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IN PHYSICIAN PRACTICES

INSIDE

■ **Ask the patient:** Surveys offer an easier way to gather outcomes 4

■ **A better way:** For Kaiser, electronic data mean quality care 6

■ **Byte by byte:** How to win physician buy-in for electronic medical records 6

■ **Happiness index:** Concerns over drug restrictions, customer service cause drop in satisfaction with health plans. 8

■ **Tracking true outcomes:** The Health of Seniors measure asks if they got better or worse . . 9

■ **The big picture:** Baldrige assessment tool brings a holistic view to improvement 10

■ **News Brief:** Little choice of health plans 11

■ **Inserted in this issue:** Baldrige assessment tool

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We can't fix flaws in data without electronic records, experts say

Technological investments seen as an outcomes imperative

When a medical group or health plan scores poorly on a standard performance measure, is the problem inadequate care? Or inaccurate data? Pointing to serious problems with data collection, performance measurement experts are calling for a massive national investment in computer technology and a new willingness for physicians to move from old-fashioned paper systems to electronic records.

Some large health care purchasers are becoming fed up with the slow pace of improvement in performance assessment, and antiquated systems are partially at fault, says **David Hopkins**, PhD, director of health information improvement for the Pacific Business Group on Health in San Francisco. "[Purchasers are saying,] 'We don't think you have the quality of information to ensure optimal quality of care.'

"If health plans and providers cannot identify even who their diabetic patients are from automated systems, then we have a problem," he says. "If physicians cannot readily ascertain when they last gave a Hba1c test to their diabetic patients and quickly get those patients in, that's a problem."

Medical groups that can track care electronically will set a new standard, says Hopkins. For example, Kaiser Permanente, based in Oakland, CA, has

EXECUTIVE SUMMARY

- Claims data and medical record reviews produce inaccurate and incomplete data, problems that must be overcome through a transition to electronic medical records, performance assessment experts say.
- An audit of 1996 Medicare Health Plan Employer Information and Data Set (HEDIS) data found sufficient errors to render two measures inappropriate for comparison.
- The National Committee for Quality Assurance in Washington, DC, recommended that health plans offer financial incentives for medical groups to improve the quality of their data.
- The huge capital costs of installing electronic medical records may force medical groups to form distinct alliances with health plans.

committed hundreds of millions of dollars over the next five years to automate physician offices, clinics, and other facilities nationwide. **(See related article, p. 6.)** Brown & Toland Medical Group, an independent practice association (IPA) in San Francisco, spent $3.75 million to develop an Internet-based system with Healtheon, a Santa Clara, CA, software firm. While that system is geared toward administrative information, it sets the foundation for future, clinical-oriented applications.

"Some large IPAs and multispecialty groups are stepping up to the plate and making those investments," Hopkins says. "Once a few of them have done that, I think it puts a lot of pressure on everybody else to explain why they're not doing it."

Scrutiny reveals incomplete, inaccurate data

As the measures used for performance assessment become more complex, the weaknesses in health care data collection become more apparent. Audits show that HEDIS (Health Plan Employer Data and Information Set) data collected for reporting to the National Committee for Quality Assurance (NCQA) in Washington, DC, are fraught with inaccurate coding, inadequate documentation, and misinterpretation of the indicators' specifications.

For example, in its 1996 audit of Medicare data for selected measures, IPRO, a health care quality improvement organization based in Lake Success, NY, concluded that two measures contained enough errors to make them invalid for comparison. The measures were eye exams for people with diabetes and follow-up after hospitalization for mental illness.

Some problems, such as misinterpretation of HEDIS specifications, can be resolved through audits before the data are reported. But other issues, such as the incompleteness of claims databases, can only be fixed with fundamental — and expensive — changes, says **Herman Jenich**, MPP, associate vice president for managed care of IPRO, which conducted audits of Medicare managed care data for 1996 and 1997.

"What you're left with is those difficult core system problems that you can't change [easily]," says Jenich.

"As we move toward deeper, more clinical issues, without some movement toward electronic capture [of information] above and beyond claims data, you're going to have thousands of medical records that have to be reviewed."

The results of medical record abstraction rely greatly on the skills and training of the reviewers and the data collection tools they use. The American Medical Group Association (AMGA) in Alexandria, VA, found problems with medical record abstraction early in its outcomes program and now requires participating medical groups to gather information at the time of care.

"We highly advise that people initiate some form on concurrent data collection like an electronic medical record from which they can abstract the standard data they need," says **Julie Sanderson-Austin**, RN, AMGA's vice president for quality management and research and corporate operations.

