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Open access ends delays for appointments, delights patients

Medical groups discover efficiencies in same-day care

Imagine all the doctors walking into your office each day with a wide-open schedule. Patients call and get appointments the same day, whether they need a physical exam or an acute care visit.

This revolutionary concept of "open access" is taking hold among some practices that have managed to eliminate backlogs and remove barriers to patients who want appointments. The result: ecstatic patients, happier doctors, and a competitive edge in the marketplace. One practice even reported a boost in patient satisfaction with access of 14 percentage points within a year.

"In every other industry, in every other walk of life, we've eliminated delays," says **Mark Murray**, MD, MPA, co-chair of the Boston-based Institute for Healthcare Improvement (IHI) collaborative on "Improving Efficiency and Access to Care."

"In health care, we institutionalize delay," says Murray, who also is clinical director for Sacramento (CA) Appointment and Advice Services of the Permanente Medical Group. "You call and get put on hold. You come in, and you get stuck in the waiting room. If you can eliminate the wait in other industries, you can eliminate the wait in health care.

"There's no reason we can't do all of today's workload today," he says. "The only reason we can't is because we're doing last month's work today."

Others came to the same conclusion after reducing appointment types and holds and creating new efficiencies. At Sauk Trails Health

EXECUTIVE SUMMARY

By reducing their backlog and improving processes, medical groups are moving toward open access that allows patients to be seen for any type of appointment on the same day they call.

- Multiple appointment types are a barrier to open access and often create delays.
- Supply and demand for appointments reach a natural balance once doctors and other providers work down their backlogs.
- Some practices begin by setting aside time for same-day appointments.

Capacity vs. Demand

Day of Week	(Demand) Average number of appointments booked per day*	Current average number of appointments seen per day	Number of patients not seen
Monday	61	26	35
Tuesday	57	46	11
Wednesday	66	55	11
Thursday	44	34	10
Friday	40	24	16
Total	**268**	**185**	**83**

* Number of patients who wanted to be seen on each day of the week.

Source: HealthSystem Minnesota, Minneapolis.

Center, a part of Group Health Cooperative of Madison, WI, patients typically waited a month or two for a physical exam. Now, they can schedule one the same day they call.

When the system changed, they responded with disbelief — then with delight, says **J. Fred Brodsky**, MD, Group Health primary care site chief. "It really was doable. The reason it seems impossible is you're walking into clinic every day with 20 people on your schedule. If you make the commitment to ride the wave every day, it's possible."

What are the steps toward open access? Physician leaders in practices that developed open access offer this advice:

1. Begin with adequate support, especially among top leadership.

Expect skepticism when you suggest open access, but look for allies. You'll need colleagues who are willing to join you in the effort. And you'll need the clear and strong support from practice leadership.

For example, access team members at HealthSystem Minnesota in Minneapolis meet with senior vice presidents monthly to report on their progress and receive help breaking down barriers to the changes they needed. But such help isn't always immediate.

Murray recalls first broaching the idea of same-day scheduling when he was assistant chief of adult medicine at the Permanente Medical Group in Roseville, CA. "People thought we were crazy," he recalls. "[But then] we met other people who were just as crazy as we were."

Murray won over doctors who were frustrated with schedules that simply didn't work. Long waits for appointments breed patient dissatisfaction, and overbooked schedules put unnecessary pressures on physicians and staff. Meanwhile, when patients can't get in to see their own doctors for acute problems, they end up with a partner or at an urgent care clinic. In fact, physicians may be seeing each other's patients because of scheduling nightmares.

At Peekskill (NY) Area Health Center, medical director **Paul Kaye**, MD, received eight patient complaints about access in the three months before the center began the IHI quality improvement project. There have been no access complaints since the center implemented a version of open access.

You can't do it alone

But the center's initial experience was also telling. **Duane Stoner**, PA, began by reserving half of his schedule for same-day appointments for his own patients. Soon, doctors who couldn't accommodate their patients' demands started sending them to Stoner, since he always had open

Appointment Scheduling Grid

Old Way		New Way					
8:00	GE20	8:00	S	10:00	S
8:20	AVL	8:15	N	10:15	N
8:40	WC1	8:30	S	10:30	P
9:00	GE40	8:45	N	10:45	S
9:50	ACUT	9:00	N	11:00	N
10:00	WC2	9:15	S	11:15	N
10:40	WCH	9:30	P	11:30	S
11:00	ACUT	9:45	N	11:45	P
11:15	ACUT				
11:30	ACUT				

GE20	general exam, 20 minutes
AVL	available
WC1	well child newborn
WCH	well child visit, new patient other than newborn
GE40	general exam, 40 minutes
ACUT	acute care visit
WC2	well child, previous patient

S	same day
N	next day
P	pause

Source: Mayo Clinic, Rochester, MN.

spots. His plans to remain available for his own patients fell apart.

