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PHYSICIAN'S MANAGED CARE REPORT

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Root cause of noncompliant patients may be low health care literacy

Patients who don't understand cost $73 billion a year

If you have patients who appear to be noncompliant — who frequently miss appointments and seem to ignore your advice — they may be suffering from poor health literacy instead of a bad attitude. The fact is, they may not be able to read the material you gave them and don't understand your instructions.

"My personal experience when dealing with care delivered in the hospital, the emergency room, and the urgent care center is that when dealing with patient noncompliance, it's often because they don't understand," says **Mark Williams**, MD, associate professor of emergency medicine at Emory University in Atlanta.

Poor health literacy is a pervasive problem that accounts for an estimated $73 billion a year in unnecessary doctor visits, hospitalizations, and longer hospital stays.

Consider these shocking statistics from the American Medical Association Foundation and the National Adult Literacy Survey:

- More than 90 million Americans demonstrate low health literacy.
- The highest prevalence of low health literacy is among native-born whites.
- More than 66% of Americans over age 60 have either inadequate or marginal literacy skills.
- About 45% of functionally illiterate adults live in poverty.
- Patients hide their illiteracy well. A study of adults with reading difficulty showed than 67% had never told their spouse about their problem.
- About 21% of American adults are illiterate, and an additional 27% have difficulty with ready comprehension.

"Health care illiteracy is a big problem, and it's a newly recognized problem that we need to work on to figure out what kind of interventions will be most effective," says **Ruth Murphey Parker**, MD, associate professor of medicine at Emory University School of Medicine and

chairwoman of the AMA's steering committee on health literacy. "The problem crosses the socioeconomic strata and affects all types of people. We also know that it's a major problem with the elderly, who have the most health care information needs."

Health literacy is the ability to read, understand, and effectively use health information to improve health status and reduce health disparities, says **Barbara A. DeBuono**, MD, MPH, medical director, public health for Pfizer in New York.

"Health literacy is more than just the ability to read. It means improving communication between and among providers, the health care delivery system, and the patient in an effective way so as to enhance the patients' real understanding of and their ability to use health information effectively," DeBuono says.

Pfizer is funding seven projects this year to find out what interventions will work best to improve health literacy for culturally diverse, low income, and senior citizen patients.

Patients need to do more than just get the information you are offering. They need to know what you are saying or showing them, understand it, and act upon it, adds **Scott Ratzan**, MD, of the Academy for Educational Development in Washington, DC.

Forgetting normal language

"Physicians and other health care providers have a much larger vocabulary than the average person because of what they have to go through to learn. Once they've learned the technical language, they forget the normal language that the patients understand,"

Shame prevents many patients from asking questions and seeking help when they don't understand instructions, Parker points out. "As physicians, we need to do a better job of making sure our patients understand us and create an environment that encourages questions," she adds.

Information is a two-way street, Ratzan points out. You need to make sure you are getting the proper information from the patients, as well. Patients who have a low literacy level often check "no" for everything so they don't have to explain it, he adds.

Health illiteracy can take different forms, depending on the patient. One may not understand a consent form. Another may not understand test results or be able to fill out his or her medical history form. Others may not know what their health insurance covers or how to use a pharmacy.

"Physicians and other providers need to be very sensitive to the specific health literacy of each patient. It may be a cultural difference. It may be a different language, or you may be giving the patient too much information for them to handle," DeBuono says.

Older patients with chronic illnesses require special care because of their high incidence of low health literacy and because they may process information in a different way from younger patients.

That's why physicians need to go beyond just handing a diabetic a brochure from the American Diabetes Association, Ratzan adds. For instance, when you write a prescription, don't just rip it off the pad and hand it to the patient. Instead, tell the patient what their condition is, what the medicine is for, how it should be taken, and what will happen if they don't comply with the treatment plan, DeBuono says.

Tell them you want to make sure you've done a good job of explaining it and ask them to teach you the information. "Handing a patient a brochure without any explanation is like giving school children a book, sending them home, and telling them they'll have a test in six weeks," Williams points out.

Health illiteracy requires re-engineering

"Health literacy isn't just teaching people to read. It includes the providers and the system re-engineering themselves to enhance patient understanding of what to do, how to take medications, and how to follow up," DeBuono says.

It's up to everyone in a physician office — the nurse, the receptionist, the support staff, and the doctor — to work to enhance patients' understanding of their own illnesses, DeBuono says.