"We've had years of trying to get information out of medical records," she says. "We know that it's flawed. Everyone's going to interpret what they see on paper differently unless it's a standard template of objective data."

NCQA, which accredits health plans and developed HEDIS to measure quality of care, recognizes the clash between the need for information and the availability of it. In 2000, health plans seeking accreditation will be required to collect data on six diabetes measures, including blood glucose levels. Such clinical information cannot be derived from claims data.

Similar measurement sets are under development for other medical conditions.

In its publication titled *A Road Map for Information Systems*, NCQA urged health plans to provide financial incentives for providers to automate their clinical information. **(For ordering information, see editor's note, p. 4.)** Some

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health plans do provide financial incentives related to the quality of data, such as encounter data. Aetna US Healthcare, based in Blue Bell, PA, recently implemented E-Pay in some of its markets, which promises physicians payment within 15 days if they submit "clean" claims (without errors) electronically.

But will health plans provide financial support to medical groups for the computer systems themselves? Only if the medical group predominantly serves one health plan, says **Allan Pryor**, PhD, chief medical informatics officer of Intermountain Health Care (IHC), an integrated delivery system in Salt Lake City that includes a health plan. It works with 400 salaried physicians and 1,500 affiliated physicians.

IHC is installing its new Healthcare Enterprise Management System, which was developed with 3M Health Information Systems of Minneapolis, in the offices of all salaried physicians. **(For a related story on physician buy-in for computer-based patient records, see p. 6.)**

Independent physicians who are "tightly aligned" with IHC — those who mainly treat IHC health plan members and use IHC facilities — receive the HEMS software and training free of charge. However, they must provide their own hardware, which may include wireless handheld or laptop computers to allow for instant decision support.

In fact, the huge capital costs of installing electronic medical records may force medical groups to form distinct alliances with health plans. "More and more, some of the health plans are only going to work with those who are tightly aligned," he suggests.

Medical groups link with software vendors

Some medical groups and IPAs are teaming up with software vendors to support the development of electronic records.

Tom McAfee, MD, chief medical officer of Brown & Toland, says he's convinced that an electronic connection between physician offices and the central administrative offices will produce efficiencies and significant cost savings.

"I think we're going to continue to see pressure from employer groups to reduce costs," says McAfee. "The major purchasers of health care continue to believe that health care expenditures are higher than they should be because there's waste in the system. We're going to have to continue to be more efficient to continue to provide quality care for less money."

Initially, the Internet-based RACER (referrals, authorizations, claims, eligibility, and reporting) system is designed to automate such tasks as determining health plan eligibility, obtaining referrals and authorizations, and filing claims. But McAfee says the system will evolve into a more complete electronic record, with disease management and outcomes data collection.

"This is the road map," says **Cecilia Montalvo**, vice president of strategic development for Brown & Toland Physician Services Organization, the administrative arm. "You're putting the highway down. It creates the potential for all kinds of future applications."

Still, few medical groups have made the investments necessary to allow electronic collection of clinical data. Among health plans, only Kaiser Permanente can collect and submit most of its HEDIS data electronically. **(See related story, p. 6.)**

Many health plans provide financial incentives to medical groups to improve data collection related to HEDIS. But Hopkins says they haven't gone far enough.

"We're trying to standardize it so incentives are aligned from one plan to another [and] providers have one set of incentives," he says. "We don't think it works so well if every plan has its own incentives.

"The ultimate purpose is to improve quality of care," Hopkins says. "The ability to collect and report data relating to quality of care is going to be a very key part of [improving care]."

Want more information?

For more information on computer-based patient records, contact:

- **American Medical Informatics Association**, 4915 St. Elmo Ave., Suite 401, Bethesda, MD 20814. Telephone: (301) 657-1291. Fax: (301) 657-1296. World Wide Web: http://www.amia.org.
- **Computer-based Patient Record Institute**, 4915 St. Elmo Ave., Suite 401, Bethesda, MD 20814. Telephone: (301) 657-5918. Fax: (301) 657-1296. World Wide Web: http://www.cpri.org.
- ***M.D. Computing***, Nhora Cortes-Comerer, Executive Editor. Published by Springer-Verlag, 175 Fifth Ave., New York, NY 10010. Telephone: (212) 460-1572. E-mail: ncomerer@springer-ny.com.

Editor's note: To obtain a copy of the report, A Road Map for Information Systems *($75 plus $10 shipping and handling), contact the NCQA Publications Center, 2000 L St. NW, Suite 500, Washington, DC 20036. Telephone: (800) 839-6487. Fax: (202) 955-3599. World Wide Web: http://www.ncqa.org.* ■

Should performance data rely on patient reports?