The lesson: He couldn't do it alone. "We weren't able to sustain [the open access] because we didn't have everyone focused on the same goal," Stoner says. "It is a team effort." The health center then launched efforts to improve efficiency and patient "cycle time," or time in the office, as a prelude to opening up access.

2. Evaluate your current practice.

How big is your backlog? What is your daily demand for appointments?

You can determine your backlog by looking at the schedule as far out as it goes and counting the number of patients who are on it, says Murray, who works with medical groups to help them implement open-access systems.

Or you can use a chart such as one developed by HealthSystem Minnesota to tabulate the third available appointment and the average number of appointments seen per week to determine the backlog of individual physicians.

(For a sample chart to determine backlog, see insert. For a sample chart of excess demand, see p. 14.)

IHI recommends tracking access with the third available appointment, since cancellations or no-shows may skew results if the "next available" were used as a measure.

HealthSystem Minnesota is implementing open access with 196 provider teams, led by **Linda Peitzman**, MD, an associate medical director. The backlog sheet is a first step — even before the site has altered appointment types or any other processes. It gives physicians a sense of how much work it will take to catch up with the demand, says **Laura Frazier**, access specialist.

Some backlog is expected. For example, pregnant women will have future prenatal exams, children will have well-child visits, and some patients must follow up with a return visit. You will never have a backlog of zero.

"The key is getting rid of unacceptable backlog," says Murray, who began his open-access efforts with a backlog of about three months.

You'll also want to reassure doctors that they could see all of the current demand if they had little backlog. "You measure true demand," he says. "You add up all the patients who call you today for an appointment at any time, plus those that walk in, plus the number that went to urgent care because you couldn't see them."

Murray contends that unless a physician's panel size — or total number of patients — is out of line, the daily demand will not exceed 20 patients.

"The myth out there is that demand is insatiable," says Murray. "Backlog is finite. The demand is determined by the illness burden and the panel size."

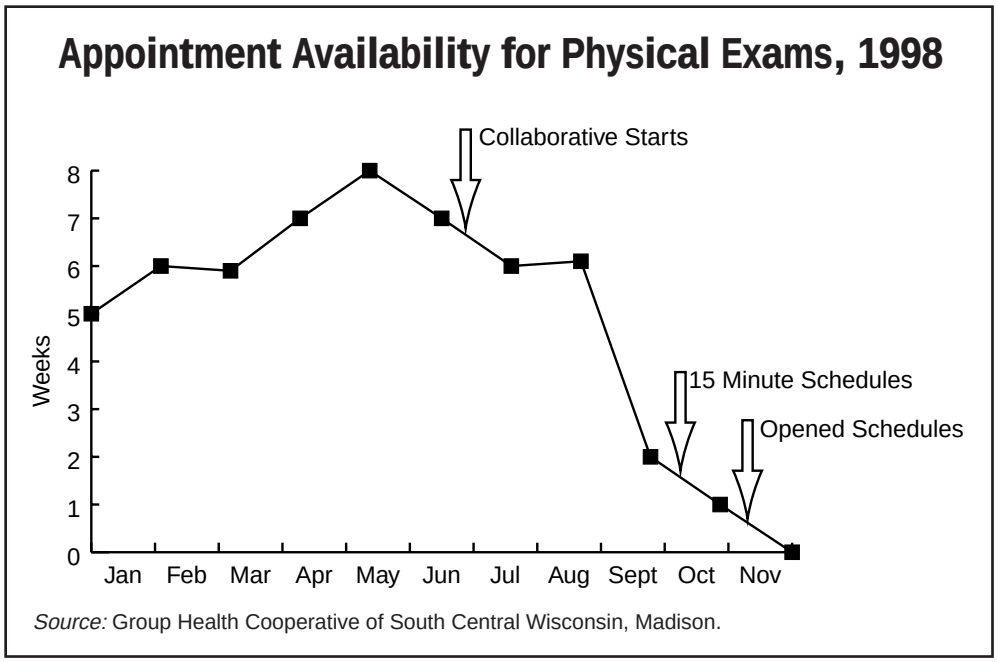
Of course, there are times of the year when the demand for appointments rises along with the spread of infectious diseases. But even then, Brodsky says, the variability isn't as great as he expected, rising only as high as 24 patients in a day.

