEARWAY MINNESOTA



of tobacco can encourage people to quit smoking and prevent young people from starting. “A \$1.50 increase on the cost of a pack of cigarettes will keep 41,000 kids from ever picking up a cigarette,” Willoughby says. “We funded a study that showed of all policy changes, raising the cost of tobacco products is the most effective tool in prevention and cessation.”

In addition to working to raise the tobacco tax, ClearWay will continue its advertising efforts that draw attention to the dangers of tobacco use. If you are watching television and a sobering commercial about tobacco use comes on, odds are ClearWay is behind it. This year’s campaign is focusing on the health consequences of tobacco use (the ads feature people who have lost limbs as a result of smoking). “Smoking is still a major health issue with emotional, physical and financial costs,” Willoughby says. “Physicians know this, but the general public tends to forget because smoking isn’t as prevalent in public areas such as bars and restaurants.”

Physician partnerships

Willoughby believes physicians are critical to supporting and carrying forward ClearWay’s mission. “We’ve always had physicians on our board, engaged in research and participating in testimony at the state Capitol,” he says. “Physicians bring passion to this issue because they are on the frontline. We look to them to give advice and guidance.”

He urges physicians to never underestimate the influence they have with their patients. “It’s a tough job to be out there

trying to help people change behavior,” he says. “But we often hear through our helpline the influence physicians have in getting people to take that step and quit smoking. That kind of life-changing guidance is invaluable to our efforts.”

When asked what success will look like when ClearWay’s funding runs out in 2023, Willoughby offers a new vision for

the social landscape of Minnesota. “Success to me will be when kids and adults see it as not normal to smoke—in advertising, movies and daily life. Success will be a shift in the social norm and when physicians will no longer have smoking as a major issue for their patient populations.”



Mandy Rubenstein



Brian Strub



Janet Silversmith



Dave Renner

MMA in action

Terry Ruane, MMA director of membership, marketing and communications, and **Mandy Rubenstein** and **Brian Strub**, MMA managers of physician outreach, attended the Minnesota Medical Group Management Association Winter Conference in St. Paul in early March.

In February, **Janet Silversmith**, MMA director of health policy, attended the Minnesota HIT Trailblazers Project Advisory Group meeting. The group is a learning collaborative designed to help participating states (Minnesota, Oregon, Massachusetts, Arkansas, California, Michigan, Maine and Rhode Island) leverage

investments in HIT, data analytics, quality measurement/reporting and quality improvement programs to meet goals around health care delivery reform. The project is being led by the Minnesota Department of Health. Silversmith also presented on the status of Minnesota’s Health Insurance Exchange to the Eden Prairie Rotary Club in March.

Dave Renner, MMA director of state and federal legislation, provided a legislative update in late February to Central Minnesota Clinic Managers, a group that meets monthly in St. Cloud. He also gave a legislative update to the Southeast Chapter of the Minnesota Academy of Family Physicians in Rochester in February.



PHOTO BY DAN HAUSER

Forum attendees voted on a number of questions regarding Minnesota's public programs.

Of forum attendees, 89 percent support the expansion of Medical Assistance, but 80 percent worry about the capacity of the state's primary care physicians to serve the new Medicaid patients.

sion of Medical Assistance, 80 percent worry about the capacity of the state's primary care physicians to serve the new Medicaid patients.

"We will be using the polling mechanism at all future forums," says Janet Silversmith, the MMA's director of health policy. "It's a great way to build engagement and take the temperature of the group that is gathered."

The public health programs event was the first of several forums the MMA is planning for 2013. Future topics include prescription opioid addiction, abuse and diversion; prior authorization for prescription drugs; primary care physician workforce capacity; and Minnesota's quality measurement agenda.

The forums aim to bring physicians together to discuss important issues affecting medical practice in Minnesota; facilitate discussion through accessible and inclusive formats in a variety of locations; and educate, debate and influence MMA policy positions.

"It was a great start for our policy forum program," Silversmith says. "The group was very engaged in the discussion and provided great input regarding public programs and Minnesota's capacity to handle an influx of new patients."

The MMA will gather all of the input and data from each policy forum this year and report the results to the House of Delegates in September.

MMA kicks off policy forums

The MMA kicked off its policy forum series in early March with an interactive discussion exploring the future of Minnesota's public health programs.

The event featured a combination of presentations, discussions and electronic polling regarding the Medical Assistance and MinnesotaCare programs.

In February, the Legislature voted to expand Medical Assistance to those earning up to 138 percent of the federal poverty level. This means that approximately 34,000 previously uninsured, low-income Minnesotans will have access to health care coverage.

An additional 53,000 individuals currently covered by MinnesotaCare will shift to the Medical Assistance program.

According to a poll taken at the forum by the MMA, attendees were concerned about the changes. Although 89 percent of the forum attendees support the expansion

Next forums to discuss prescription opioids

Minnesota physicians will have the opportunity to weigh in on the topic of prescription opioid abuse, addiction and diversion at policy forums on May 2 in the Twin Cities, May 9 in Rochester and May 16 in Duluth. For more information go to www.mnmed.org/events/policyforum.

VIEWPOINT

Change is up to you

BY DAVE THORSON, M.D.

You must be the change you wish to see in the world.” – Mahatma Gandhi

It’s an oft-quoted sentiment probably because it’s so true. In order to change our surroundings, we must become active participants. We can’t sit idly by and expect things to get better without our involvement.

That’s why the word “engagement” has become such a buzzword these days. Generally, I ignore buzzwords because they are usually nothing more than that. But “engagement” is more than a word at the MMA this year.

We are busy working on a number of new ways to engage physicians in our activities. After all, ours is a representative association. We represent all Minnesota physicians, whether or not they are members. And we represent all members, whether or not they are active. But wouldn’t it be ideal if more members got involved and helped us shape policy that represented and benefited the broadest group of physicians?

In 2013, we are taking several new steps to do that. First off, we produced our first podcast in February. We are also working on adding a new, interactive blog on our website. We will gauge our success with these communications efforts by the extent to which members use them and provide feedback. (The blog will provide a way for members to sound off on all sorts of topics.)

It doesn’t stop there. For the past two years, the MMA has examined how it can remain strong and relevant to all of its members. The work began with input from members; we then held discussions with component medical society leaders,

other members from across the state and other state medical societies. Our board formed a Governance Task Force, and the last two House of Delegates sessions have dealt at length with the issue of how our organization should be run.

This year, we are continuing that work in earnest. We have expanded the Governance Task Force to make it more representative of the entire state. Plus, we are exploring how to replace the House of Delegates with multiple policy forums to increase opportunities for members to have their say. In addition, we are conducting a number of listening sessions throughout the state to better understand the needs of all physicians and what the MMA can do for them.

The policy forums will be open to all MMA members, not just delegates, and the agenda at each one will include giving attendees an opportunity to both learn about and discuss important issues facing all physicians in Minnesota. In early March, we held our first policy forum on Minnesota’s public programs—Medical Assistance and MinnesotaCare. We will conduct additional forums later in the year on the problem of prescription opioid abuse, prior authorization of prescription drugs, the primary care physician workforce capacity and Minnesota’s quality measurement agenda.

The listening sessions will be held at clinics and other sites throughout the state and organized through component medical societies and our student, resident and young physician sections. These sessions will be open to members and nonmembers alike—in other words, any physician who has an opinion about the future of health care in Minnesota can participate.



Dave Thorson, M.D.

PHOTO BY STEVE WEVERKA

“

Podcasts. Blogs. Policy forums. Listening sessions. All are new ways to engage and gather feedback from people like you. But they will only work if you and your colleagues get involved.

”

MMA staff will be on hand to listen and record what is said and then report back to the MMA leadership.

Podcasts. Blogs. Policy forums. Listening sessions. All are new ways to engage and gather feedback from people like you. But they will only work if you and your colleagues get involved. We need to hear a range of voices from across the state. The more voices, opinions and feedback we get, the better.

The MMA is for all of us. Be the change you wish to see in the world.

News briefs

MMA files two “friendly” briefs in medical cases

The MMA has filed friend-of-the-court briefs (also known as amicus briefs) with the Minnesota Court of Appeals in two cases.

In March, the MMA filed an amicus brief in a case regarding the guardianship of Jeffers J. Tschumy, in which a Minnesota District Court judge found that under current statute and case law, Tschumy’s guardian, Joseph Vogel, could not direct removal of life support without express approval from a court. The judge expressed concern that a guardian may not be trained in making complex end-of-life decisions and suggested that a judicial examination of end-of-life decisions is superior to a clinical examination.

The MMA’s amicus brief, which was filed jointly with the Minnesota Hospital

Association in support of Vogel’s appeal, argued that a guardian does have the statutory and legal authority to make end-of-life decisions on behalf of his ward. The brief will also help the Court of Appeals understand the adverse impact of the lower court’s ruling on patient care and medical practice.

“This ruling has resulted in a lot of confusion and could delay end-of-life decisions,” says MMA CEO Robert Meiches, M.D. “The MMA believes that guardians, with the proper consultation of appropriate medical professionals, should have the authority to give permission for the removal of life support of a ward who has no chance of recovery.”