Some docs advocate using surveys, not records

When it comes to measuring health care performance, even simple indicators can present major headaches. For example, a parent may take a child to a clinic or school for needed vaccines. Meanwhile, records from the pediatrician show the child isn't properly immunized.

Some physicians and outcomes experts are advocating a low-tech, less expensive way of solving data collection problems: Ask the patients themselves. Surveys also allow patients to answer questions about care that go beyond mere calculations: Did you receive adequate education about your condition? How much is your chronic illness interfering with your daily activities? Did the treatment alleviate your symptoms?

Including the patient's experience

"There's a patient experience of care that needs to be incorporated into the performance system overall," says **Ted von Glahn**, a consultant with the Foundation for Accountability (FACCT) in Portland, OR, a coalition of consumer and purchaser groups that develops condition-specific performance measures. FACCT is testing a survey, titled FACCT/ONE, to answer questions about how patients live with chronic illness. The first surveys focus on diabetes, asthma, and coronary artery disease.

In an article in the *Archives of Family Medicine,* Arch G. Mainous III, PhD, of the department of family medicine at the Medical University of South Carolina in Charleston, argues that surveys could replace some Health Plan Employer Data and Information Set (HEDIS) data collection. They would provide standardized outcomes data while avoiding the accuracy problems of administrative data and medical record reviews, he states.

Moreover, the surveys could ask patients why they didn't receive needed services, such as mammograms, states Mainous and his co-author, Jeffrey Talbert, PhD, of the Martin School for Public Policy at the University of Kentucky in Lexington.

That dramatic shift in data collection isn't likely. von Glahn and others cite a need for multiple sources of information on performance measurement. But surveys are an important component, he says. "The key issue is asking the question we heretofore haven't asked: 'What happens to people who are sick?'" says von Glahn.

An easy way to collect data

Patient surveys themselves are nothing new. It's the only way to find out about patient satisfaction and health status. And it's a simple way to gather other information.

The National Committee for Quality Assurance (NCQA) in Washington, DC, already uses surveys to measure flu shots in older adults, a quality indicator that is required by HEDIS. After all, the shots are available in grocery stores, pharmacies, churches, and synagogues. Likewise, several pediatric measures under consideration are likely to be gathered through surveys, as is the Health of Seniors measure. **(See related article, p. 9. For more information about pediatric measures, see *Patient Satisfaction & Outcomes Management,* December 1998, pp. 125-138.)**

The Pacific Business Group on Health (PBGH) in San Francisco collects a more extensive range of health care performance information from patient surveys for its comparisons of medical groups. For example, patients report whether they received cholesterol screening. The business coalition is also measuring health status changes and satisfaction.

"We consider this just one method of collecting data," says **Anne Castles**, MA, MPH, senior project manager for PBGH. "It is the easiest way because of the paucity of information you can get via administrative data systems. But we don't want to rely exclusively on patient surveys." She says. "What we would like to see over the long term is medical groups making the commitment to building data system infrastructure so that evaluation of clinical data becomes far easier, even easier than getting it from patient surveys."

How accurate are patient reports on the care they received? PBGH plans to find out with a

special survey of a subgroup of patients with diabetes, heart disease, low back pain or sciatica, and asthma or lung disease. "We are asking for their consent to go into their medical chart to validate what they're telling us [about their care on the surveys]," says Castles. "We will have a lot more information about the accuracy of patient report on these indicators."

Based on prior research, FACCT considers the patient reports on diabetic foot exams and eye exams to be reliable, says von Glahn. Those items, which are difficult to collect from administrative data or even medical records, have been incorporated into FACCT/ONE.

Who answers the surveys?

Even if patients remember the care they received and respond accurately on surveys, that method has its drawbacks, notes Castles. "If you're not capturing the whole population [through the survey] then you always have to be concerned about which patients are responding and how they may differ from patients who are not responding. That's a key methodological concern," she says.

"The best way to capture high-quality data is for providers to make investments in information systems," Castles says. "We'll always have to use them to measure satisfaction, but in terms of other things, we very much prefer relying on high quality clinical data systems. Surveys are enlightening in many respects about quality. But they're not going to give us the whole picture."

Still, the surveys can bolster the outcomes information that is available — without the burden caused by medical record reviews, says von Glahn. "It's particularly nice to have this as another tool, given the [current] shortcomings of all of electronic information systems." ■

Filtering Patient Care Experiences into Report Cards

Numbers aren't everything when it comes to evaluating care experiences, several industry groups argue. **(See related story, p. 4.)** Groups such as the Portland, OR-based Foundation for Accountability (FACCT) advocate that physician practices determine how patients are being educated to live with chronic conditions such as diabetes, asthma, and coronary artery disease.