Brodsky says he manages those high demand times by maintaining good clinic flow, using physician assistants or nurse practitioners, or, as a last resort, referring patients to an urgent care clinic.

3. Reduce appointment types.

Sometimes the problem isn't a lack of appointments. It's a lack of the right kind of appointment. "For any kind of access improvements, appointment types have to be simplified," says Murray. "Appointment types are just barriers."

The department of community pediatric and adolescent medicine of the Mayo Clinic in



Source: Group Health Cooperative of South Central Wisconsin, Madison.

Rochester, MN, had about 60 appointment types, including camp physicals, well-child visits, general exams of various lengths, and acute care.

"Everyone thought we needed to make sure we had these appointments and save them for different patient needs," says **Jill Swanson**, MD, assistant professor of pediatrics in the Mayo Graduate School and section head of community pediatric and adolescent medicine for Mayo Clinic. "It really worked against us instead of for us."

After joining the IHI collaborative, the pediatric section created two appointment types: same day and next day (which could include any future, return visit). Appointments are scheduled in blocks of 15 minutes. An "N+" indicates a next day visit that requires two blocks of 15 minutes. **(For a before-and-after example of appointment scheduling, see box, p. 15.)**

Sauk Trails Health Center, which has 4.7 physicians and 2.7 physician assistants, reduced 10 appointment types to four: physicals, procedures, obstetrical, and everything else. "We were laboring under a system of scheduling templates and lockout codes," says Brodsky.

No more excuses

The receptionists had become experts at making excuses to patients, he says. Now, they are paired with a particular physician so they can learn that physician's preferences. Every day, either at the beginning or end, the receptionist confers with a physician and nurse to discuss scheduling issues.

4. Eliminate your backlog.

To get rid of your backlog, physicians and their staff have to work harder in the short term. They add hours, perhaps in the evening or weekends, or agree to see more patients in a day. **(For changes in backlog, see chart, at left.)**

Practices also have to function more efficiently, getting the most out of each patient visit, say Murray and Brodsky. For example, if a patient who comes in with a sinus infection has a physical scheduled a couple of weeks later, Brodsky will go ahead with the physical at the time of the acute visit. He then opens the other slot.

"You need staff that are sensitized to those issues," says Murray. If a patient calls at 11 a.m. asking for an appointment to inspect and remove a cyst, then is scheduled at 11:30, the staff has a half-hour to get ready.

Instead of scheduling a return visit for the procedure, the physician removes the cyst during the initial visit. If a nurse performs the suture removal, then a process that could have taken three physician visits now requires only one, he says.

At Sauk Trails Health Center, physicians are treating cystitis, or uncomplicated urinary tract infections, by phone without an office visit. Physicians also try to anticipate the scheduling impact of vacations and peak times, such as flu season.

After determining that the average patient spent 16 minutes with a provider, the appointments were changed from 20 or 40 minute intervals to 15 or 30 minute intervals. That alone added seven time slots per day per provider.

5. Gradually add access.

As you work down your backlog, time slots begin to open on the daily schedule. "Gradually, you start seeing more of your daily demand," says Brodsky. "If you start accommodating daily demand, eventually you do reach the end of your backlog."

Working down backlog should be part of an

overall access plan and process improvements, advises Frazier. For example, HealthSystem Minnesota developed a minimum staffing policy to prevent sudden backups.

"You can't just work down the backlog and expect it to fix your access problem," she says. The health system's goal is to see all patients within two weeks and to meet all acute care needs within the same day. About half of the teams have met that goal.

Some practices choose to take an intermediate step toward open access by blocking out a portion of the schedule that is reserved for same-day appointments.

In fact, it may be unrealistic for some practices to anticipate a fully open access system. For example, in the dental department of Peekskill Area Health Center, dentists generate about half of the backlog by asking patients to come for return visits. But a policy of retaining half of the appointments for same-day use still has transformed the access. Previously, patients waited two months or more for an appointment.

"It's been a godsend for allaying patient complaints about not being able to get appointments," says dental director **Clifford Hames**, DDS.