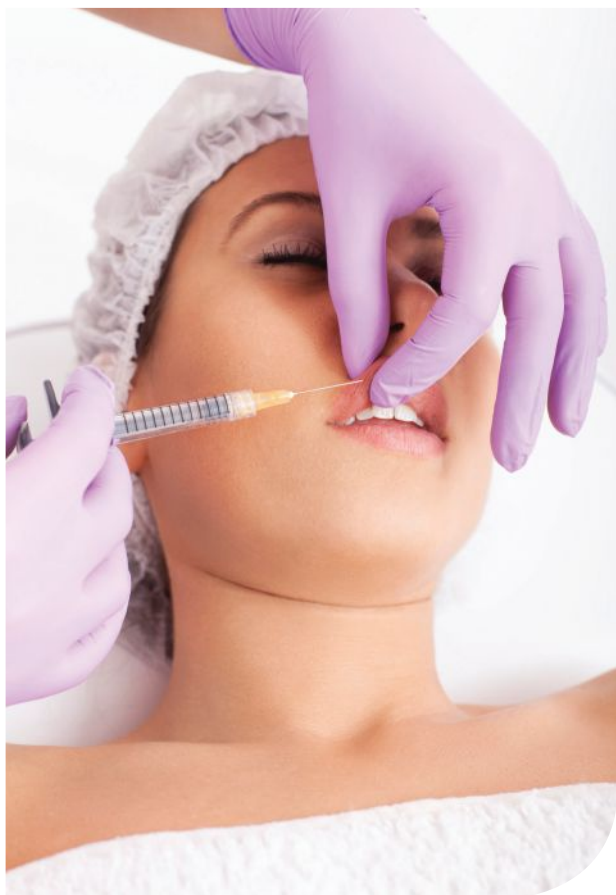
In February, the MMA filed an amicus brief jointly with the AMA, the American Osteopathic Association, the American Academy of Family Physicians and the

Minnesota Academy of Family Physicians in the case of Avera Marshall Medical Center Staff vs. Avera Marshall Regional Medical Center.

This brief supports the Avera medical staff, led by Steven Meister, M.D., former chief of staff, and Jane Willett, D.O., chief of staff. Last November, they filed an appeal in response to the September 2012 ruling by a Lyon County district judge that said the medical staff bylaws do not constitute a contract between the staff and the hospital, and that the hospital could, in effect, unilaterally change the bylaws, which the hospital had done.

The MMA has supported the medical staff’s fight to maintain autonomy when it comes to making decisions on behalf of patients.

An amicus brief is filed by a party not directly involved in a suit, but with an



MMA opposes “botax” bill

The MMA recently opposed legislation that would tax certain cosmetic procedures, calling the tax subjective and vague.

Referred to as the “botax” bill, it calls for taxing “any medical procedure performed on an individual which is directed at improving the subject’s appearance, body image or self-esteem and which does not meaningfully promote the proper function of the body or prevent or treat illness or disease.”

MMA member Michael Tedford, M.D., an otolaryngologist and head and neck surgeon based in Edina, spoke against the bill on behalf of the MMA and the Minnesota Academy of Otolaryngologists during a House committee in February.

He called the proposed legislation “extremely vague, making application and compliance extremely difficult.” He said determining whether a procedure improves someone’s “appearance, body image or self-esteem” or improves function or provides a “more normal appearance” is difficult.

He also noted that the services are already subject to the state’s 2 percent provider tax at least for six more years. In addition, he told lawmakers the bill would compromise a patient’s privacy because their medical records would need to be reviewed to determine whether or not a procedure was taxable.

interest in the outcome of the litigation. It provides helpful information to the court in its consideration of the issues raised by the parties and usually urges the court to reach a decision favorable to the interests of the amicus.

The MMA will continue to follow both cases.

Stiffer background checks suggested for licensure

As a follow up to last year's debate on the health licensing disclosure bill (often referred to as the Board of Medical Practice bill), Minnesota lawmakers have introduced a measure that would implement stiffer background checks, including fingerprinting, on licensure applicants.

The legislation calls for physicians and other licensed health care professionals "to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation" when applying for initial or reinstated licensure.

The bill requires health licensing boards to have a system in place for new applicants no later than January 1, 2018. In addition, the bill requires all licensing boards to develop a plan by January 1, 2017, to eventually ensure that all licensees (not just new applicants or those wishing to reinstate their license) have undergone criminal background checks.

Some physicians have questioned the value of requiring these background checks, which are required in 37 other states. Because the new requirement applies to all health care professionals, the MMA has chosen not to oppose the bill.

Federal legislation could spell the end of SGR

In early February, U.S. Rep. Allyson Schwartz (D-Pennsylvania) and Rep. Joe Heck (R-Nevada) reintroduced the Medicare Physician Payment Innovation Act, which would eliminate Medicare's sustain-



Bill introduced to prohibit minors from using tanning beds

A bill that would prohibit the use of tanning beds by those younger than 18 years of age was introduced at the Capitol in February. Current Minnesota law allows children younger than 16 to use tanning facilities with parental consent; there currently are no restrictions on those 16 and older.

"We're happy to see this bill introduced, though it doesn't appear that it will move ahead this session," says Eric Dick, the MMA's manager of state legislative affairs. "There's clear evidence of a link between rising skin cancer rates and artificial UV exposure. Minnesota needs to treat this carcinogen just as we do tobacco, and one way to do that is to prohibit minors from using artificial tanning facilities."

According to the American Cancer Society, approximately 120 Minnesotans die each year from melanoma, making it the most deadly form of skin cancer. Eleven states already have banned the use of tanning beds by children ages 13 to 18 years.

able growth rate formula (SGR).

The bill seeks to stabilize payments to physicians for 2014; promote the rapid development and implementation of improved payment and delivery models that offer incentives for high-quality, high-value care; and continue to provide incentives for adoption of alternative payment and delivery models by physicians and other providers.

At the AMA National Advocacy Conference in February, Rep. Fred Upton (R-Michigan), chair of the House Energy and

Commerce Committee, told attendees that he would like Congress to fix the SGR formula before leaving for its August recess.

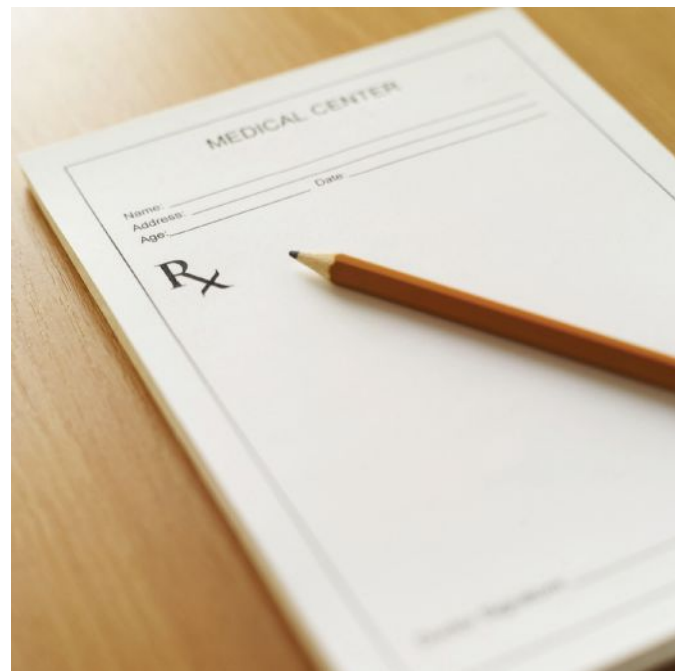
The move to eliminate SGR was recently bolstered by the Congressional Budget Office (CBO), which lowered estimates for the cost of repealing it. The CBO now says the 10-year cost for a total repeal is \$138 billion, more than \$100 billion less than previous estimates.

"We're hopeful that the legislation moves forward," says Dave Renner, the MMA's director of state and federal legisla-

tion. “Eliminating SGR has the support of many in Minnesota’s Congressional delegation. It’s time to get rid of it once and for all.”

MMA members making a difference

In March, the Association of Community Cancer Centers awarded Patrick Flynn, M.D., its David King Community Clinical Scientist Award for his outstanding service, leadership and com-



Bills propose increasing APRNs’ independence

The Minnesota House and Senate have both introduced bills that would grant advanced practice registered nurses (APRNs) authority to practice and prescribe medications independently.

The bills expand these nurses’ scope of practice to include “performing acts of advanced assessment, diagnosing, prescribing and ordering.” They would apply to certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), certified clinical nurse specialists (CNSs) and certified nurse practitioners (CNP).

The MMA has made maintaining a team approach to health care a top priority for the 2013 legislative session.

“While APRNs serve a critical role in the care of patients, we maintain that they continue in a collaborative role rather than be granted more independence,” says Dave Renner, MMA director of state and federal legislation. “Given the growing concerns about prescribing practices and increased illegal access to prescription drugs, many MMA members question whether it’s prudent for the state to expand the authority of other health care providers to prescribe independently.”

mitment to the oncology community. Flynn is medical director of Autologous Bone Marrow and Stem Cell Transplant at the Virginia Piper Cancer Institute at Abbott Northwestern Hospital.