"Communication is absolutely critical to improve and enhance patients' understanding of disease. If patients manage their chronic illnesses better, they get better health care," DeBuono points out.

And, in addition to improving your patients' health, you'll reap other benefits if you take a few minutes to make sure patients understand what you are saying.

"Patients are extremely appreciative that their health care provider is willing to make sure they do understand," Williams says. ■

Use these techniques to enhance understanding

Make sure your patients are getting the message

It's up to you, the provider, to make sure your patients understand what you say to them.

"Patients don't come with labels. It's very important for physicians to set up a system where each patient's understanding is checked," says **Mark Williams**, MD, associate professor of emergency medicine at Emory University in Atlanta.

That's why you need to try to determine each individual patient's level of literacy.

"People need to get information through a variety of different communication channels, but most physicians and most health plans think the old-fashioned way," asserts **Scott Ratzan**, MD, of the Academy for Educational Development in Washington, DC, and a member of the American Medical Association's steering committee on health literacy.

> Ask your patients to show you or "teach back" how they are supposed to take their medications or what diet they should follow.

Instead of a giving patients a quick run-through from the doctor or a sheet of paper with instructions, Ratzan suggests using the Internet, videos, CD-ROMs, audio cassettes, and for illiterate people, visual presentations that don't even have words.

Rewrite your patient information sheets to give the information as simply and plainly as possible, suggests **Ruth Murphey Parker**, MD, associate professor of medicine at Emory University School of Medicine and chairwoman of the AMA's steering committee on health literacy.

However, she cautions, you can't assume that simplifying your written materials will necessarily bridge the gap. Find ways in your own office to re-engineer your systems to ensure patients understand what you are saying. Consider enlisting the aid of the office manager or the nurse to help patients understand their care.

"It may mean saying to the nurse, the office manager, or the pharmacist that they need to spend an extra five minutes with a patient because he doesn't know how to read or isn't understanding the instructions," says **Barbara A. DeBuono**, MD, MPH, medical director, public health for Pfizer in New York.

"The information system in most physician offices is paper-based and dates from when they started the practice," Ratzan points out.

Revise your forms to make them simpler and have a couple of places that prompt you to ask for the same information in a different way to make sure you are getting everything you need to know.

If the nurse or someone else asks for patient information verbally, try to ascertain what they are asking and how. Do a mini-trial to find out if the information you are getting is accurate.

"I guarantee that there is information you need that is slipping through the cracks," Ratzan says.

Look at what your patients take home with them. Do they get only a prescription slip, or do they get something that gives them information about their care? Give the patient additional information beyond just the prescription. Refer them to their health plan's toll-free number or an Internet site for more information.

"In a competitive marketplace, physicians have to have value-added services. Giving patients more information can be a big help because it shows the patients that you care," Ratzan says.

Here are some other tips for ensuring that your patients have the information they need:

- Make an assessment of every patient. Ask yourself if this patient is struggling with health literacy because of culture, illiteracy, or for other reasons.
- Make it a point to use language that your patients can understand.
- Use visual and other cues to make sure patients understand the appropriate treatment plan and what they should do to follow up.
- Develop materials that don't require high literacy to understand them. Remember that if a patient can't read, it doesn't help to give him a brochure or information sheet.
- Ask your patients to show you or "teach back" how they are supposed to take their medications or what diet they should follow.
- If you find that a patient doesn't understand what you are saying, develop strategies to deal with it. You could refer them to an adult literacy program. Or, in the meantime, show them a video about their disease. ■

AMA Foundation launches patient literacy campaign

Literacy kit available to practices

The American Medical Association Foundation has launched a nationwide campaign to improve health literacy among Americans. A steering committee of health literacy researchers and policy experts is developing program objectives, strategies, and activities for a two- to three-year campaign.

Seven corporate sponsors who have provided program-planning grants are funding the program, titled "Partnership in Health — Improving the Patient-Physician Relationship through Health Literacy".

The goals and objectives of the program will be announced this month at the Annual Meeting of the AMA House of Delegates.

"We are living at a time when the amount of health information available to us is almost overwhelming. Yet most Americans would be shocked at the number of their friends and neighbors who can't understand the instructions on their prescription bottle or understand how to prepare for a simple medical procedure," says **William H. Mahood**, MD, FACP, president of the AMA Foundation.