At Kaiser, Murray saw patient satisfaction with access rise by 14 percentage points after implementing open access. That improvement took about a year, as patients slowly realized that the easy access to appointments was no fluke.

Brodsky recalls the stunned comments of patients. "It's amazing how many people actually laughed when told they could come in at any time for an appointment," he says. ■

'Fast track' puts clinic on the right track for patients

Express service means better productivity

Medical director **Sharon Buttress**, MD, and her access team wanted to know what happened to patients when they entered the CAMcare Health Corp. community health center in Camden, NJ. So they followed patients from the moment they walked in the door to the time they left, clocking each movement as they went.

Their findings: Patients spent an average of 31 minutes in the waiting room, then waited another 29 minutes in the exam room. They finally spent 12 minutes face to face with a physician or nurse practitioner; their total time in the clinic averaged 95 minutes. "Our patient satisfaction surveys told us, 'We like what you do, but we hate how you do it,'" says Buttress.

Just tinkering with the center's processes wouldn't be enough. The access team set out to re-engineer the system through a quality improvement project that was a part of a collaborative on "Improving Efficiency and Access to Care" of the Institute for Healthcare Improvement (IHI) in Boston.

In fact, **Mark Murray**, MD, MPA, co-chair of the Boston-based IHI collaborative, cautions medical groups to work on access along with efficiency issues. Process changes such as fast-track influence, not just cycle time but access to appointments, with a patient's regular physician, he says.

The CAMcare team adopted the acronym NIKE, for "New Ideas — The Key to Excellence," with the motto, "Just do it!" The team focused on the patient experience as it sought to remove barriers — such as pharmaceutical representatives lingering in the hallways and distracting doctors — and create efficiencies.

"The office flows [now] around the patient," says Buttress. "The patient is central."

One primary change transformed the way the CAMcare center handled visits. With the support of several providers and CAMcare leadership, the center created an "express lane." Patients with needs that could be handled quickly, such as suture removal, blood glucose monitoring, or wound checks, went on a "fast track."

A dedicated team of providers and staff works just on the expedited visits. The team rotates onto the fast track, so the providers can see their regular patients on other days.

To make things even smoother, Buttress gave walkie-talkies to providers, receptionists, and medical assistants. Now, if doctors need a chart, they don't wander the halls looking for someone to help. They just get on the walkie-talkie.

"Walkie-talkies allow the [care] team to communicate in real time," he says. "It was the team support and communication that made the difference."

When the access project began, providers saw an average of 2.1 patients per hour. Fast-track

providers average 5.4 patients per hour. Those patients wait an average of six minutes; 60% of them are sent directly back to the fast-track team with no wait at all.

The center as a whole now has an average cycle time (patient arrival to departure) of 41 minutes. The average provider productivity has risen to 4.2 patients per hour. "[With fast track], we opened up capacity," says Buttress. ■

Are your patients sicker? Try using risk adjustment

Yet be aware of limitations of adjustment methods

For performance assessment to be meaningful and fair, comparisons among physician practices must account for significant differences among patients such as comorbities and age.

Lisa Iezzoni, MD, MSc, an expert on risk adjustment and professor of medicine at Harvard Medical School and Beth Israel Deaconness Medical Center in Boston, spoke to *Patient Satisfaction & Outcomes Management* about some common questions and concerns surrounding risk adjustment.

Question: When physicians are presented with comparative outcomes data, such as mortality rates following bypass surgery, they often respond by saying, "But my patients are sicker." Should they feel more trusting of data when told that they were severity-adjusted?

Answer: The first thing you have to acknowledge is that some doctors will have sicker patients, but other doctors won't. Not all doctors will have patients who are sicker than average. It's important to respect the concerns that a doctor may have sicker patients, but you have to prove it.

If you're going to be looking at outcomes such as mortality rates, absolutely you need to adjust for risk. It's just not meaningful to leave risk out of the equation. But doctors have to be prepared that they may not have sicker patients and realize that sometimes data contain surprises.

Question: Your research indicates that different severity-measurement methods can produce significantly different results. Does that mean that severity adjustment doesn't work?

Answer: No, that's not what it means. What it means is that even severity-adjusted data are simply a screen. They're a first-cut pass at what's going on. It should not be the only way that you look at the data.

For example, if you find even after severity adjustment that a doctor has higher mortality rates, then you have to go back to the data and see if there are other things that could explain those rates such as unadjusted risk factors.