Integrity Health Network (IHN) honored Christopher Wenner, M.D., of Cold Spring with the 2012 Achievement Award for his practice’s high scores in optimal vascular care and optimal diabetes care. IHN also honored Paul Lundstrom, M.D., and Dermatology Professionals, PA of Baxter with the 2012 Specialty Clinic Award for “monitoring and improving follow up on melanoma patients and consistent, valuable contributions to quality at all levels within the network.”

MMA member Greg Plotnikoff, M.D., has published a book with Mark Weisberg, Ph.D., titled *Trust Your Gut: Get Lasting Healing from IBS and Other Chronic Digestive Problems Without Drugs*.

MMA receives Choosing Wisely grant

The MMA learned in mid-March that it is one of 21 organizations receiving a grant to help promote the ABIM Foundation’s Choosing Wisely program.

Choosing Wisely, launched in April 2012, encourages physicians and patients to think and talk about medical tests and procedures that may be unnecessary and even harmful in some cases. Since its creation, 25 medical specialty societies have created lists of tests and procedures they say are overused or unnecessary.

The MMA will work on projects to help educate Minnesota physicians about the tests identified by the specialty societies and develop tools they can use in their conversations with patients about whether those tests are necessary.

The grant runs from April 1, 2013, to March 31, 2015, and is funded by the Robert Wood Johnson Foundation. For more information, go to www.choosingwisely.org.

Annual Meeting resolutions due

MMA members have until July 12 to submit resolutions to be considered by the House of Delegates at the 2013 Annual Meeting September 20 and 21 at the Minneapolis Marriott Northwest in Brooklyn Center.

The Resolution Review Committee will review all submitted resolutions and develop a report with recommendations for how to manage each one. Resolutions may be 1) referred to a reference committee; 2) reaffirmed (current MMA policy is reaffirmed in lieu of the resolution because the resolution is identical to, or substantially similar to, current MMA policy); 3) referred to the MMA Board of Trustees; or 4) returned/rejected.

If you have any questions about the deadline for submitting resolutions or about the processes planned for 2013, please contact the MMA Annual Meeting office at am@mnmed.org.



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Beyond Obamacare

How a single-payer system could save health care in the United States.

BY DAVE DVORAK, M.D., M.P.H.

As Minnesota's physicians, health care leaders and legislators grapple with the complex changes brought by the Affordable Care Act (ACA), many are concerned that even after the law is fully implemented, hundreds of thousands of people will remain uninsured while health care costs continue to spiral.

What if there were a simple, streamlined solution that would guarantee health coverage for every Minnesotan while saving the state billions of dollars? A growing number of Minnesota physicians are endorsing what they consider to be such a solution: single-payer health care.

Weary of having to comply with hundreds of different insurance plans' administrative requirements while their patients are denied needed tests and treatments, these physicians are drawn to the simplicity, cost-effectiveness and truly universal coverage offered by a single-payer system. Their views were supported by an independent analysis last year demonstrating that with a state-based single-payer system, every Minnesotan could have comprehensive coverage while the state would save billions annually.¹

A deeply flawed system

The desire for meaningful reform comes in the face of the U.S. health care system's long-recognized dysfunction. Despite health care accounting for 18% of the nation's economy—twice that of other wealthy democracies—48 million Americans lack health coverage.^{2,3} Another 29 million are underinsured, having poor coverage that exposes them to unaffordable out-of-pocket expenses.⁴ Health

insurance premiums have doubled over the past decade, with the average annual cost for family coverage now exceeding \$15,700;⁵ and health care costs now account for two-thirds of personal bankruptcy filings in the United States.⁶

At the root of these problems is the fact that we have a fragmented, highly inefficient system. Employed Americans younger than 65 years of age have job-based insurance, if their employer chose to provide it; the elderly and disabled are covered through Medicare; the poor by Medicaid; military veterans through the Veterans Administration; and American Indians through the Indian Health Service. Persons who do not fall into any of those categories must try to purchase individual coverage in the private market, where it is often prohibitively expensive or unobtainable if they have a pre-existing health condition.

Owing largely to this fragmentation and inefficiency, a staggering 31% of U.S. health care spending goes toward administrative costs, rather than care itself.⁷ Inefficiency exists at both the provider and payer level. To care for their patients and get paid for their work, physicians and hospitals must contend with the intricacies of numerous insurance plans—which tests and procedures they cover, which drugs are on their formularies, which providers are in their network. Meanwhile, private health insurance companies divert a considerable share of the premiums they collect toward advertising and marketing, sales teams, underwriters, lobbyists, executive salaries and shareholder profits. The top five private insurers in the United States paid out \$12.2 billion in profits to investors in 2009, a year when nearly

3 million Americans lost their health coverage.^{8,9}

The ACA of 2010, known widely as Obamacare, is expected to extend coverage to 32 million more Americans.¹⁰ But it accomplishes this goal primarily by expanding the current fragmented, inefficient system and maintaining the central role of the private insurance industry in providing coverage. As a result, the ACA is expected to do little to rein in health care spending.¹¹ Furthermore, it will fall far short of achieving universal coverage, as tens of millions of Americans (including 262,000 Minnesotans) will remain uninsured after its full implementation.^{1,10}

The solution

The central feature of a single-payer health care system would be one health plan that covers all citizens, regardless of their employment status, age, income or health status. Having a public fund that pays for care would slash administrative inefficiencies and eliminate profit-taking by the private insurance industry.

Under a single-payer system, the way society pays for health care would change, but the market-based health care delivery system would remain. Physicians and hospitals would continue to compete with one another based on service, quality of care and reputation. The chief difference is that they would bill a single entity for their services, rather than numerous insurers.

Individuals would benefit immensely by having continuous coverage that is decoupled from their employment. This would alleviate "job lock," in which people remain in undesirable employment situations in order to maintain coverage. In

a single-payer system, individuals could choose to see any provider, in contrast to the current system in which choice is restricted to those who are in-network. Deductibles and copays would be minimal or eliminated, removing cost as a barrier to obtaining needed care.

A single-payer system would be funded through savings on administrative costs, along with modest taxes that would replace the premiums and out-of-pocket expenses currently paid by individuals and businesses. The cost savings to individuals, businesses and government would be considerable. The nonpartisan U.S. General Accounting Office concluded that single-payer health care would save the United States nearly \$400 billion per year, enough to cover all of the uninsured.^{7,12,13}

Physician support for a simplified, universal health care system is robust and growing. A 2008 survey published in *Annals of Internal Medicine* found that 59% of physicians supported a national health insurance system—up from 49% in 2002.¹⁴ Physicians for a National Health Program, a national organization advocating for single-payer reform, reports a membership of 18,000.¹⁵ In Minnesota, single payer has been formally endorsed by nearly 800 physicians, other providers and medical students.¹⁶

The Minnesota model

Recognizing the implausibility of achieving single-payer reform at the national level in the current political climate, many single-payer advocates have turned their attention to state-level reform. The ACA provides for “state innovation waivers” to be granted beginning in 2017, allowing states to implement creative plans they believe would work best for them. With this in mind, organized single-payer movements have taken root in states as varied as Colorado, Hawaii, Illinois, New York, California, Oregon and Vermont. Vermont’s governor and Legislature passed a law in 2011 setting the path for the state to move toward single payer.¹⁷

In Minnesota, two advocacy organizations—Health Care for All Minnesota and the Minnesota chapter of Physicians for a

National Health Program—are garnering public support for a single-payer system. Gov. Mark Dayton has expressed support for single payer,¹⁸ and Sen. John Marty (DFL-Roseville) has authored legislation to establish such a system in Minnesota. Known as the Minnesota Health Plan, it would replace the current inefficient patchwork of private and public health plans with a single statewide fund that would cover the health needs of all Minnesotans—inpatient and outpatient services, preventive care, prescription drugs, medical equipment and mental health and dental care.¹⁹ A 2012 study by the Lewin Group confirmed the feasibility of single payer in Minnesota. It concluded that adoption of a single-payer system would provide coverage to every Minnesotan, including the 262,000 left uncovered by the ACA, while saving the state \$4 billion in the first year alone.¹ The average Minnesota family would save \$1,362 annually in health costs, while the average Minnesota employer that currently provides insurance would realize savings of \$1,214 per employee per year. The analysis showed these savings came primarily from administrative simplification; provider compensation remained unchanged.

Conclusion

With nearly 50 million uninsured people in the United States and skyrocketing health costs, the need for profound reform of our health system could not be more clear. The ACA is a start, but it will fall far short of achieving universal coverage, and it allows unsustainable spending growth to continue. Single-payer health care would eliminate administrative waste and inefficiency, thereby creating an opportunity to achieve truly universal, cost-effective health care. **MM**

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Paying for and delivering pregnancy care

It's time to revamp the care delivery and payment model to improve the value of pregnancy care.

BY STEVE CALVIN, M.D., AND AMY ROMANO, C.N.M.