These questions are excerpted from a sample survey FACCT is testing to look at those issues:

1. **Patient education & knowledge**
— Did patients receive education about managing their conditions and was it useful?

2. **Patient's disease management**
— Do diabetes patients test their blood glucose?
— Do moderate/severe asthma patients use their peak flow meter?

3. **Involvement in care decisions**
— Are patients offered choices in care, and do doctors discuss treatment options?

4. **Maintaining regular activities**
— To what extent do the patients' conditions keep them from participating in regular activities?
— How many days during the last four weeks was the patients' physical/mental health not good?

5. **Symptom control**
— Are patients experiencing mild, moderate, or severe symptoms?

6. **Access to good care**
— How satisfied are patients with access to specialty care?
— How satisfied are patients with the overall health care and the experience with the health plan?

7. **Functional status**
— What is the patient's level of physical and mental health status and functioning?

8. **Communication with providers**
— Do the doctors and nurses communicate effectively with the patients about their diseases and what to expect?

9. **Coping**
— How much of a problem or hassle is it for patients to follow their plan of care — organizing daily routine, taking medications, exercising, and eating right?

10. **Getting essential treatments**
— Did diabetes patients get foot exams?
— Did asthma patients get instructions on using their inhalers?

Source: Foundation for Accountability, Portland, OR.

Kaiser's EMR brings better data, HEDIS scores

Major computer investment pays off in outcomes

When a California collaborative recently issued a report on the state's health plans, Kaiser Permanente was the only one with above-average scores in every category. The secret of its success: an electronic patient record that helps physicians track care delivery and outcomes and enables the health plan to report accurate data.

Unlike other health plans around the country, Kaiser Permanente in northern and southern California can submit most Health Plan Employer Data and Information Set (HEDIS) effectiveness of care data without pulling medical charts.

"I believe that those results demonstrate a better ability to capture data and a better ability to provide care in these areas," says **Tracy Rodriguez,** MPH, MBA, director of performance reporting for Kaiser Permanente in Oakland.

Kaiser will spend hundreds of millions of dollars in the next three to five years to implement electronic records nationwide, says **Michael Ralston**, MD, director of quality demonstration for the Permanente Medical Group of Northern California. "We believe that clinical information systems development is extraordinarily important," he says.

At Kaiser, every physician has a computer terminal on his or her desk with on-line access to a patient's visit histories, lab results, X-ray and diagnostic imaging, pharmacy records, hospitalizations, and immunization history. Physicians can quickly learn whether the patient is due for preventive care, such as a mammogram, and receive an alert for possible drug interactions or allergies and other concerns. "Most of our systems are capturing [data] right at the point of service," says Rodriguez.

Kaiser creates "individual practice management" reports for physicians detailing the care given to groups of patients such as diabetes or those with congestive heart failure. Other reports reveal outcomes such as the stage of cancer at diagnosis.

The next phase will incorporate narrative text: written progress notes, hospital discharge summaries, and written consultant reports. While physicians still look at paper as well as computer screens, gradually the paper record will become obsolete and the electronic health record will contain all pertinent information, says Ralston.

Kaiser also plans to implement decision support, which would calculate risk profiles and issue recommendations on care.

The HEDIS reporting is a sidelight to the clinical benefits of electronic records, says Rodriguez. "HEDIS is just a proxy for making health improvement on a population basis," she says.

Kaiser spends about $1 million a year collecting and submitting HEDIS data in California, a figure that would be much higher if the health plan conducted massive medical record reviews, Rodriguez says. ■

Will doctors use electronic medical records?

Gradual transition overcomes fear of technology

Physicians pride themselves on being on the cutting edge of medical advances. But when it comes to computer technology, they are often reluctant to move away from their age-old paper trail.

Even at Intermountain Health Care (IHC), an integrated delivery system in Salt Lake City that is a pioneer in electronic medical records, gaining physician buy-in is a slow process, says **Allan Pryor**, PhD, chief medical informatics officer.

In some cases, physicians are simply not computer literate. Others worry that using a computer-based patient record will create more hassles than it will eliminate. "The fear of that technology is a barrier," Pryor says.

The move from paper to electronic records is a gradual one, and the transition must be designed to address physician concerns, says **Michael Ralston**, MD, director of quality demonstration for the Permanente Medical Group of Northern California. "A lot of physicians are used to looking through a paper chart," he says. "They know where to look for certain information.

"If you have an electronic medical record that is too cumbersome, if it takes too much time to enter information, physicians would see that as burdensome [rather than helpful]," he says.