Video shows effects of health illiteracy

The AMA Foundation offers a health literacy kit that includes a video showing a series of vignettes of people affected by health illiteracy, fact sheets, a discussion guide, and a questionnaire for CME credit. The kit is a self-study program that shows how literacy problems extend across racial, educational, and socioeconomic backgrounds.

The purpose of the initiative is to bridge the communication gap between physicians and patients.

The video shows how patients struggle to understand instructions. One patient featured is a mother who guessed at the appropriate dosage of Children's Tylenol for her children because she couldn't read the instructions. Her guess was equivalent to eight adult doses.

To order a copy of the Health Literacy Introduction Kit, contact Georgianne Cooper at the AMA at (312) 464-5563. ■

Geriatric 'nurse partners' boost care, cut costs

Program slashes hospitalization, lengths of stay

Partners in Care, a case management program for the high-risk elderly, has dramatically reduced hospitalization, shortened lengths of stay, and improved care for targeted patients at Carle Clinic Association, PC, in Mahomet, IL.

The population served by the program includes 2,000 Medicare patients covered by capitated managed care contracts who are at high risk for mortality, functional decline, and increased use of health care resources. **(For information on how patients are chosen for the program, see related article on p. 86.)**

Carle Clinic Association is a multispecialty physician-owned practice with 290 physicians in primary care and medical/surgical specialties. The practice is part of a health care system that includes a hospital, an HMO, and other service companies such as home health, pharmacies, and durable medical equipment suppliers.

Program reduces bed days, hospitalization

Carle Clinic's Partners in Care program received the Models of Excellence in High-Risk Patient Management award from the American Medical Group Association (AMGA) in Alexandria, VA, and Pfizer, Inc., of New York.

Since its inception in 1998, the Partners in Care program has dramatically reduced utilization of health care resources for patients in the program. For instance, patients in Partners in Care were hospitalized for a total of 1,721 bed days per thousand per year, compared with 4,162 bed days per thousand per year among a similar population not in the program. Patients not in the program were hospitalized 858 times per thousand per year, compared to 433 hospitalizations per thousand per year for patients in the program. Partners in Care patients visited their doctors 13.2 times a year, compared with 11.8 visits for those not in the program.

In the Partners in Care program, nurses trained in geriatric care function in an expanded role and are called nurse partners. Primary care physicians provide geriatric care and serve as team leaders.

The nurse partner concept combines the duties

of an office nurse with a community-based home health provider. Among their duties are:

- performing the initial assessment and developing a care plan;
- facilitating communication between physician and patient;
- regularly calling the patient to ascertain his or her health status;
- acting as a patient advocate to help the elderly and their families obtain community care;
- seeing the patient in the hospital, the nursing home, or the home;
- working with discharge planners, home care nurses, and payers.

The nurse partners actively monitor the patients. The nurses visit the patients in multiple venues, such as their homes, the hospital, or nursing home, in addition to the clinic. They give the information they gather during site visits back to the primary care physician.

"This really helps with the ongoing support of the patient population. It helps the patients understand what is happening, what kind of treatment and recommendations their physicians have, and it helps the patients implement the recommended treatments," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

When the patients meet with their doctors, the nurses have an opportunity to sit with them and review what the doctor says to make sure the patients understand it.

"We find the same thing is effective after a patient has been hospitalized. They may have heard a lot of things, but they don't remember it later," Schraeder says.

Elders need continuity of care

Outside the office or hospital setting, the nurses help the elderly patients and their families overcome any obstacles to getting the care they need, such as getting proper diet, purchasing medicine, getting enough exercise, or accessing community services.

"One issue with an elder who has multiple needs is hooking them to appropriate services such as Meals on Wheels. Partners in Care really helps to provide continuity, monitoring, and support for a person with complex care needs," Schraeder says.

The practice sends nurses into the community cautiously, only when an issue can't be handled by telephone.

"You have to be judicious. They can't do it all with home visits. It gets too expensive. We are a rural practice and cover a big geographic area," Schraeder says.

The nurse partners are trained to understand the community in which they work as well as the complex medical needs of elderly patients. The nurse partners typically have a history of dealing with a patient population over time as opposed to nurses who see patients who come and go in an acute care setting.

"Nurses who are used to seeing people in acute care generally don't have the kind of skill sets they need to manage patients over the long term," Schraeder says.