Each year, more than 68,000 Minnesota women give birth. Public health insurance programs pay for the care of nearly 30,000 of these women and their newborns. Nationally, maternal and perinatal care are the most common and costly reasons for hospitalization.¹ There is consensus among policymakers that pregnancy care is an ideal investment in the future, and that the health of a community depends on the care provided to its pregnant women and newborns. Minnesota makes a larger per-capita investment in prenatal care than many other states. Pregnant women with incomes up to 275% of the federal poverty level are eligible for coverage under Medical Assistance (the state's name for Medicaid) and MinnesotaCare, a subsidized insurance program for the working poor who do not have access to other coverage. These women pay no co-pays or deductibles for pregnancy or newborn care. Undocumented immigrants are also eligible for these programs. As a result, pregnancy care coverage is nearly universal in Minnesota. Given this commitment, it is important to ensure that the mothers who enroll in these programs and the taxpayers who fund them are getting value for their money—that is, care that is both cost-efficient and high-quality.

How much care costs

Until recently, the cost of pregnancy, birth and newborn care was unknown. A 2013 analysis of maternity claims in the United States showed commercial insurers paid \$18,239 for vaginal births and Medicaid paid \$9,131 for such births, on average.

For cases involving cesarean section, commercial insurers paid \$27,866 and Medicaid \$13,590.²

A number of things about these findings are significant. The first is that commercial insurers paid, on average, twice the amount Medicaid paid for both types of deliveries. Second, total maternal-newborn payments were 50% higher for cesarean deliveries than for vaginal births for both the commercial payers and Medicaid. Finally, facility fees, which account for between 59% and 66% of the cost of an episode of maternal and newborn care, and professional service fees, which account for 20% to 25% of the cost, make up the majority of the total cost of a full episode of maternal and newborn care.³

According to the Minnesota Department of Human Services, 29,870 women received birth care during 2012 through Medical Assistance and MinnesotaCare. In both programs, the mother is covered for an average of nine months (including two months post-partum) and the newborn for 12 months. Using the pre-negotiated 2013 capitation rates, we can estimate that this year the average pregnancy episode will cost the state more than \$14,000 and that the total amount the state will pay for pregnancy and newborn care through these programs could exceed \$500 million. Given such expenditures, it's important to examine how we are both delivering and paying for maternity and newborn care.

How should we pay for pregnancy care?

Payment for pregnancy care should be aligned with the triple aim of improving health, lowering cost and satisfying patients. In pregnancy care, we know we have met those goals when satisfied mothers have a healthy pregnancy that ends in the uncomplicated vaginal birth of a healthy term newborn—all for a reasonable price. But our current delivery and payment system is fragmented and expensive, and health outcomes are lagging. If we are to have high-value pregnancy care, we need to change our approach.

First, we need to view pregnancy and newborn care as a comprehensive single episode, and the team of providers who deliver care and the facilities at which it is delivered should receive payment for the entire episode. (The 2009 state health care reform group that worked on what was called “baskets of care” at the time unwisely split pregnancy into prenatal and birth care components.) Paying for the entire episode of care would encourage care providers to work collaboratively, which would ultimately maximize desired outcomes. Likewise, it would discourage the overuse of expensive technologies and procedures that decrease the chance of an uncomplicated vaginal birth. Although the joke during residency was that pregnancy is a disease curable only by cesarean section, our current 32% cesarean section rate is no laughing matter. A recent review of evidence-based studies found that overuse of cesarean section increases the likelihood of at least 25 adverse health outcomes. For the woman, those risks include infection, hysterectomy and death. For the infant, they include respiratory problems and chronic illnesses such as asthma and diabetes.³ An international multicenter prospective study suggested that a more reasonable cesarean rate is probably between 10% and 15%.⁴ Providing a single payment for labor and delivery would encourage use of the most cost-effective settings and discourage elective early inductions and cesarean sections.⁵

Second, we need to give women who are having low-risk pregnancies the better choice of primary maternity care directed by a midwife in a setting other than a hospital. Two major studies, the Birthplace study in England, which involved more than 64,000 women, and the recent Outcomes of Care in Birth Centers study, which included more than 15,000 women, have demonstrated that low-risk women who have midwife-directed care in a freestanding birth center receive excellent care at a lower cost. Additionally, these studies documented that care provided in this way reduced cesarean sections and operative vaginal births without increasing adverse perinatal outcomes.^{6,7} The State of Minnesota has been paying for midwife care in licensed birth centers through Medical Assistance since January 1, 2011.

The pregnancy care and delivery home model

Although midwifery and birth centers are not new ideas, health care reform offers new opportunities for these options in the context of an integrated, high-value maternity care system. In 2010, a multistakeholder group created a Blueprint for Action that called

for ensuring that “every woman has access to a woman- and family-centered maternity care home.”⁸ Although federal, state and private entities have shown increasing interest in a health care home model for maternity care, most apply the model only to prenatal and postpartum care, carving out hospitalization. By doing so, they severely limit the potential to influence the most costly phases of care—intrapartum and newborn care. We propose a comprehensive pregnancy care and delivery home (PCDH) model that encompasses all aspects of pregnancy, labor, birth, postpartum and neonatal care. The key features of a PCDH are:

- continuity of care from a primary maternity care clinician (midwife or physician)
- coordination with and timely access to specialists (maternal-fetal medicine, neonatology, nutrition, endocrinology, etc.)
- use of evidence-based practices
- commitment to woman- and family centeredness, shared decision-making and a positive care experience
- use of appropriate health information technology to enable patient engagement, care coordination and data-driven quality improvement.

Midwives are well-suited to be primary maternity care providers because they are experts in normal pregnancy and birth, and they place a high value on wellness and preventive care. They are also trained to collaborate with other care providers.

Birth centers provide midwife-led care in a low-technology environment that is focused on the needs of the woman and the family rather than on the capabilities of the health care system. The hospital then serves as a safety net for women who need additional care. About one in six women who begin labor in a birth center will be referred to a hospital because of complications or the need for high-tech intervention; but fewer than 2% of women or babies will transfer emergently, and most women who are transferred during labor will still give birth vaginally.⁹ Because facility fees for birth centers are less than those paid to hospitals, and because midwife-led birth center care dramatically lowers cesarean rates, birth centers offer payers high value.

If payers abandoned the fee-for-service model and offered a single bundled payment to cover both facility and provider fees for pregnancy, birth and postpartum care, incentives would shift from encouraging the use of technology-intensive care to encouraging the use of low-technology, high-value approaches. Midwife-led birth center care in a PCDH can provide that alternative. The savings derived from fewer c-sections and lower facility fees for the majority of women would easily offset the costs associated with the small number of complicated births that would require hospital care. A specific pregnancy insurance component could provide outlier payment adjustments if the costs for a patient or her baby exceeded a certain amount. This would reduce the financial risk to providers and facilities participating in the bundled payment program.



Conclusion

Our current health care system is financially unsustainable. Reform will require payers and providers to establish new relationships and take on new responsibilities. Pregnancy care is one area where we can start making such changes. Including all professional, facility, imaging and pharmacy costs in one package price would encourage providers to take a true team approach to care and provide primary pregnancy care in cases where it is appropriate.

We propose piloting the PCDH as a Department of Human Services Health Care Delivery Systems Demonstration Project. With its reputation for innovation in health care, Minnesota is well-positioned to test such a model and become a leader in the reliable delivery of high-quality, high-value maternity care. **MM**

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Care of the Frail Elder

The Nexus of Geriatrics and Palliative Care

BY ABDULLAH LADHA, M.B.B.S., SAURABH SHARMA, M.B.B.S., JOHN A. BATSIS, M.B.B.CH., GREGORY A. HANSON, M.D., AND KEITH M. SWETZ, M.D., M.A.

The number of frail elderly individuals living in the United States is expected to increase. Frail patients tend to suffer from a number of chronic symptoms including pain, weakness and depression, and frailty is associated with dependence on others and increased mortality. Thus, palliative care is often appropriate for these individuals. This article describes frailty among the elderly, how frail patients might benefit from palliative care and several community-based programs that can improve the quality of life for home-bound frail elders.

By 2020, the number of persons age 65 years and older in the United States is expected to increase to 55 million—up from 40 million in 2010.¹ An estimated 18.9% of the population in Minnesota will be 65 years and older by 2030, up from 12.4% in 2010.² Given the changing demographics across Minnesota and in the United States, physicians will undoubtedly encounter an increasing number of older patients in their practices. In most developed countries, a person is considered “elderly” if he or she is older than 65 years of age. In the United States, we have traditionally considered the elderly to be those of a certain age who either have some type of functional impairment or limitation or are at risk for one.

The concept of frailty differs substantially from that of elderly. “Frailty” has been used to describe a physiologic state of increased vulnerability to stressors. More recently, “frailty syndrome” has been used to describe a condition arising from mul-

tisystem physiologic dysregulation that results in a state of high vulnerability for adverse health outcomes, including diminished ability to perform activities of daily living, falls, dependency and institutionalization, and death.³ Multiple comorbidities and multimorbid illnesses often induce frailty. An elderly person with multiple comorbidities who may not bounce back from injury or illness as readily as someone who is less debilitated is considered to meet the criteria for frailty syndrome.