So here's the bottom line for physicians: How much will they gain, and at what cost?

IHC has documented immense cost savings

and quality improvements from its electronic records. For example, an IHC study found that adverse drug events cost the system about $1 million a year in extra care, as well as increasing the morbidity and mortality of patients. Computer-generated alerts through the hospital-based HELP (Healthcare Evaluation through Logic Processing) system now help prevent those events.

HEMS (Healthcare Enterprise Management System), developed with 3M Health Information Systems in Salt Lake City, provides similar alerts in the outpatient setting and incorporates decision-support software and disease management programs.

HEMS also makes the computer a practical aid. Medication refills can be a "one-click function," says Pryor. The physician quickly learns whether this patient has any contraindication and whether the preferred drug is on the formulary of the patient's health plan. Physicians at home on call can quickly access a patient's record if necessary. And records never get stuck between one office and another.

Some of the new efficiencies can be as simple as printing out labels for lab samples and as fundamental as eliminating the hassles of medical record storage, says **Melinda Costin**, manager of patient care products for 3M Health Information Systems. "You're doing a much more high-quality job in a shorter amount of time," she says.

Beyond the day-to-day advantages, physicians can learn detailed information about how they practice compared to their peers and how well they are managing chronic illnesses such as asthma and diabetes.

IHC regularly monitors "clinical process failures," or incidents in which something went awry, which are coded from 1 to 4 for severity of complication. Physicians also can log onto an internal network to compare outcomes. (Other physician names are blinded except to the regional medical leader.)

Expect to invest time, money

What is the price of this progress? Initially, an electronic medical record requires a substantial investment of time and money. "To optimize the productivity of the electronic record, you've got to make some adjustments in your patient flow," says Pryor. "And change is not the easiest thing for people."

What data are collected by the nurse? What gets entered at the reception desk? Do patients enter information directly, or do they fill out paper forms and staff put the information in?

Physicians need easy access with computer terminals in the exam rooms, laptops, or hand-held computers, says Pryor. Without real-time data collection, the physicians can't fully benefit from decision support and alerts.

Transferring those old records

Then there's the issue of transferring old records to the computer version. Pryor suggests paying overtime to nurses to enter the patient information each afternoon for the next day's patients until the records become current.

"[Implementing an electronic medical record] usually results in several months of additional costs to the clinic," says Pryor. "Then they start reaping the benefits."

The cost of the system, of course, is a major issue. You want your electronic medical record to be compatible with other health care partners, such as the lab, pharmacy, hospitals, and health plans you primarily work with.

The HEMS system costs roughly $300,000 to $500,000. It is priced based on the number of users, so the cost can vary considerably. The cost is offset by savings elsewhere, such as reductions in the need for transcription of notes, says Costin. **(For information resources on computer-based patient record software, see box, p. 3.)**

Electronic medical record vendors also are alert to the security and confidentiality concerns of physicians and others. The 3M system, for example, allows the physician to block items from access by others. "If there are some things physicians don't want to share, they can mark those things as private," says Costin.

Meanwhile, advances in technology are making the electronic medical record easier to use. 3M is working on voice recognition software that would allow physicians to bypass the transcriptionist entirely. The physician would speak into a microphone, and the software would convert the voice into written text.

"I think voice recognition will be the final key that throws all the physicians into doing something like that," predicts Costin.

For more information on the Healthcare Enterprise Management System, contact 3M Health Information Systems, 575 West Murray Blvd., Murray, UT 84123. Telephone: (800) 367-2447. ■

Patient ratings of health plans decline

Interpersonal issues shape ratings of docs

Patients are voicing slightly less satisfaction with their health plans, particularly as they face problems over prescriptions and customer service, according to a report from CareData Reports, a managed care consumer research company in New York City. While 57% of patients said they were "highly satisfied" with their health plans, that reflected a drop of 3% from 1996.

The report also shows that patient satisfaction varies dramatically based on the type of treatment received. For example, only 25% of those treated for arthritis and 30% of those treated for pain rated their care as "excellent," while 78% of maternity patients gave top ratings to their care during pregnancy and delivery. **(See chart, below left.)**

"That could be a reflection of the state of the art in terms of care and technology and medication," says **Tod Cooperman**, MD, president of CareData. "We do see variation by plan. Some plans are doing much better in certain disease categories than others."

Spend more time on disease management

In fact, physicians and health plans can impact patient satisfaction with specific types of care through disease management programs, says Cooperman.

"We typically see an association between plans that are known to have made a real effort in an area and scoring well in an area," he says. "It could be something as simple as sending out reminders to members to get their cholesterol checked, or [it could relate to] more involved disease management programs."