In a report-card comparison of obstetrical morbidity in obstetrical care, researchers found one of the big teaching hospitals in Pennsylvania had much higher than expected rates even after risk adjustment. This hospital knew that this was going to be published in newspapers all across the state. The risk-adjustment method had not accounted for cocaine abuse and other drug abuse.

Obviously, women who are drug abusing are likely to have worse outcomes than other women. Once they were able to show that, that gave a better understanding for what was going on.

The bottom line, when I talk to anybody about risk adjustment, is that it is literally impossible to adjust for everything. Before immediately leaping to the conclusion that people with worse risk-adjusted outcomes have worst quality, you have to ask, "Were there risk factors that were not considered in the risk adjustment?"

Question: Should all performance measures for physicians be risk-adjusted? For example, some physicians have pointed out that patient compliance may differ based on cultural issues or educational level. Should those aspects be included in risk adjustment for preventive care such as mammograms or Pap smears?

Answer: This is a very important question. If the outcome measure that's being looked at for physicians is satisfaction with care, there's good research to show that patients with behavioral or mental health problems are more likely to be dissatisfied with their care. Should you hold physicians responsible for having a patient population that happens to have more mental health problems? Yet getting access to that information is very difficult.

Poor people have different attitudes than rich people. Even [determining the influence of] educational level is hard. There are some risk factors

you would love to be able to adjust for, but it simply won't be possible.

If you have several medical groups that are looking at satisfaction and one has poor satisfaction but [the data are] not adjusted for education or cultural issues, use it to begin a dialogue. How do we do better for poorly educated patients? How do we address cultural competency issues?

Question: Should physicians use some form of risk adjustment even if they are monitoring care for internal quality improvement?

Answer: In a practice, we have access to a lot more data than a health plan does. We probably would have a lot more access to the sensitive information than the people who are using the data externally.

For internal purposes, it probably is important to do some risk adjustment, but there is going to be a cost of risk adjustment. You need not only to have the data, but you need analysts on board who are capable of evaluating it.

Everyone wants to do sophisticated risk adjustment and analysis. But there simply aren't enough trained staff who understand all the issues and are able to do that. It's really going to turn on how the data are going to be used internally, whether it's simply to start a dialogue. We hear a lot about the need to prove quality in health care, about new performance indicators and report cards. Why is there little debate about methods of risk adjustment?

There is a very strong recognition of the need to do risk adjustment. One of the problems is data availability. People can't begin to debate risk-adjustment methods until they have the data to talk about it.

Who will design the methods?

Who is going to develop these methods? There are a lot of commercial organizations out there developing these methods, and they're proprietary and treated like black boxes, which makes me very nervous.

You couldn't have figured out that the risk adjustment in Philadelphia didn't adjust for drug abusers if you didn't know what was in the black box. You have to talk about federal and foundation funding to develop risk-adjustment methods.

Question: What questions should physicians ask about risk-adjustment methods?

Answer: Physicians should ask to see the internal logic of risk adjustment. The first questions should be, "What are you adjusting for? Tell me clinically what are you adjusting for? Tell me what the hypotheses are for the relationship between the risk factors and the outcomes and the evidence that supports those hypotheses."

People talk all the time about evidence-based medicine, but you also need evidence for risk-adjustment methods.

If you're going to risk adjust for outcomes and you find the issues people are concerned about for risk adjustment but you do not have the data to adjust for it, then that's a warning sign. You should state the data don't account for all the patient attributes that the literature say are important.

In summary, you first need to feel that the appropriate clinical factors are in the method. Then you need to verify the validity of data to support risk adjustment. Finally, you need to check the statistical performance of the model. ■

Are docs listening to kids, their parents — or both?

3-way communication presents a delicate balance

A 7-year-old child complains of recurring stomachaches, so his mother takes him to a physician's office. To find out about pain, eating habits, and possible causes, does the doctor ask the parent — or the child?

While most would say the conversation should involve both, physicians often struggle to find a balance in the triangular communication that is an inherent part of children's health. In fact, one study indicates that physicians favor the parents at the expense of learning more information from kids.[1]

"The main thing you see in pediatrics is that the doctors talk to kids and are very pleasant and reassuring to the children, but they don't ask them for very much information, and they don't get very much information from them," says **Larry Wissow**, MD, MPH, a child psychiatrist who studied communication patterns in a pediatric emergency setting with children ages 4 to 9.