Frailty is highly prevalent in elderly patients. Frailty syndrome affects 7% of persons over the age of 65 and between 25% and 40% of those over the age of 80.⁴ The association of frailty with mortality increases with age and disproportionately affects females, presumably because they tend to live longer than males.⁵

Frailty is significant for several reasons. It independently is predictive of greater frequency and severity of postoperative complications, longer hospital stays, discharge to a skilled nursing facility and

poor outcomes after emergency room evaluation.⁶⁻¹⁰ Moreover, the impact of frailty on health care costs and utilization is substantial, as frail patients who undergo surgery have higher costs associated with their initial hospitalization and for six months after discharge.¹¹

Identifying and Managing the Frail Patient

Diagnosing frailty is critically important. If frailty is identified early, it is possible to slow down or reverse the process and improve outcomes.¹² A recent systematic review estimated that 3% to 5% of deaths among older adults could be delayed if frailty was prevented.¹³

Recognizing frailty, however, can be a challenge for physicians. One reason is the lack of a consensus about how to diagnose it. Some of the commonly reported measures associated with frailty include

slow gait speed, decreased hand grip and self-reported exhaustion. And several validated instruments are available to monitor and assess specific domains of frailty. The box (“Defining Frailty”) describes some of these. A referral for a comprehensive geriatric assessment may be beneficial for diagnosing the patient with suspected frailty syndrome.

Optimal management of the frail elderly requires a multidisciplinary approach. Such an approach should involve primary care and other physicians, and providers such as nurses, nutritionists, physical therapists and social workers, and the patient’s caregiver. Various pharmacologic and nonpharmacologic measures have been studied to prevent and treat this syndrome. Among these, exercise, including strength, balance and endurance training, has been shown to have potential for improving muscle mass, strength, gait speed and physical function.¹⁴ Home-based physical therapy targeted toward specific disabilities has been shown to slow the progression of functional decline among frail patients who live at home.¹⁵ In addition, nutritional supplementation with vitamin D has been shown to preserve muscle strength and may play a role in the management of frailty.¹⁶

Palliative Care and the Frail Elder

A number of frail elderly patients could potentially benefit from palliative care sooner rather than later in their disease course. The World Health Organization defines palliative care as an approach that seeks to improve the quality of life of patients facing life-threatening illness. This is done by preventing and mitigating suffering, assessing and identifying problematic symptoms, and treating pain and other sources of physical, psychosocial or spiritual discomfort.¹⁷ Palliative care is usually provided by an interdisciplinary team.

Over the past decade, palliative medicine has been one of the fastest-growing fields in health care, with the number of palliative care programs increasing

Defining Frailty

Although there is no clear consensus definition of frailty, a number of researchers have attempted to measure it in different ways. Here is a summary of some of the approaches they have used.

In the Canadian Study of Health and Aging (CSHA), three approaches to assessing frailty are described.¹⁻³ The first involves classifying patients into four levels:

- those who walk without support, are able to perform activities of daily living (eating, dressing, bathing, bed transfers), have bladder and bowel continence, and are not cognitively impaired
- those who have bladder incontinence only
- those who require assistance with mobility or activities of daily living, have cognitive impairment, or have bowel or bladder incontinence
- those who are totally dependent for transfers or one or more activities of daily life, incontinent of bowel and bladder, and have diagnosis of dementia.

The second involves counting a patient’s clinical deficits, identified by signs, symptoms, diagnoses and abnormal test results, which requires the physician to assemble a real-time list of no fewer than 70 attributes. This can be cumbersome in clinical practice without a robust, dedicated electronic medical record.

The third approach involves development of a seven-point scale categorizing patients from “very fit” to “severely frail.” Categorizing a patient is based on clinical judgment using patient history and clinical examination.

Fried and colleagues⁴ proposed a model that uses five measures to assess frailty. These include weight loss ≥ 10 pounds in the past year; weak grip strength, self-reported exhaustion, slow gait speed and low physical activity. Patients who meet three or more of the criteria are considered “frail,” those who meet one or two are categorized as “pre-frail” and those who meet none of the criteria are “robust.” This model can be used to identify frailty early on in primary care settings. However, certain components—gait speed, physical activity and grip strength—are difficult to measure in a clinical environment.

The frailty index developed for the Study of the Osteoporotic Fracture (SOF) solves that problem.^{5,6} The SOF frailty index uses three components: unintentional weight loss, inability to rise from a chair five times without using arms and having a low energy level—all of which can be easily measured in primary care setting.

The Precipitating Events Project (PEP) examined seven criteria for assessing frailty. They include Fried’s criteria plus cognitive impairment and depressive symptoms.⁷ This assessment tool places greater emphasis on cognitive impairment, slow gait speed, low physical activity and weight loss, and less emphasis on grip strength (ie, muscle weakness), self-reported exhaustion and depression.

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by 138% since 2000. Here in Minnesota, there has been substantial growth in the number of both hospice and palliative care programs at community-based hospitals and urban medical centers. Much of the growth that has taken place in rural settings has been the result of efforts by Stratis Health to encourage the development or expansion of community-based palliative care initiatives.¹⁸ As a result, palliative care is now available in more than 80% of Minnesota's hospitals,¹⁹ and the state is one of the eight to receive the grade of "A" from the Center to Advance Palliative Care for developing and providing access to such programs.

A common misperception is that palliative care is synonymous with end-of-life care or hospice. This can lead to the belief that palliative care and curative therapies are mutually exclusive, meaning patients must choose one or the other. Palliative care offers both, and transitions from predominantly curative to mostly palliative interventions are the norm.

Hospice and palliative care generally are considered appropriate for patients with diseases such as cancer and advanced cardiac and pulmonary disorders. They are often recommended for patients with advanced neurocognitive disorders such as dementia, as well. According to Centers for Medicare and Medicaid Services (CMS) criteria, only patients with highly advanced disease or with failure to thrive or who are experiencing a general decline are eligible for hospice care. Medicare beneficiaries qualify for hospice when a physician certifies that they have six months or less to live and they agree to forgo curative therapy. Palliative care is generally thought to be appropriate for those with advanced life-limiting illness before they qualify for hospice care. Given the complex needs of the frail, their heavy symptom burden and the multiple dimensions of goals of care, physicians trained in palliative medicine may provide the extra assistance these patients require.

Community-Based Initiatives

Providing palliative care for the frail elderly will not necessarily require the

invention of new programs or the outlay of new resources. Many communities have comprehensive home-care programs for frail elders that include components of palliative care. The Program of All-inclusive Care for the Elderly (PACE), for example, provides all the care and services covered by Medicare and Medicaid such as adult day care, emergency services, home care, laboratory services, meals, medical specialty services, nursing home care, occupational therapy, physical therapy, social services including caregiver training, support groups, and respite care, prescription drugs, preventive care, and even transportation to PACE centers. Many of these components are elements of palliative care.²⁰

Other palliative care programs also target seniors. One is Palliative Access Through Care at Home (PATCH), a home-care program developed through the University of Chicago's Section of Geriatrics and Palliative Medicine in 2006. PATCH aims to provide palliative care including pain control and management of other symptoms to patients who are older than 65 years of age, enrolled in Medicare Part B, are homebound as defined by Medicare and have a limited life expectancy.²¹ Another program is Optimizing Advanced Complex Illness Support, developed by Lehigh Valley Health Network in Pennsylvania. It provides in-home comprehensive palliative care assessment, advance care planning, pain and symptom assessment and management, coordination and care during transitions between hospitals or long-term care facilities and home care agencies, and referral for hospice services.²² In addition, several programs sponsored by the Kaiser Permanente system in California, have been shown to effectively address chronic care issues of patients approaching the end of life.²³

Home-based palliative care programs can reduce health care spending at the end of life by 45% as compared with usual care.²⁴ In a randomized controlled trial, patients who received high-quality in-home palliative care services showed increased satisfaction and were 2.2 times more likely to die at home than those who

received usual care; the average daily cost of palliative care was \$95.30 compared with \$212.80 for usual care.²⁵ The benefits of such interventions, however, go beyond cost savings. Ultimately, the benefit of incorporating palliative medicine into the care of the frail elders is that it is the best care.

Shared Decision-Making

Shared decision-making is a key component of palliative care. By embracing this process, clinicians show respect for their patients' preferences by encouraging their active participation in their care. Shared decision-making has been shown to be appropriate for patients considering treatment options for cancer, advanced heart failure,²⁵ end-stage renal failure²⁶ and frailty.²⁷ In shared decision-making, skilled clinicians can support and advise a patient and their loved ones and assist them with the often overwhelming burden of making decisions about their care;²⁸ they also can clear up confusion and dispel misperceptions about treatment and its benefits. For example, a recent study revealed that 69% of patients with metastatic lung cancer and 81% of those with metastatic colorectal expected palliative chemotherapy to cure their cancer.²⁹ Palliative care providers may be well-suited to assist primary care physicians in discussions about the benefits and risks of treatment and patient's goals and priorities.