In the 1998 Merck Report on Medicare Managed Care Satisfaction, prepared by CareData, Medicare patients cited interpersonal and communication issues as the top drivers of their satisfaction with primary care physicians.

Beyond having a wide choice of doctors in the health plan network, patients ranked their top three factors that lead to satisfaction with the primary care physician:

❒ physician's explanation of diagnosis and treatment;

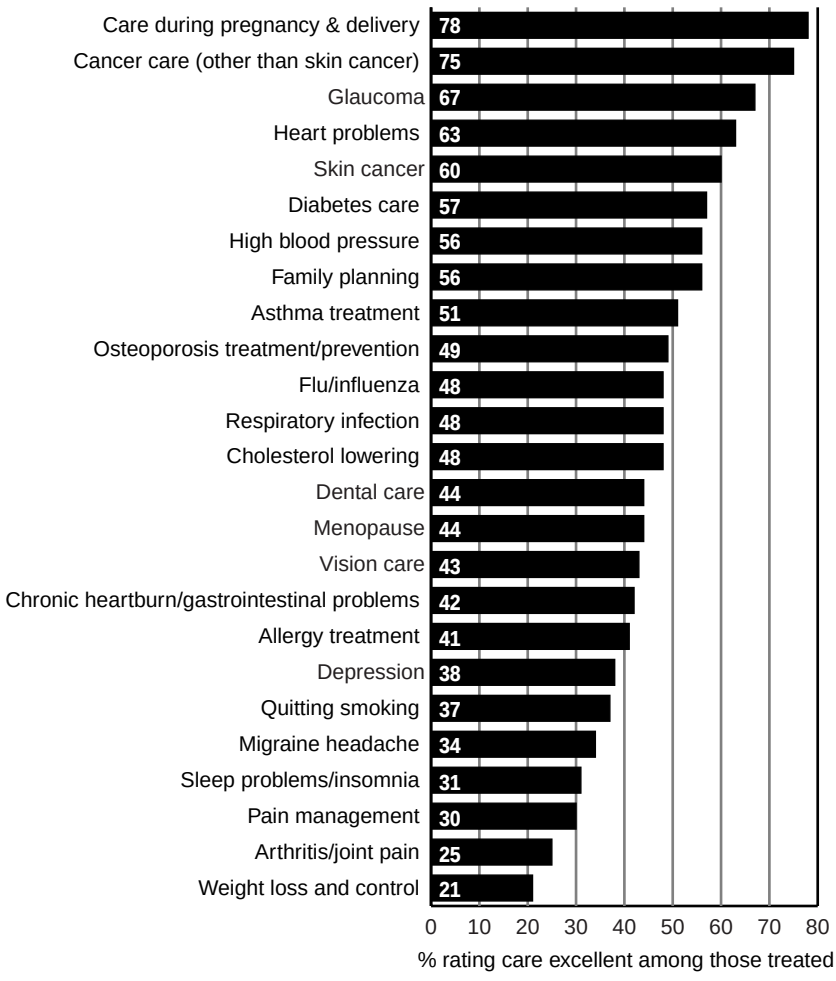
❒ physician's interest in getting to know you;

❒ physician's advice on how to stay healthy.

Those issues were even more important than the amount of time spent with the physician notes Cooperman. "It's quality rather than quantity that's important," he says.

The Merck report suggested that health plans could provide draft letters for physicians to send to patients with strategies on staying healthy, and for customer service representatives to follow up after sick visits.

Perceived Adequacy of Care



Source: CareData Reports, New York City, 1998.

Meanwhile, cost-saving policies that restrict pharmaceutical formularies appear to be brewing dissatisfaction. Some 20% of patients who requested a specific medication from their doctor were not prescribed that drug, according to a CareData survey of commercial health plan members. Those who didn't receive the requested medication were twice as likely to be dissatisfied with their health plans — even if they received a generic equivalent or another brand drug, the report found.

In fact, satisfaction with pharmacy benefit, typically the highest rated aspect of plans, fell 7% to 69%.

CareData surveyed about 60,000 commercial and Medicare health plan members in 27 major managed care markets and measured satisfaction on 138 indicators. ■

Ultimate outcome: Are patients better or worse?

Health of Seniors measure tracks health status

For the first time, health plans are being evaluated on the essence of their job: Over time, are the changes in patients' mental and physical health better or worse than would be expected?

Some 279,000 Medicare beneficiaries responded to surveys last summer for the "Health of Seniors" measure, and they will be surveyed again in 2000 for a comparison of changes in their health status.