"What they mostly do is talk to the parents," says Wissow, an associate professor of health

policy at the Johns Hopkins School of Hygiene and Public Health in Baltimore. "If there's any flow, it's being directive to the kids, getting some information from the kids, and then turning around and talking to the parents. The parents get pretty much all the education; the parents get most of the questions."

In contrast, some physicians have trouble relating to parents, who can range from over-anxious to unconcerned. "I have worked with a lot of pediatricians who went into pediatrics because they love kids, and they forgot they had to deal with parents until they got in," says **Vaughn Keller**, EdD, associate director of the Bayer Institute for Health Care Communication in West Haven, CT. "That became their major challenge."

Managing the parent-child-physician dynamic has broad implications for outcomes, Wissow says. How well physicians engage both parents and children will influence parent satisfaction with care and a child's likelihood to follow treatment advice, he says.

Start early to set good habits for kids

Encouraging children to participate in their care also sets up habits that children will carry into adulthood, notes **Barbara Korsch**, MD, a leading researcher of doctor-patient communication and author of *The Intelligent Patient's Guide to the Doctor-Patient Relationship.*

"It encourages good attitudes toward health care," says Korsch, who is a professor of pediatrics at Children's Hospital of Los Angeles. "If the doctor treats children with respect, they will be more inclined to [seek needed medical care] than if he treats them as passive victims."

In the early years of a child's life, physicians clearly focus most of their questions and information toward the parent. The parent expects not only a level of information from the visit but varying degrees of interpersonal sensitivity and partnering.

That match between a parent's expectations and physician's style will impact the success of the office visit, says **Frances Prevatt**, PhD, director of the school psychology program at Florida State University in Tallahassee.

In a study at a small pediatric group practice, Prevatt found that parents who were happy with their interactions were less likely to call later with follow-up questions for physicians.[2] The practice of five physicians fielded about 50 calls a day

New programs address the whole family

Communication, mentoring play major role

The scope of children's health doesn't end with the doctor-parent-child triangle in the medical visit. Other family members play a vital role, as does the dynamic of family support at home.

That is why the Bayer Institute for Health Care Communication in West Haven, CT, decided against a special course geared toward pediatricians and instead is focusing on how physicians relate to family members.

"We will discuss what the physician needs to do to move beyond just dealing with the patient, to dealing with caretakers, close friends, and family," says **Vaughn Keller**, EdD, associate director.

For example, siblings of children with chronic illnesses may have fears or concerns that need to be addressed.

A family in turmoil may not provide the support a child needs to comply with a treatment regimen, says **Barbara Korsch**, MD, a leading researcher of doctor-patient communication and author of *The Intelligent Patient's Guide to the Doctor-Patient Relationship*.

Children's Hospital of Los Angeles set up a mentor program for children with juvenile diabetes that is similar to Big Brothers-Big Sisters of America, Korsch says.

"If there is not a supportive adult, like a mother or a sibling, we assign a mentor, an adult model who has dealt with diabetes and will support the child," she says.

Adolescents need support from both parents and peers. And, above all, "communication in the family about the illness is tremendously important," says Korsch.

Editor's note: For more information about programs at the Bayer Institute for Health Care, contact the institute at 400 Morgan Lane, West Haven, CT 06516. Telephone: (800) 800-5907. Fax: (203) 812-5951. E-mail: bayer.institute @bayer.com. World Wide Web: http://www. bayerinstitute.org. ■

from parents, she says.

In fact, the study found that physicians often underestimated the parents' needs for information, interpersonal sensitivity, and partnering.

"When there was a closer relationship between what the parents wanted and what parents thought the physicians were giving them, they did better [on measures such as patient satisfaction]," Prevatt says.

As soon as a child becomes verbal, the physician can address some comments or questions to him or her, says Wissow. "You can set the stage very early on that you'd like the child's input," he says.

From then on, the three-way dynamic will shift as the child's competence and sense of independence increases, and the parent's own confidence grows. How do physicians cope with the ever-changing communication needs?

"They have to do a lot more permission-asking," says Keller. "They cannot make the assumptions that internists can make. They have to ask the mom or dad permission for things. Later, they have to ask the kid's permission. Do you want your mother with you? Do you want your father with you? They're always testing the relationship, and they have to do that out front and verbally."