Communicating across the spectrum

"We look for someone with very good clinical skills and independent practice skills. They will be dealing with a panel of complex patients and they need to be able to communicate with the physician, the patient, the family member, and the community," she adds.

Each nurse manages the patients of specific primary care physicians. There are about eight nurse partners, each of whom supports the patients from five to six primary care physicians, spread out in clinics throughout the Carle Clinic Association treatment area. They are coordinated by a nurse manager and a program developer.

The nurse partners are assisted by care assistants, most of whom have worked in community agencies. They answer the telephone, take care of some administrative tasks, arrange for services (such as a homemaker service), and do some telephone monitoring, checking in with the patients and alerting the nurse partner if the patient needs to make an appointment.

"The care assistants tend to be mature with some experience. Because they are talking with the elder population, they need to feel comfortable with that group. It's not just administrative work; it's communicating with patients and negotiating with service providers," Schraeder says.

[Editor's note: For a copy of a Compendium of the AMGA-Pfizer Models of Excellent awards, contact Clese Erikson, director of research, American Medical Group Association, 1442 Duke St., Alexandria, VA 22314-2340. Telephone: (703) 838-0033, ext. 347. E-mail: cerikson@amga.org.] ■

Case management program uses proven methodology

Concept evolved over 12-year period

When the Carle Clinic Association launched the Partners in Care program for the elderly, the Mahomet, IL, multispecialty practice already had 12 years of case management for the elderly under its belt.

The current program evolved over time out of a case management model that was implemented to address the needs of the rapidly growing geriatric population the clinic leaders knew they would be serving in the future.

"We went through a lot of changes in the model. We started with volunteers, then nurse social workers, and finally found that the best solution was a community-based specially trained nurse," explains **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

Carle Clinic Association started its case management program for the elderly in 1986 with initial funding from the Kellogg Foundation, Schraeder says.

"When we started the concept, it was ahead of its time. There was nothing like it in group practice in the country. Most of the case management at that time was in the social service field with underserved populations, primarily in psychology and public health," Schraeder says.

At the time, nurses were not an integral part of case management programs. This was a concern to the Carle Clinic leadership because they had found that older adult patients, particularly those from the rural areas served by the clinic, often were reluctant to describe accurately how well they were functioning.

The clinic doctors and nurses had found that the patients felt freer to discuss their living situations and health problems with nurses than with doctors.

The solution seemed to be an integrated program in which nurses work with the primary care physician, the patient, and the patient's family to develop and coordinate a health care plan.

The practice tried having all of the nurses working in a centralized setting, then moved on to having them decentralized but in their own space. They found that it was most effective for the nurses to be in the community clinic setting where they could be closely aligned with the primary care physicians to enhance the team treatment concept.

That led to the current system in which "nurse partners" are located in clinics throughout the clinic's treatment area and are responsible for managing the care of patients for specific primary care physicians.

"We tried all kinds of communication with physicians, including e-mails and written summaries, but we found that if the physicians and nurses are in the same facility, they can communicate in the hallway or before the start of the day and do quick case reviews instead of scheduling long-term meetings," Schraeder says.

The clinic is one of 15 sites chosen to participate in a Medicare Coordinated Care Demonstration Project. They are taking the same concepts and applying them to chronic conditions such as diabetes, chronic obstructive pulmonary disease, coronary artery disease, stroke, and congestive heart failure. ■

Program focuses on elderly with highest risks

Patients are carefully screened

The Carle Clinic Association in Mahomet, IL, carefully screens the patients who are chosen to participate in its Partners in Care case management program. The typical patient has two or more chronic conditions, such as congestive heart failure, diabetes, cancer, stroke, or coronary artery disease, and takes at least five medications daily.

Patients have limitations in activities of daily living (such as walking or feeding themselves), limited instrumental activities of daily living (cooking, driving, and shopping), and a history of previous hospitalizations.

Over time, the practice has automated its system of identifying patients at risk who should be referred to the program.

"We are continually refining and automating our clinical records and triggering systems," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

Medicare patients who have seen a family practice or an adult medicine physician more

than four times in a year are automatically referred to the program.

Patients also are referred to the program directly by physicians.

Once a patient is referred to the program, he or she receives a 50-item questionnaire that gathers information such as demographics, medications, current health conditions, and prior health care utilization. The information from the questionnaire is entered in a computer database that classifies patients into risk categories based on responses to the questions.