While this first true outcomes measure applies only to Medicare managed care, health status is evolving as a performance measurement tool for medical groups and for use with younger patients as well. In fact, the Health Care Financing Administration (HCFA) is conducting a pilot project with medical groups using the Health of Seniors survey to monitor fee-for-service patients.

The Pacific Business Group on Health in San Francisco included a short version of the health status questionnaire in its Physician Value Check Survey, which is being used to create report cards on medical groups. "We're defining outcome as the change in your score," says **John E. Ware Jr.**, senior scientist at The Health Institute of the New England Medical Center in Boston and developer of the SF-36 health status survey that forms the core of the Health of Seniors survey. The measure was developed jointly by HCFA and the National Committee for Quality Assurance in Washington, DC.

"We subtract the baseline score from the outcome score [after two years]," he says. "We're holding the plans [and medical groups] accountable for maintaining health or improving it."

Treatment changes health status

Some physicians may question how much impact they have on patients' overall physical and mental health, particularly with those who fail to follow their treatment advice.

But Ware points out that trust and communication can strengthen compliance, and he asserts that specific interventions clearly affect the health status of patients with conditions such as diabetes or hip fracture. "Therapies improve these scores," he says. "There is a link between treatments we know are effective and health improvement."

In the Health of Seniors measure, health plans will be compared based on changes in the overall physical and mental health scores. But the SF-36 also provides scores for subscales, such as pain and vitality, that plans can use to guide quality improvement. "They might look at those processes that are contributing to their [mental and physical health] outcomes," says **Chris Haffer**, PhD, director of the Health of Seniors-Managed Care Project for HCFA.

The Health of Seniors survey includes additional questions on activities of daily living and medical conditions. The results will be risk-adjusted based on such factors as age and illness. Plans will receive state, national, and regional norms as well as their own scores.

While mental health among this Medicare group should remain stable or even improve slightly, physical health will decline in two years, says Ware. "Probably twice as many seniors will decline each year in physical functioning as will improve," he says.

Such projections are based on studies using the SF-36, such as the massive Medical Outcomes Study that provided the foundation of current knowledge of health status assessment. Yet even one round of the Health of Seniors survey will dwarf the prior research. "They will have almost as many seniors in each of 280 plans as we had in the entire Medical Outcomes Study," says Ware. "This is a much higher degree of precision than we've ever had."

The plans each surveyed 1,000 members, and

HCFA officials say they hope to receive completed responses for both baseline and follow-up from 500 members per plan. That final number will likely be lower due to variation in response rate. "That would have given us very, very strong statistical power," says Haffer. "We can detect meaningful change if we have 250 people completing both surveys."

In fact, response rate is one statistical aspect that may impact performance on the Health of Seniors measure. The response rate for plans ranged from 29% to 79%, says Haffer.

The first respondents to a health status survey tend to be healthier than those who need many reminders before responding, says **James Cooper**, MD, a geriatrician and senior medical adviser for the Center for Primary Care Research at the Agency for Health Care Policy and Research in Rockville, MD. "We don't know if they're more likely to change, to get better or worse."

Haffer says HCFA will keep a close eye on demographic and other differences among respondents to plans with different response rates. The agency may set a cutoff, excluding plans that don't have a sufficient response rate for comparison, he says. "So far we haven't answered that question yet," he says.

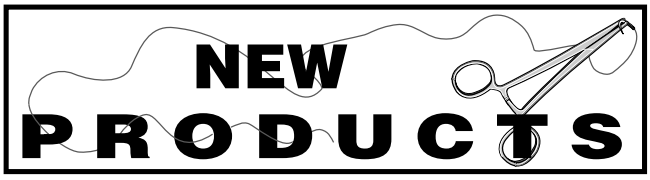
Will measure change physician behavior?

Even while the technical details are worked out on the Health of Seniors survey, the project promises to have a broader impact on care. Medical groups, hospitals, and home health agencies are implementing interventions to determine how they can improve health status scores among older people.

Cooper predicts that the Health of Seniors measure will broaden the way physicians and other providers view their jobs. "[The measure] will lead to providers taking more responsibility for broader concerns about health — getting people to exercise, improve their diet, control alcoholic consumption," he says.

Ware says he would like to see more physicians using the SF-36 as a monitoring tool of overall health of individual patients. "My own belief is that they should be doing this [health status assessment] regardless of whether it's an outcome in an accountability system," he says. "Just as they monitor the organ of the body they're treating, physicians should be monitoring your entire health. They really need a barometer that tells them overall how you're doing."