A major challenge in the process of shared decision-making is delineating the goals of care for frail elders, as they often face an uncertain trajectory. In contrast to patients with malignancy, who more predictably experience a rather abrupt decline once therapeutic options are no longer effective, frail elders are more likely to experience slow progression of their diseases punctuated by recurrent exacerbations.

tions over an extended period of time. In one study, the health trajectories in the last year of life for community-dwelling elders were found to be variable with no specific pattern for patients with organ failure, cancer and frailty without organ failure.³⁰ Therefore, discussions regarding care goals tend not to be one-time events, and shared decision-making needs to evolve as the patient's clinical status and psychosocial situation changes.

Conclusion

As people live longer with chronic diseases, it is becoming increasingly important for physicians to recognize frailty and its impact on health and mortality. Attempts to reduce the effects of frailty through exercise and nutrition are important as are discussions between physicians and patients about their preferences regarding health care.

We believe it is important to consider palliative care once frailty syndrome is recognized in order to optimize care decisions and symptom management. Physicians should engage patients and their families in discussions about this type of care early on, as it can enhance a person's quality of life, facilitate end-of-life decision making and be a sensible approach to using health care resources. **MM**

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Value-Based Purchasing for Physician Services

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Growth in Medicare expenditures has forced legislators and policymakers to look for ways to slow spending and get more value for their money. This article reviews previous federal efforts to control Medicare costs as well as current ones required by the Patient Protection and Affordable Care Act. It also describes a proposal for value-based purchasing that the authors developed under contract to the Centers for Medicare and Medicaid Services. This approach uses two measurement systems—one for physicians who practice primarily in outpatient settings and one for physicians who practice primarily in the hospital.

If there is one recurrent theme in U.S. health policy discussions, it is the discrepancy between the amount of money spent on health care services and subsequent health outcomes. Comparisons with other developed countries cast the United States in an unfavorable light. The differences in spending from one country to another can be divided into two categories: differences in the quantity of services delivered and differences in unit prices (fees). Interestingly, our higher expenditures on physician services appear to be primarily the result of higher fees, rather than higher utilization.¹

Health expenditures in this country, particularly in public health insurance programs (eg, Medicare and Medicaid), are putting budgetary pressure on both the federal and state governments. In the spring of 2012, the Medicare Trustees projected that Medicare will have an unfunded deficit of \$27.2 trillion over the

next 75 years.² This is not the cost of the program. This is the portion of the cost that the government does not know how it will pay for. As noted by the Trustees, the situation probably is worse than it looks because their forecasts include the effects of legislation that likely never will be implemented. A case in point is the Sustainable Growth Rate or SGR formula. The Balanced Budget Act of 1997 mandated an across-the-board cut in Medicare's physician fee schedule if expenditures on physician services grew too rapidly. The legislation actually resulted in a 5.4% cut in physician fees in 2002; but since then, Congress has found ways to ignore or circumvent the legislation. Today, maintaining compliance with the SGR legislation

would result in a reduction in Medicare fees of approximately 30%. Other attempts at Congressional self-discipline, such as the 45% rule* have been no more successful. Evasion of inconvenient laws has a long and bipartisan history.

Changes in the ACA

The 2010 Patient Protection and Affordable Care Act (ACA) includes a number of initiatives designed to reduce the rate of increase in spending on physician and hospital services. They include the usual across-the-board payment reductions, the creation of accountable care organizations (ACOs) and demonstrations of bundled payment. A number of Medicare demonstration projects including the Medicare

*The Medicare Prescription Drug, Improvement and Modernization Act of 2003 contains the following provision: If in two consecutive Trustee reports, general revenue funding for Medicare divided by total Medicare outlays is projected to exceed 45% at any point during the next seven years, the president and Congress need to act. The 2012 Trustees report contained the seventh such warning. President Bush submitted legislation proposing a fix to Congress in 2008, but no action was taken. President Obama has not responded at all to the subsequent Trustee warnings. For more information on the 45% rule, see "Medicare Trigger" by Patricia Davis, Christopher Davis and Todd Garvey, Congressional Research Service (April 2012) 7-5700. www.crs.gov/R52279

Physician Group Practice Demonstration and the Premier Hospital Quality Incentive Demonstration have attempted to put physicians and hospitals at greater risk for the cost of care, and the results have not been particularly promising. One exception is the Diagnosis Related Group (DRG) payment system for hospitals that bundled a large number of inpatient costs into one prospective payment and did produce some savings.

Bundled payments are thought to be the most promising approach to payment reform in the traditional fee-for-service Medicare program,³ and the ACA calls for more demonstrations of bundled payments. However, similar demonstrations were started and then cancelled 20 years ago. In addition, the ACA requires the Centers for Medicare and Medicaid Services (CMS) to implement value-based purchasing systems for hospital and physician services paid through fee-for-service Medicare.

Quality Meets Cost

The concept of value incorporates both cost and quality and can be thought of as the answer to the question, “What are the beneficiaries, the government and the taxpayers who pay most of the costs associated with Medicare getting for their money?” Of course, the most important product of health care spending is the health and functional status of the patient. However, there also is considerable interest in “process” measures of quality and intermediate outcomes.

Thirty years ago, little information was available on either process or outcome measures of quality, but now it is possible to glean a large number of “claims compatible” measures of both cost and quality from administrative data. Such data are

being enhanced through initiatives such as Medicare’s Physician Quality Reporting System, which allows physicians to enter health outcomes data on standard CMS claim forms. Additional quality information is being collected at the health plan level through initiatives such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. That information is being made available to consumers. The Medicare program now posts comparative data on nursing homes, hospitals, Medicare Advantage plans and Part D drug plans online. Although there have been attempts to incorporate quality data into payment systems in Medicare, those efforts have yet to be extended to physician services.

One Proposal, Two Measurement Systems

We recently developed a value-based purchasing system for physician services under contract to CMS.⁴ We emphasize that our proposal is nothing more than that; we have no information regarding its implementation. Our idea is relatively simple. All of our proposed cost and quality measures can be computed from administrative data and, with one exception, are based on publicly available “open source” computer code, so physician organizations could run their own data through the cost and quality algorithms.

Our proposal does not depend on specific measures, and none of the measures used in our analysis are perfect. However, as health policy analyst Walter McClure once noted, “The best way to improve cost and quality measures is to use them.” You can be sure that you will hear about the deficiencies of these measures from the people who are being measured. Once that happens, the work of addressing legitimate concerns can begin.

Many approaches to measuring cost and quality begin by defining episodes of illness. That is a challenge with the Medicare population, as older patients often have multiple comorbidities. Our approach begins by asking how and where

physicians practice. It then uses two measurement systems—one for physicians who practice primarily in outpatient settings and one for physicians who practice primarily in the hospital.

Our unit of analysis is the tax identification number or TIN. TINs include both individual physicians and large group practices, and are representative of how providers deliver care.

The system, designed for physicians who practice in outpatient settings, collects data for one year for each beneficiary assigned to a TIN. We assigned beneficiaries to the TIN that provided most of their nonhospital evaluation and management visits.

The system designed for physicians who primarily work in the hospital aggregates all the information associated with an inpatient admission. All inpatient admissions for patients covered by Medicare are assigned to a DRG adjusted for medical severity. We aggregate information from the date of admission through a post-discharge observation period. (We analyzed results for both 30 and 60 days post-discharge.) Costs are assigned to a TIN based on the proportion of total Part B costs accounted for by the TIN during the inpatient admission. The DRG cost of the inpatient stay is excluded because the decision to hospitalize a patient is not made by the hospital-based physicians; however, outlier payments† are included, as they are a consequence of care provided during hospitalization.

For both the inpatient and outpatient systems, we developed measures of risk-adjusted cost, modifying the hierarchical condition category system currently used by CMS to adjust payments to Medicare Advantage plans. (For example, we excluded costs associated with trauma that are beyond physician control.)

Our quality measures were vetted not only by national organizations such as the National Quality Forum but also by two expert panels assembled specifically to

†Outlier payments are made to hospitals whose costs for a particular case exceed a pre-specified amount. For details, go to www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html.

review the measures for this project. Quality measures for the outpatient physician system included:

- Inappropriate use of the emergency department
- Ambulatory care-sensitive admissions
- Potentially preventable re-hospitalizations
- Measures of colon and breast cancer screening
- Measures for beneficiaries with chronic illness, including HbA1c measures, LDL-cholesterol levels, medical attention for nephropathy for diabetics; lipid testing for beneficiaries with kidney disease; and CVD-LDL testing for patients with cardiovascular disease.

The quality measures for the inpatient physician system included:

- inappropriate ED visits
- preventable readmissions
- all-cause mortality during the observation period.

These measures were combined with data from Medicare's Hospital Compare database and with Patient Safety Indicator measures developed by the Agency for Healthcare Research and Quality.

To form a value index, we combined cost and quality data. For physicians practicing in outpatient settings, we used data envelopment analysis (DEA) in which the TIN's annual average risk-adjusted total cost of care per attributed beneficiary is the "input" and all of the claims-computable quality measures are the "outputs." An important advantage of DEA over other analytic methods is that DEA can incorporate more than one quality measure into its assessment of value.