If a patient has positive responses to three of 13 "trigger" questions, he or she is initially given a status of "At Risk." A "nurse partner" conducts a second, more detailed screening either during an office visit or over the telephone. Using this information, the nurse partner and physician determine the patient's final risk status.

Participating patients are given a medical assessment by the physician to determine current and potential medical and psychosocial needs. Then, the patient, physician, and nurse partner develop a coordinated health care plan that includes medical services, community services, and assistance from family, friends, and neighbors. ■

Electronic records simplify documentation, coding

'I don't go home at night and worry' about coding

Not long ago, **Mark Deis**, MD, got a letter from an insurance company refusing to pay a bill for a patient treated for abdominal pain without more documentation for a Level 4 patient visit.

Instead of spending time looking at patient records and dictating a letter as he did in the past, Deis merely called up the patient's electronic medical record, and in a matter of seconds had a six-page printout documenting everything he did during the patient visit.

The insurance representative was so impressed that she called Deis and pointed out that the documentation would have supported a Level 5 visit.

Deis is one of five pediatricians at the Cleveland Clinic's Independence (OH) Family Health Center who pioneered a new electronic medical records system beginning in October.

"The system has changed our lives in a lot of ways," he says.

About 60% to 80% of the center's 45 doctors have made the transition to the electronic medical records system. The practice includes physicians in internal medicine, surgery, family practice, OB/GYN, pediatrics, and 25 subspecialties.

"We wanted to start slow and eventually get the whole building on the system," he says.

Deis, a pediatrician with the Cleveland Clinic, estimates that he can see four to five more patients a day and stay on schedule better by using electronic medical records instead of the paper system.

He no longer worries about providing enough proper documentation for payers. The system prompts him through a series of templates and even records the "no" answers. It automatically records the ICD-9 code for the diagnosis and documents the level of patient visit.

"Coding is a big concern throughout medicine. With this system, it's so much easier to capture all of the information. I don't go home at night and worry, hoping I documented appropriately," he says.

Adjusting to the new system was easy, says Deis. He practiced using the system for two weeks on a laptop loaned to him by the software firm. When he went live on the morning of Oct. 26, he used the new system with about half of his patients.

"It was no problem to use. Since then, I've seen 100% of my patients on the system," he says.

Frustration with the paper chart system led the center to look at moving to an electronic medical records system. "We used to have a paper chart system, and we still do. But it was complicated because an internist or plastic surgeon might want the chart at the same time, and getting it from one place to another was complex," Deis says.

After studying products offered by several companies, the clinic chose Noteworthy, a Mayfield Heights, OH, technology firm. The firm developed the system for the Cleveland Clinic with the help of a single practitioner who used it for about a year before the Independence Family Center went on-line.

The five pediatricians at the center still sit down regularly with the medical information writer and walk through changes they would like to see in the system.

Here's how the system works: When a patient comes in for a visit, the nurse enters the reason for the visit on a template on the computer screen

and then answers a series of questions designed to find out more information about the patient's complaint.

"Some of the doctors' nurses ask all the questions. Some ask only a few and leave the rest for the doctor," Deis says.

Detailed questions automatically pop up on the screen if the answer to any question is "yes." For instance, if the patient reports having a fever, the computer will ask how long the patient has had the fever and how high the temperature has reached.

"The wonderful thing from the physician perspective if that it records the 'no' answers. You have a record of all those thing you never could adequately document in the past," Deis says.

There are multiple screens for every encounter. The face sheet contains ongoing data about a patient including past history, allergies, and problems. The history and physical screen has two different templates — one for a well-child visit and one for an ill-child visit.

The diagnosis and decision-making screen automatically enters the ICD-9 code. If there are several ICD-9 codes for a diagnosis, the doctor selects the right one.

Physicians can create a "problem list" for each patient, which comes up on the template each time the patient comes in for a visit. For instance, when a patient comes in with an ear infection, Deis can quickly see if it's a frequent complaint and decide whether to refer him or her to a specialist.

"I can write prescriptions in the computer, order lab work, or if I want to give specific instructions to the patient, I can type notes in there and print it out," Deis says.

With the new system, patients also received a printed prescription, which is easy for the pharmacist to read.

There is a computer in every examining room and at a workstation in the hallway in case the doctor wants to finish his notes after he leaves the patient. The clinic plans to eventually link the examining room computers to the billing system.