Editor's note: For more information on the Health of Seniors survey or a copy of the manual ($75 plus $10 shipping and handling), contact the National Committee for Quality Assurance Publications Center, 2000 L. St. NW, Suite 500, Washington, DC 20036. Telephone: (800) 839-6487. World Wide Web: http://www.ncqa.org. ■



Baldrige criteria offer overall move to quality

Model adapted for health care puts results first

Medical groups often focus attention on one identified problem area, such as access to appointments, in a quality improvement project. But is that method too narrow? Are they missing other, related opportunities to improve? A new consulting service offered by Stratis Health of Bloomington, MN, uses the Malcolm Baldrige Health Care Criteria for Performance Excellence to assess the entire organization, then help implement changes to drive continuous improvement.

"What often happens is an organization decides to measure a particular outcome. They measure it, but they never understand the framework [behind it]," says **Paul Grizzell**, MBA, director of consulting services for Stratis Health. "[The Baldrige assessment] looks at the organization in a holistic way."

The Baldrige Health Care Criteria, developed in 1995, are a version of the Baldrige criteria developed for general businesses. The seven categories are: leadership; strategic planning; focus on patients, other customers, and market; information and analysis; staff focus; process management; and organizational performance results. "The categories are weighted to give you a score based on [data from] high-performing organizations," says Grizzell. Yet the criteria are not rigid. Medical groups can customize them by determining what is most important to their particular practices, he says. For example, the mission and processes of a small, single-specialty medical practice may differ from that of a large, multispecialty group.

In the business model, the Baldrige assessment generally places greatest emphasis on customer satisfaction and financial and market results. In the health care version, "the greatest weighting is put on health care results," he says. "This acknowledges that the most important thing for a health care organization is making or keeping people well."

Even with some customization among medical groups or other health care organizations, the criteria "help bring a common language of quality to the health care industry," says Grizzell. "There are so many definitions of what quality is. This rolls it all together.

A Baldrige assessment begins with a survey of leaders and staff about the areas they feel are most in need of improvement. They respond to 60 behaviorally based statements, such as "All leaders and managers review the organization's performance against goals." **(See sample questions, inserted in this issue.)** Their written comments are also collected. In smaller organizations, every employee and leader may be surveyed; in large groups, a representative sample could be used.

Through this assessment, leadership can learn about problems identified by staff that they hadn't even been aware of, says Grizzell. After a year of work on improvements, the medical group can repeat the assessment to measure progress, he says. "We use it as a tool for organizations to focus their improvement efforts."

Editor's note: For more information on the Baldrige Express assessment, contact Paul Grizzell, Director of Consulting Services, Stratis Health, 2901 Metro Drive, Suite 400, Bloomington, MN 55425-1525. Telephone: (612) 853-8501. Fax: (612) 858-9189. World Wide Web: http://www.stratishealth.org. ■

NEWS BRIEF

Consumers rarely have choice of health plans

Managed competition, in which health plans compete in a consumer-based marketplace on both cost and quality, is still just a dream. Only 17% of private employers that offer insurance to employees provide a choice of plans, according to a report of the Center for Studying Health System Change in Washington, DC.

Even when employers offered alternatives, only 27% provided financial incentives for employees to choose the lower-priced plans, the report says. Few provided quality information on the health plans. Only 22% of the largest employers provided comparative data.

The Center for Studying Health System Change is an independent research organization funded by the Robert Wood Johnson Foundation. The survey of 21,000 employers was conducted by RAND in Santa Monica, CA, and Research Triangle Institute in Research Triangle Park, NC. ■

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CME questions

1. In an audit of 1996 Medicare HEDIS data, IPRO, a health care quality improvement organization in Lake Success, NY, found two measures contained enough flaws to render them invalid for comparison. Which were they?
   A. Flu vaccine and cholesterol screening.
   B. Health status and beta blocker use after a heart attack.
   C. Access to clinicians and credentialing of providers.
   D. Eye exams for people with diabetes and follow-up after hospitalization for mental illness.

2. The primary goal of FACCT/ONE, a patient survey under development by the Foundation for Accountability in Portland, OR, is to:
   A. Answer questions about how patients live with chronic illness.
   B. Replace other methods of collecting HEDIS data.
   C. Find out about satisfaction with care.
   D. Allow patients to evaluate individ ual caregivers.

3. In the Health of Seniors Medicare managed care performance measure, health plans will be held accountable for:
   A. Satisfaction with overall experience of care.
   B. Change in health status over a two-year period.
   C. Health status at one point in time.
   D. Health of Seniors is just a pilot test and not a mandatory measure.

4. According to a recent survey on managed care conducted by CareData Reports of New York, patients are least satisfied with what types of care?
   A. Care during pregnancy & delivery.
   B. Cancer care.
   C. Heart problems.
   D. Weight loss and control.