Train all parties to communicate

At the University of California at San Francisco, pediatrician **Robert H. Pantell**, MD, found that even a short educational intervention could improve communication if it is directed at all parties — parents, physicians, and children.[3]

In his study, children ranging in age from 5 to 15 saw a 10-minute videotape in which a child actor demonstrated how to ask doctors questions and become more active participants in their care. Patients also received workbooks to write down possible questions or information they learned from physicians.

Parents and physicians also viewed targeted videotapes about increasing the involvement of parents and children in medical encounters. As a result, physicians directed more of their recommendations to the child or child and parent, and children increased their participation. Children also reported a greater rapport with the physician and a higher preference for an active role in medical visits.

"Bob Pantell's work has shown that if you have a normally developed child, at 5 or 6 years of age, they should be asked to participate," says Korsch. "By [ages] 7, 8, and 9, they are great sources of information."

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Outcomes project can make you a $60,000 winner

AMGA sponsors QI award for medical groups

When quality improvement leads to better outcomes, patients are the winners. But you can be a winner, too, with a new award program sponsored by the American Medical Group Association (AMGA) of Alexandria, VA.

The Acclaim Award recognizes "physician-directed health care organizations that measurably improve health outcomes and quality of life for patient populations with a specific disease." The Grand Prize winner will receive a Steuben crystal statue and a $60,000 grant to continue outcomes management projects. As many as four other honorees will receive $10,000 grants. The award program is sponsored by Pharmacia & Upjohn Co. in Kalamazoo, MI.

The deadline for applications is March 1.

"We want to encourage people to share information, and we want to provide incentives for medical groups to collect outcomes," says **Clese Erikson**, MPAff, research coordinator for AMGA. "Eventually, we plan to put together a compendium of different ideas on health outcomes projects, to develop a resource guide for other medical groups to use."

In evaluating applications, judges will evaluate the commitment of the medical group's senior leadership to outcomes improvement, says Erikson. "Did leadership give the necessary

resources to the project?" says Erikson. "Did they see it as a priority?"

The project also must demonstrate improvement in patients' health and quality of life, says Erikson. "They have to have a demonstrated improvement in patient outcomes," she says. "It can't just be that the organization improved response time over the telephone. You have to tie that to how patient care improved."

Medical groups with more than one project that qualifies can submit multiple applications, says Erikson. "But only one can win," she says.

Editor's note: For more information about the AMGA Acclaim Award, contact Clese Erikson at AMGA, 1422 Duke St., Alexandria, VA 22314. Telephone: (703) 838-0033. World Wide Web: http://www.amga.org. ■

NCQA urges protecting patient information

Ensuring privacy of medical and personal health information is critical to quality of care and outcomes, the National Committee for Quality Assurance (NCQA) in Washington, DC, and the Joint Commission for Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, stated in a joint report.

Patient distrust may cause them to limit the information they share with physicians and other health care providers, possibly leading to misdiagnosis and mistreatment, the organizations said.

The report recommends that consent for identifiable health information "should be truly informed, specific, and voluntary." Information systems should provide "a high level of security and confidentiality protection, including encryption, detailed user access controls, transaction lobs, and blinded files."

Both organizations include patient confidentiality requirements in their accreditation standards.

For a free copy of the report, *Protecting Personal Health Information: A Framework for Meeting the Challenges in a Managed Care Environment*, contact the Joint Commission Customer Service Center at (630) 792-5800 or the NCQA Customer Service Center at (202) 955-5697.

The report is also available on the World Wide Web sites of both organizations: http://www.jcaho.org and http://www .ncqa.org. ▼

Free software calculates inpatient measures

A new computer software tool is available free of charge to calculate 33 inpatient clinical performance measures. Using discharge data, hospitals can calculate potentially avoidable adverse outcomes (mortality rates among low-risk patients and complication rates), utilization rates, and potentially avoidable hospital admissions, such as hospitalization for immunization-preventable pneumonia among the elderly.

The Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, is offering the software diskettes, manual, and other information in a kit titled "Outcome, Utilization, and Access Measures for Quality Improvement" (AHCPR 98-0048). For more information, contact the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907. Telephone: (800) 358-9295. World Wide Web: http://www.ahcpr.gov. ▼

AHCPR issues first evidence reports

As research centers issued the first evidence reports and technology assessment, the Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, announced 12 new topics. The reports involve a comprehensive review of scientific literature and may shape the development of clinical practice guidelines and performance assessment nationwide.