"The hardest thing about using the electronic medical record system is to make the patient feel that you're paying attention to them and not the computer," Deis says. He usually chats with his patients about school and sports activities while he finishes making notes on the chart.

The Cleveland Clinic made the decision not to re-enter all the old data on the new electronic medical record. Therefore, the physicians use both paper and electronic charts.

Deis' subspecialty is children with developmental disabilities, a group of patients who often have multiple medical problems and make frequent visits. For these patients, Deis has entered data from the paper chart showing each problem, the day it occurred, and a synopsis of the status. This gives him a quick history on the electronic medical chart.

Deis uses the old paper records only occasionally, such as when he wants to check whether he prescribed a particular medication for a patient in the past.

"Some of the doctors here are computer-phobic, and they are having a harder time," he adds. ■

Tips for setting up an electronic records system

Ensure you have a customer-friendly vendor

If you're considering setting up an electronic medical records system, **Mark Deis**, MD, has some advice: Do it sooner rather than later.

Deis was one of the pioneers of a new system at the Cleveland Clinic's Independence (OH) Family Practice Center. He offers the following tips for a good experience with your electronic medical records system:

- Shop around for a vendor that has the type of system you need. There are a lot of systems to choose from. Make sure you get a system that is compatible with the other computer systems your practice uses so you can interface easily.
- Make sure your system meets the requirements of the Health Insurance Portability and Accountability Act.
- Look for a vendor that will work with you to customize the system to meet the specific needs of your practice.
- Make sure your vendor will offer good support during the implementation process.

For instance, when the pediatricians at the Cleveland Clinic went live with the system, Noteworthy had a staff member assigned to every doctor and to the triage nurse.

"That's the kind of support you need. If you have a question, you don't want to have to spend five minutes looking for someone," he says.

- Make sure you have 24-hour telephone support when the system is up and running. ■

Most pay flatlines, but some subspecialties soar

Physician employees face possible pay cuts

Except for some subspecialists who can expect double-digit increases, most physician pay raises will hover around the inflation rate, experts predict.

One factor helping to hold the line on provider salary increases is the fact that more large not-for-profit institutions are tying compensation packages more closely to production incentives — while also raising the production bar.

With a median income in 1999 of $145,397, general internists remain among the best-paid generalists, but other primary specialties are fast gaining economic ground.

According to the Englewood, CO-based Medical Group Management Association's annual "Physician Compensation and Production Survey," the median income for primary care physicians such as non-obstetric family physicians and pediatric/adolescent medicine physicians rose 9.56% to $141,493 between 1995 and 1999. During the same period, pay for pediatric/ adolescent primary care doctors rose 10.79% to $143,011.

Hematologists, oncologists see steep raises

Several subspecialties, however, far outpaced these pay hikes. For instance, hematologist/oncologist compensation skyrocketed 35.32% to $255,167, while pay for gastroenterologists jumped 26% to $264,500.

For the 17 categories of subspecialists tracked by MGMA, five-year median pay rose 13.86% to $245,910. In contrast, primary care pay only rose 7.98% to $143,970.

The methods used to reimburse physicians have a major influence on how much they end up making. For instance, practitioners whose compensation is based solely on production tend to be higher paid than practitioners who work under a mixed productivity/salary compensation package or who are paid a straight salary, according to the MGMA. About 37% of group practices pay physicians just based on productivity, says the survey.

In 1999, for example, general internists made a median of:

- $151,188 when pay was based solely on productivity;
- $145,610 when over half of their compensation was linked to production;
- $143,857 when salary made up more than half of their compensation package;
- $134,688 when on straight salary.

This connection is especially important because many experts say the trend is for more health care organizations, especially institutions employing physicians, to base a greater portion of their providers' paychecks on productivity.

Among the most popular productivity incentives and methods for calculating physician pay were gross and adjusted charges, net collections, patient encounters, patient panel size, and relative value units (RVUs).

Besides medical groups, other health care organizations are turning to production-based pay packages. According to Detroit-based Sullivan, Cotter and Associates, the most popular tools for measuring physician production among not-for-profit hospitals and medical centers are: patient encounters (79%); direct patient care hours (78%); patient satisfaction (60%); cost-effectiveness (49%); total RVUs (33%); work RVUs (32%); net collections (29%); and gross revenues (23%).

These incentives account for about 15% of total provider pay for generalists at these institutions, with some marked differences between primary care and subspecialist comp packages.