For physicians who work in inpatient settings, quality data were combined into a single composite measure using relative importance weights assigned by a physician expert panel. Next, we formed quality tiers, then compared the cost of care for physicians in each tier.

Any health plan, public or private, could use this information in a number of ways. First, they could simply make the data

available to consumers. In the past, however, such initiatives have had a limited effect on expenditures. Second, they could use it to calculate incentive payments. Provider fees could be tied directly to assessments of value, or consumer copayments could vary for providers in different value tiers. There are a number of variations on these themes.

An important question is whether providers should be judged against an absolute measure of performance or by performance relative to each other. Our general position is that improvement should be rewarded, and high-performing physicians who already have met a performance standard should not be penalized for their past success.

Another challenge is risk-adjustment. Suppose a physician sees a disproportionate number of patients who are less likely to adhere to prescribed treatment regimens or keep appointments for maintenance care of their chronic conditions. Failure to adjust for those patients in the quality measures will unfairly penalize that physician. The question becomes how to adjust the quality measures to avoid penalizing that physician without implicitly accepting a lower standard of care for vulnerable patients. This will require continued discussion and analysis. Our approach to risk adjustment for some quality measures for inpatients such as mortality and readmission rates gives more credit to physicians who obtained favorable outcomes with sicker patients.

In summary, we found that a rudimentary value-based purchasing system for physician services could be implemented quickly and relatively easily using transparent, publicly available algorithms to measure risk-adjusted cost and quality of care. The measures would not be perfect, but they would improve over time, as would other elements such as patient attribution rules and risk adjustment. Participation in the PQRS system has been voluntary since its inception in mid-2007; physicians who participate can receive a reward for doing so. Beginning in 2015, however, those who do not will be penalized; thus participation is likely to increase.

Conclusion

As policymakers attempt to confront the growth in Medicare spending, they have only a finite set of options at their disposal. Taxes and beneficiary cost-sharing are likely to increase; however, provider payments also are on the table, and providers are likely to face a variety of unpleasant options. Our hope is that physicians and policymakers will agree that value-based purchasing approaches are better than across-the-board fee cuts. If so, physicians will be in a position to make an important contribution to improvement of those systems as they develop. **MM**

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Measuring Medical Productivity to Gauge the Value of Medicare

BY STEPHEN T. PARENTE, PH.D.

Having a measure of productivity that relates funds and effort spent on medical treatment to health outcomes could help policymakers better understand whether they are getting value for the money spent on public health insurance programs. This article describes such a metric, the medical productivity index (MPI), and illustrates how it was used to analyze a sampling of Medicare claims from 2007 through 2009.

With federal, state and local governments projected to spend trillions of dollars in coming years on publicly financed health insurance, it seems prudent to consider whether we as a society are getting value for this expenditure.^{1,2} To assess this, we would need a measure of medical care productivity, something that accounts for both our outlay of funds and effort and the effect of care on individual consumers.

Productivity is the ratio of products produced in a given time (the numerator) to the labor or capital used to produce them (the denominator). In general, it refers to industry- or firm-specific output. For example, in the manufacturing sector, productivity indices inform about changes in industrial output given labor or capital inputs.

A number of measures have been used to understand trends in health care spending and utilization. The most commonly used economic index is the medical price component of the Consumer Price Index (CPI). The U.S. Department of Labor's CPI program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.³ Medical goods and services

are measured as part of the CPI program. The medical CPI has compared the rate of price changes for medical services with the general inflation rate for more than three decades. During that period, the inflation rate for medical care costs has been significantly greater than, and sometimes double that of, the general inflation rate in the United States.

The Dartmouth Atlas, the findings of which are based on Medicare health insurance claims data, is the most frequently cited measure of health care resource utilization.⁴ The Dartmouth Atlas is most often used to analyze region-specific differences in health care utilization per capita and the hospital discharge mortality rate per capita. The range of geographic differences in health care and care-related mortality shown by the Atlas have driven national efforts to systematically improve clinical outcomes through the development of clinical guidelines, and more recently, federally financed health improvement pilots.

What had not yet been developed was a means of assessing the productivity of medical care. It was thought that a productivity metric could help address growing concern that medical care expenditures are sapping the economic vitality of the

nation. That prompted a group from the University of Minnesota to develop the medical productivity index (MPI).⁵

The two primary components of the MPI are a measure of health outcomes and a measure of medical care. Health outcomes were defined as patient disease burden; medical care was defined as physician time. We used the John Hopkins Adjusted Clinical Group (ACG) system to arrive at a score for illness burden. We scored physician effort using Resource-Based Relative Value Scores associated with certain CPT and HCPCS codes.

One significant feature of the MPI is that the input measure (medical care) used for one quarter of the year is tied to the output measure (health outcomes) for the following quarter. The rationale for this lag is that the impact of medical care is generally felt after an appreciable period of time. For example, for a patient who suffered a mild heart attack, measuring their outcomes several months after treatment would be more meaningful than measuring them immediately after the event.

Putting the MPI to the Test

We applied the MPI to Medicare National Claims History File data. Specifically, a

random sample of claims data from 5 percent of all Medicare beneficiaries who received services in calendar years 2007 through 2009 was used. Data about medical effort were collected for the third quarter of each year; outcomes data were gathered for the fourth quarter of each year.

The value of using the Medicare data is that its format is commonly found in other U.S. health insurance data architectures, so the MPI could also be applied to the Medicaid and commercial insurance populations. Furthermore, the importance of the Medicare data to public policy is underscored by the impact of the program on future U.S. debt projections if Medicare spending continues on its current trajectory.

Altogether, we collected data on 1.875 million Medicare beneficiaries who received care between 2007 and 2009. To qualify, a beneficiary had to have been eligible for Medicare for at least four quarters. Included were those on traditional Medicare along with those who are enrolled in a Medicare Advantage health plan. Those who died during that time period were also included. A decision was made to allow for unequal numbers of participants in the two quarters studied because that was likely to be the reality if the index technology were used in real time.

The results for the time period we studied are presented in Figures 1 and 2. Figure 1 shows the changes in medical productivity over three years. We noticed a distinct seasonal pattern, as medical productivity was lower in the first half of the year. This could indicate that seniors experienced more medical illnesses that are difficult to treat in the first quarter than in later quarters. The other major observation is the general decrease in productivity over time. Our calculations show a drop in medical productivity between the fourth quarter of 2008 and the first quarter of 2009. The decrease by a percentage point in the second quarter of 2009 coincides with the worst period during the recent economic recession. By the third quarter of 2009, productivity had increased to 0.110, but it was still less than what it had

FIGURE 1

Tracking Medical Productivity Using the Medical Productivity Index, 2007-2009, Traditional Medicare Data



been in the third quarter of 2008 (0.117), when the recession began.

Figure 2 shows a comparison of medical productivity by state during the third quarter of 2009. The MPI values for each state were categorized to represent a high, medium and low placement on a distribution scale. Minnesota was well above average in terms of providing value for medical effort expended. Many other states with high MPI score were also located in the Upper Midwest. The states with lowest MPI scores were largely located in the Southeast and include Georgia, Florida, Alabama, Tennessee and North Carolina. Texas, California, and New York had moderate MPI scores.

Implications

Our main finding from this first application of the MPI was that it does in fact demonstrate that a measure of productivity based on health insurance claims data can be generated. Thus, we propose that the MPI is a tool that can be used to ex-

amine the value of care health insurance beneficiaries receive.

Another interesting finding from this first use of the MPI is the substantial reduction in productivity during the economic recession in 2009. This could have been because seniors simply did not seek care because of concerns about the cost or a general decrease in health brought on by the anxiety that may have been triggered by the recession. Understanding whether the decrease in MPI score was the product of a genuine reduction in health will require additional analysis.

Another interesting finding is the productivity variation among states. It is well-documented that some states are more efficient than others, and our findings appear to confirm this trend. Our findings show that southern states are less productive than northern states. Again, further analysis would need to be done to identify some of the potential root causes of this difference.



The C.A.S.E. Approach

Guidance for Talking to Vaccine-Hesitant Parents

BY ROBERT M. JACOBSON, M.D., F.A.A.P., LINDA VAN ETTA, M.D., F.A.C.P., F.I.D.S.A., AND LYNN BAHTA, R.N.

Primary care physicians are encountering a growing number of parents who have concerns about vaccinating their children. This article describes the C.A.S.E. (Corroborate, About me, Science, Explain/Advise) approach to talking to such parents about the importance of vaccination.

Primary care physicians are encountering an increasing number of parents who are hesitant to immunize their children against preventable diseases. According to a recent survey of parents in the upper Midwest, 25% to 30% had significant concerns about the need for vaccines as well as their safety—and that was among those whose children were up-to-date on their immunizations.¹

During the last 10 years, more and more parents have asked to delay or skip vaccines, and experts point to a number of reasons why.² First and foremost, vaccines have reduced the frequency of many of the diseases they aim to prevent to the point where most parents are not familiar with them and have no reason to fear them. Second, highly educated and well-meaning parents often believe false claims about the effects of vaccines in popular media and on the Internet. Stories about bad outcomes claimed to be related to vaccines are compelling, whereas scientific studies can be difficult to assess and understand. Finally, some Americans are suspicious of “big government,” “big industry” and “big medicine.” These factors have led some parents to view vaccination as unnecessary exposure to risk.