The new topics are: the use of erythropoietin in hematology and oncology; management of acute chronic obstructive pulmonary disease;

criteria for determining disability in patients with end-stage renal disease; treatment of acne; anesthesia management during cataract surgery; criteria for weaning from mechanical ventilation; management of cancer pain; management of acute otitis media; prevention of venous thromboembolism after injury; management of pre-term labor; management of chronic hypertension during pregnancy; and management of unstable angina.

For more information on the evidence reports, which will be available free of charge, contact the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907. Telephone: (800) 358-9295. World Wide Web: http://www.ahcpr.gov. ■

SourceKit

Bayer Institute for Health Care Communication, West Haven, CT. Vaughn Keller, Associate Director. Telephone: (800) 800-5907.

Beth Israel Deaconness Medical Center/ Harvard Medical School, Boston. Lisa Iezzoni, MD, Professor of Medicine. Telephone: (617) 662-5871.

CAMcare Health Corp., Camden, NJ. Sharon Buttress, MD, Medical Director. Telephone: (609) 541-9811, ext. 270.

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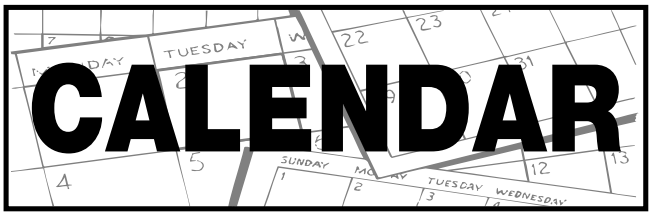
The Permanente Medical Group, Sacramento (CA). Appointment and Advice Services. Mark Murray, MD, Clinical Director. Telephone: (916) 480-2459. E-mail: Mark.Murray@ncal.kaiperm.org. ■



Quality Measurement & Quality Improvement: The Third Annual Disease Management Congress — Feb. 2-5, Pasadena, CA. For more information, contact the National Managed Health Care Congress customer service department, 1549 Ringling Blvd., Suite 500, Sarasota, FL 34236. Telephone: (888) 882-2500 or (941) 365-0157. World Wide Web: http://www.nmhcc.org.

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Results: Learning from the Past, Planning for the Future — Feb. 4-5, Savannah, GA. For more information, contact the American Health Quality Association, 1140 Connecticut Ave. N.W., Suite 1050, Washington, DC, 20036. Telephone: (202) 331-5790. Fax: (202) 331-9334. World Wide Web: http://www.ahqa.org.

Strategies in Healthcare Leadership — Feb. 4-7, Nashville, TN. For more information, contact the American Medical Group Association, 1422 Duke St., Alexandria, VA 22314. Telephone: (703) 838-0033. World Wide Web: http://www.amga.org.

Quality Improvement Initiatives: Meeting the Standards, Achieving Your Goals — March 15-16, Fort Lauderdale, FL. For more information, contact the National Committee for Quality Assurance, 2000 L St. N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-5697. Fax: (202) 955-3599. World Wide Web: http://www.ncqa.org.

Improving Day-to-Day Practice Operations — March 22-23, Chicago. For more information, contact the Medical Group Management Association, 104 Inverness Terrace E., Englewood, CO 80112-5306. Telephone: (303) 799-1111. Fax: (303) 643-4427. World Wide Web: http://www.mgma.com. ■

CME questions

1. The goal of open access in a medical group is:
   A. to offer appointments to any new patients who call
   B. to offer same-day appointments for any type of care
   C. to answer phones quickly and respond to patient questions
   D. to offer appointments for routine visits within three weeks

2. What was an important component of the success of the fast-track system at CAMcare Health Corp. in Camden, NJ?
   A. physicians who were willing to work faster
   B. patients who would arrive early or on-time for appointments
   C. better communication, including the use of walkie-talkies
   D. construction of new exam rooms

3. According to Larry Wissow, MD, MPH, a child psychiatrist at Johns Hopkins University in Baltimore, at what age should physicians begin addressing comments or questions to children?
   A. from birth
   B. as soon as they become verbal
   C. when they reach school age
   D. appropriate age varies from child to child

4. According to Lisa Iezzoni, MD, MSc, professor of medicine at Harvard Medical School and Beth Israel Deaconness Medical Center in Boston, what questions should physicians ask about risk-adjustment methods?
   A. they should ask what patient population is covered by the severity adjustment
   B. they should ask how often the severity adjustment tool is revised
   C. they should ask for data before and after severity adjustment
   D. they should ask about the clinical factors included in the adjustment and the validity of data it is based on