For example, 69% of the organizations surveyed by Sullivan calculated primary care incentives only on individual performance, and only 3% used group performance to determine production pay. Patient satisfaction, net revenue, and patient encounters were the top three performance baselines used to reward individual physicians. In contrast, net revenue, patient satisfaction, and utilization are the leading performance compensation measures among primary care-driven groups.

For subspecialists, however, 65% of not-for-profit health care organizations based incentives on individual performance, while 10% considered group performance. Subspecialists' incentives were most commonly based on gross revenue, net revenue, and patient satisfaction. This was also the same for subspecialty medical groups.

The Sullivan survey also found that about half of the health systems and hospitals that use physician performance standards planned to "raise the bar," making it potentially more difficult for their physicians to max out on their productivity-based bonuses. ■

Southern internists not just whistlin' Dixie

Pay may depend on location

Where a physician practices plays a major role in how much he or she is paid, according to information collected by the Englewood, CO-based Medical Group Management Association. For instance, internists in the South are generally better paid than their colleagues in other parts of the country. Median 1999 income for southern internists was $167,513, compared to $154,162 in the North, $148,182 in the West, and $138,506 in the East.

Median compensation levels for primary care physicians and specialists also tend to be higher in the South. In 1999, southern primary care physicians earned a median income of $153,096, compared to $142,708 for primary care physicians in the East, $144,006 for those in the Midwest, and $137,970 in the West.

Specialists practicing in the South earned a median of $326,144, compared to $233,356 in the East, $278,392 in the Midwest, and $215,879 in the West.

Why the big difference in regional pay? Most experts attribute it to the fact managed care penetration is not as extensive in Southern states, while there is relatively less competition among groups for patients. ■

Patient surveys: A good tool and a good investment

Keep them happy and keep them coming back

Thomas Engel, CMPE, administrator of the Heart and Vascular Clinic of Northern Colorado in Fort Collins, sees patient satisfaction surveys as a good investment, as do the clinic's physicians.

William Stewart, MD, medical director at Minor and James Medical PLLC, a 64-physician multispecialty group in downtown Seattle, says he thinks of patient satisfaction surveys as an education tool that keeps the staff aware that the practice depends on a high degree of patient satisfaction.

The patient satisfaction efforts of both practices were highlighted by the Medical Group Management Association (MGMA) in Englewood, CO, in their report "Performances and Practices of Successful Medical Groups 2000."

"I look on the survey as an important teaching tool for physicians and employees as well as a measure of patient satisfaction," says Stewart. Instead of collecting patient satisfaction data once or twice a year, Stewart runs his survey all year long, alternating among departments.

"By running the survey throughout the year, my employees and my physicians are always aware that we are providing a service and that we are dependent on a high level of patient satisfaction," Stewart says.

Heart and Vascular Clinic of Northern Colorado, a group of 11 cardiologists with a patient base including parts of Colorado, Nebraska, and Wyoming, has used the data from its surveys to make the decision to move from a 10,000 square foot building with eight examining rooms to a 33,000 square foot building with 28 exam rooms.

When the practice installed its electronic medical record systems, it included a mechanism to measure the amount of time patients wait in the lobby and examination room, two trouble spots that frequently showed up on patient satisfaction data.

"We can track the elapsed time very precisely and can identify bottlenecks," Engel says.

Some of the bottlenecks occurred because medical assistants were on the phone handling prescription refills or other things were keeping patients in the lobby.

"If anybody is taking an inordinate amount of time, we can identify that. Generally, when the physicians and staff see the data, they are motivated to respond to it," Engel says.

The two practices handle their patient satisfaction surveys in different ways. Heart and Vascular Clinic of Northern Colorado uses a mailed survey sent out quarterly. One hundred patients per physician are surveyed. The patients are selected by an automated database, with the parameter that patients are surveyed only once every two years. People who are in collection are excluded because Engel assumes their responses would be biased.

Minor and James Medical targets 50 patients for each physician. Patients are chosen at random and are given the survey to fill out while they are in the office.

"The number of patient satisfaction surveys is the same as when we did it once a year; we just collect it over a longer period. This takes out seasonal variations and is less disruptive to our office," he

says. Collecting data throughout the year has an additional benefit, Williams says: No longer do reception staff have to be trained once a year on how to greet patients, explain the survey to them, and make sure they fill it out before they leave.