Consequently, only 69% of U.S. children 19 to 35 months of age are up-to-date on their routine vaccinations (not count-

ing influenza or rotavirus vaccination).³ The rate in Minnesota is better but not by much—72%. (We do not monitor routinely on-time vaccination rates, but when they are measured they are significantly lower than the up-to-date status.)⁴ Less than 1% of children in the United States have received no vaccines by 19 to 35 months of age.³

Because most parents have strong feelings about vaccines by the time of their child’s 2-month well-child visit, clinicians often feel as if they’re fighting an uphill battle when trying to convince those who wish to delay vaccination or not vaccinate at all of the importance of immunization. Working in a clinical environment where there is as little as 15 minutes for a well-child visit adds to the challenge and makes it is easy for clinicians to acquiesce to parental requests to reschedule, delay or skip vaccinations. Studies show that most parents who request alternative schedules that delay vaccines even fail to follow those.² Delayed vaccination leaves children vulnerable to preventable diseases during a time when they are most susceptible to those that can cause the greatest harm.

An Effective Approach

Clinicians can influence parents, even those who maintain that vaccines are inherently dangerous.⁵ One way they can

do that is by using the C.A.S.E. approach.⁶ C.A.S.E. is an “elevator speech” to be used in the context of a patient visit. The acronym, which serves as a mnemonic, stands for Corroborate, About me, Science, and Explain/advise. The approach organizes the clinician’s response to an expression of vaccine hesitancy so it addresses the parent’s concern, yet keeps the communication short and to the point.

The way the conversation unfolds is important. With the C.A.S.E. approach, the clinician doesn’t immediately counter concerns about vaccine safety with scientific facts, which may come across as challenging to or dismissive of the parent. Instead, the clinician first *corroborates* the parent’s concern by acknowledging it—expressing understanding of where it might be coming from and validating that he or she is not alone in feeling this way. Parents want to be heard and expect their wishes regarding decisions for their child to be respected. The clinician empathizes with the parent while bringing his or her own emotional connection to the conversation, thus setting the tone for a respectful and ultimately successful discussion. This approach also allows clinicians and parents to find points on which they both can agree.

The next phase of the discussion is *about me*. This is where the clinician

moves from acknowledging the parent's specific concern to explaining how he or she became an expert on the issue. The clinician might discuss articles read, conferences attended and experts conferred with and show that he or she understands the data regarding the benefits, risks and burdens of the vaccine in question. The physician should refer to his or her role in the care of the child, thus appealing to the parents' trust, a very important underpinning to their acceptance of the clinician's recommendation.⁷

Next comes the *science*. This is when the clinician finally gets to the "information transfer." Clinicians should relay the information in a straightforward way and include points that are central to countering the concern.

Finally, comes *explain/advise*. This is the time for the clinician to discuss why he or she feels so strongly about the need to vaccinate and why he or she believes it is the best for the patient.

Conclusion

The C.A.S.E. approach isn't rocket science. It isn't even modern. It has its roots in how Aristotle taught his students to organize an argument—to instill the argument with *pathos* (passion), *ethos* (reputation) and *logos* (information). The C.A.S.E. approach uses all three components beginning and ending with passion (compassion for the parent and passion for the advice) and touching on reputation and science.

A recommendation from a physician does improve the likelihood that parents will vaccinate their child. By using the C.A.S.E. approach, you can connect emotionally with those who are hesitant to immunize and engage them in a thoughtful, respectful conversation that could, indeed, change their mind. **MM**

Robert Jacobson is a pediatrician at Mayo Clinic and president of the Minnesota Academy of Pediatrics. Linda Van Etta is with St. Luke's Infectious Disease Associates. Lynn Bahta is an immunization clinical consultant for the Minnesota Department of Health.

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C.A.S.E. in Action

MMR Vaccine

Parent: I don't want my child to have the vaccine that causes autism, the MMR vaccine.

Clinician: If the MMR vaccine caused autism, I wouldn't want your child to have it either. **(CORROBORATE)**

I have been studying this claim for many years and have read the studies about whether the MMR vaccine causes autism. I've also been reading the studies about autism itself. **(ABOUT ME)**

Dozens of very large, well-done studies have shown that the MMR vaccine does not cause autism. In fact, the studies about autism show that children who are going to get autism display signs long before they receive the MMR vaccine. On the other hand, the MMR vaccine prevents measles, and I have seen how serious measles can be; one in three children become so sick they have to be hospitalized. Some even die. **(SCIENCE)**

You and I both want your child to be healthy, and we certainly do not want to cause autism. Your choosing not to get the MMR vaccine will not protect your child from autism, and it will leave your child at risk for diseases that can result in hospitalization or worse. As your child's doctor, I urge you to have your child get the MMR vaccine. **(EXPLAIN/ADVISE)**

C.A.S.E. in Action

Tdap in Pregnancy

Pregnant woman: I don't want a Tdap shot, I just had one when I had my baby two years ago. It just doesn't seem safe.

Clinician: I too wondered about the frequency of getting Tdap during every pregnancy. We used to say only one Tdap ever. **(CORROBORATE)**

I read the recommendation that was just published to better understand the reasoning behind this. **(ABOUT ME)**

Pertussis can be most severe in infants who have not started their vaccinations. The majority of deaths occur in infants younger than 3 months of age. I learned that the recommendation was made to take advantage of the mother's ability to pass on pertussis protection to the baby, so the baby is protected until he or she is old enough to get vaccinated. Because the level of protective antibodies declines after the first year of vaccination, it won't protect babies during future pregnancies. Meanwhile, studies show the Tdap vaccine is safe for pregnant women and their fetuses. That's why they've made this recommendation. So far, the one side effect experts have observed is swelling and redness at the injection site. It won't cause you lasting harm, and it just may save your baby's life. **(SCIENCE)**

Protecting your baby against pertussis in the first couple months is so important. I recommend that you get the Tdap today. **(EXPLAIN/ADVISE)**

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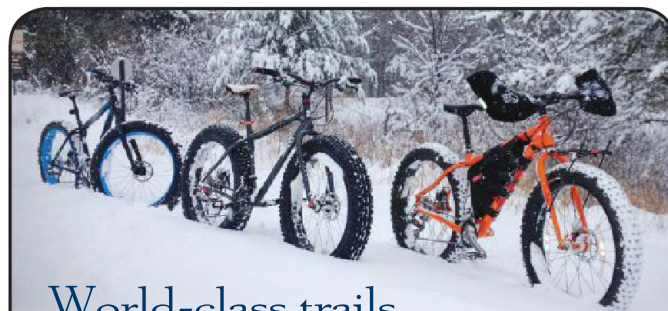


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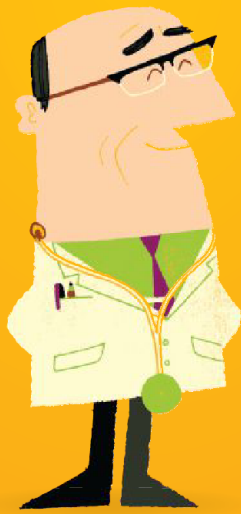
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Rose

BY MICHAEL
SHREVE, M.D.

The letter came later...

Beeper chirps
Bike ride ends
Blood, cancer, choking, drowning
I'm needed, now
Clear the airway
Stop the bleeding
Halt the death
Only nine months old

Bike, car, speeding, running
Still in shorts, to ICU
Eyes raise, parents from Rose
Hopeful
But not
Crowded with machines
Where the life is
Ready

"Thank you doctor..."

Gown glove mask
Humanness covered
Tubes lines bandages tape
She is buried
Eyes closed, swollen so
Monitors, ventilator, precisely tuned chatter
Gurgling red from her lungs

Scope in hand, seems to just happen
Plunge into windpipe
See only red
Epi, bicarb, iced saline
Rejected, blood defiant
Again
Again
Again

Red hints pink, pale
Relenting
Respite

"...for saving my baby's life..."

Merciless
Red returns
Heart rate stumbles
Monitors warn
Tiny lungs stiffen
Too much

Abandon scope for bag
Manual breaths forced
Not strong enough
She needs them
Hands alternate
To ease the fatigue
The breaths

Mom, Dad, across the bed
Kiss their baby
Alive on the monitors
Beeps slow
Whisper to her
Tears drip onto her eyes

"...so I could hold her..."

Crowded
She is small
They hold her, her equipment
Give her all their love
All of it
Even though she looks so

Breathe still, for her
Settle into rhythm
Melt into machinery
Not to intrude
Not now

Hands cramp, arms, back
Two hours
They have a lot of love to give

In her mother's arms now
Comforted, comfortable
My turn ends
Slip out unnoticed

"...when she went to heaven."

Michael Shreve practices with Children's Respiratory and Critical Care Specialists in St. Paul.

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