The Heart and Vascular Clinic survey includes a comment section in which patients are asked what the practice can do to improve its service.

Frequently, the patients identify specific physicians for complaints. If the patient also fills out the optional name and phone number section, the physician calls the patient to try to make things right or at least make the patient feel his or her opinions are being heard.

The survey costs the practice around $5,000 a year for printing, mailing, and business reply costs, but Engel feels it's worth the cost.

"Our physicians never thought of it as an expense; they thought of it as an investment," he says. ■

Impressing your patients should be a team effort

Surveys, 'mystery shopper' can guide you

Every member of the staff should consider themselves responsible for making sure your patients have a positive experience when they visit your office, **Diane Peterson** asserts.

"The whole staff should be conscious of the impact they make, whether it's the way they are dressed or the expression on their face," says Peterson, president of D. Peterson & Associates, a patient satisfaction consulting firm in Houston.

Patient satisfaction is a team effort, particularly in today's health care environment, when patient loyalty is a thing of the past in most areas, Peterson says. But in her experience, few practices work with their staffs to enhance patient satisfaction.

"I see very few doctors who feel that it's a team effort," she says.

Patient satisfaction surveys are an easy way to find out what patients think about you, Peterson says. Many professional organizations will provide simple surveys that can give you an idea of how your patients see the practice.

When you get information from a survey, act on it, Peterson advises. There are always some changes that can't be made, but you can take steps to make the problem spots less troublesome to patients, she adds.

"Maybe it's impossible to run exactly on time, which is what it takes to satisfy some patients. But people will be very reasonable if you communicate with them or call ahead and tell them you are running late," Peterson says.

Use the patient satisfaction survey as a way to compliment the staff. For instance, if the front desk clerk is praised by a patient, give her a small bonus. "It will encourage the staff to be more responsive," Peterson says.

Peterson suggests hiring a "mystery shopper," a trained individual who will make an appointment and come in for a visit and then relate his or her experiences to the practice.

"Sometimes physicians tend to look at a patient

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satisfaction survey and say that the patient who gave the practice a bad rating was just in a bad mood that day. But when they hear it from a trained consultant, the same problems take on more validity," she says.

Even if you don't make a formal effort to measure satisfaction, take a look at what's happening in your practice to find out what impressions your patients are taking away from your practice.

Is the first impression a warm and friendly greeting from the receptionist? Does the doctor review the chart in advance, call the patient by name, and apologize for any delay? Is the billing clerk friendly and cheerful?

Just as reception staff are responsible for the first impression your patients have, it's up to the billing clerk to make sure the visit ends on a positive note, she adds.

"No matter how well the encounter went with the doctor, the patient still has to face the billing clerk," Peterson says.

Warn your staff to be cautious about what they say to the patients and be especially careful not to make comments about other patients.

"From the top to the bottom, everyone in the practice should be aware that everything they say, even if it's just making conversation, has a positive or negative impact on that patient's impression of the practice," she says. ■

Health care reform urgently needed, report says

On the heels of last year's report on medical errors and patient safety, the Institute of Medicine of the National Academies has issued a report calling for reforms to fix the nation's "disjointed and inefficient" health care system.

"Americans should be able to count on receiving care that uses the best scientific knowledge to meet their needs, but there is strong evidence that this frequently is not the case," says **William C. Richardson**, chairman of the committee that wrote the report. Richardson is president of the W.K. Kellogg Foundation in Battle Creek, MI.

"America's health system is a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and failing to build on the strengths of all health professionals," the report says.

The report calls on Congress to create an "innovation" fund to subsidize promising projects and publicize the need for significant changes.

Clinicians, health care organizations, and purchasers should focus on improving care for common, chronic conditions that are the leading cause of illness and use a substantial amount of health care resources, the report says. But it says physicians, hospitals, and health care organizations often work independently of each other, rather than coordinating patient care across a variety of settings.

Information technology is the key to health care reorganization, the report concludes, calling for a nationwide effort to build a technology-based information infrastructure.

The report called for the elimination of most handwritten clinical data within the next ten years through technology-based systems such as electronic records, patient-provider e-mail, automated medication order entry systems, and computerized reminder systems.

The report, titled "Crossing the Quality Chasm: A New Health System for the 21st Century," is available on-line at www.iom.edu. Click "What's New" and look under "New Reports." ■