



PATIENT SATISFACTION & OUTCOMES MANAGEMENT

IN PHYSICIAN PRACTICES

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Listen and learn: Patient complaints can help you build a better practice

Traditional surveys don't reveal what's bothering patients

It feels good to hear from patients who love you, but the ones you need to listen to most closely are those who complain. That is the conclusion of researchers at Vanderbilt University Medical Center in Nashville, TN, who analyzed more than 14,000 patient complaints received by the health system over a six-year period and studied malpractice risk. Some of the facts the researchers discovered are:

□ A small group of doctors (about 8%) generates the most complaints, but those doctors do not differ in technical competence or outcomes when compared with their peers.¹

□ Aside from billing disputes, the most frequent complaint involves problems with diagnoses, treatment, and other aspects of care. Communication failures were another major cause of patient dissatisfaction.² (See box, p. 27.)

□ When patients of obstetricians with a high number of malpractice suits were interviewed, one-quarter complained of interpersonal issues, such as feeling that the doctor didn't listen, didn't respect their feelings, or rushed them.³

□ Traditional patient satisfaction surveys can't capture all of the dissatisfaction.

"Every marketing study that's ever been done shows that for every one complaint, there are 25 to 100 more dissatisfied people who didn't bother to complain but who left saying, 'I'm never going to deal

EXECUTIVE SUMMARY

By collecting and analyzing complaints and providing feedback to physicians, you can learn about problems in your practice and reduce sources of patient dissatisfaction.

- An analysis of more than 14,000 complaints at Vanderbilt University Medical Center in Nashville, TN, found that a few doctors received most of the complaints.
- Dissatisfaction is linked to malpractice actions.
- Complaints can reveal problems with processes (such as wait times or access) and communication.

with them again,” says **James W. Pichert**, PhD, associate professor of education in medicine at Vanderbilt.

“In medicine, we’ve dealt with complaints and lawsuits one at a time,” he says. “We’ve tried to deal with the individual customer. What we’ve failed to do is aggregate the data in a way to understand the patterns that may be occurring and attempt to intervene in a constructive way.”

Pichert and his colleagues are developing a system of collecting, rating, and analyzing complaints, followed by feedback to physicians. They are studying the impact of interventions on complaints and malpractice-related activities.

Physicians accept feedback about complaints if it is presented in a supportive, non-punitive environment — and then will act to reduce the sources of dissatisfaction, Pichert says.

Here are some steps to take to address patient dissatisfaction:

□ **Understand how complaints can lead to quality improvement.**

Rather than adopting a defensive attitude, physicians need to realize the value of complaints, says **Gerald Hickson**, MD, professor of pediatrics and vice chair of the department of pediatrics at Vanderbilt University School of Medicine.

“It’s like the old Chinese proverb, a complaint is a nugget of gold,” he says. “Traditional methods of measuring patient satisfaction focus on the satisfied patient. But that doesn’t help you target your improvements.”

Patients who are dissatisfied may be less likely to follow their recommended treatment regimen, says Pichert. They may leave the practice. And, in the case of an adverse outcome, they are more likely to sue, he says.

Yet physicians may not know about problems that occur outside the exam room. “You may be unaware of the ways your office staff, billing personnel, nursing colleagues, and others are treating your patients so your patients are really in a foul mood by the time you see them,” says Pichert.

“[Perhaps] there’s someone who’s been kept waiting, treated rudely. He had to walk half a mile because parking wasn’t convenient; there were paperwork foul-ups.”

Scheduling problems, such as overbooking, also may lead patients to feel that their physicians are rushed — and not giving enough attention to their concerns.

□ **Set up a system for collecting complaints.**

Follow the lead of other consumer-oriented businesses by making it easy for customers to report problems, say Pichert and Hickson. For example, you may place comment cards at the checkout desk.

You also can train your staff to be receptive to complaints and to record them even if the patient hasn’t taken time to put it in writing. One person may be designated as an ombudsman or patient advocate who can follow up on complaints.

Spoken complaints need to be handled in the same manner as written ones, says **Bob Dewar**, PhD, professor of organization behavior at the J.L. Kellogg Graduate School of Management at Northwestern University in Evanston, IL. “A little card takes time to fill out, [and] a lot of people are not articulate at the point of a pen.”

Your patient satisfaction surveys also should include open-ended questions, such as “Were there any aspects of your care that you were dissatisfied with?”

“You need to take a very active role in making it clear that this culture accepts and welcomes patient complaints,” says Hickson. “If we realize how valuable they are to us in molding our processes, then we should want them.”

□ **Respond quickly to individual complaints.**

Whenever Hickson receives a complaint, he follows up personally with a phone call to the patient or family member. “You may occasionally get a complaint that’s unreasonable, but I will not miss an opportunity to call the family” to allow them to air their concerns, he says.

If you leave space for comments on a patient satisfaction survey and the survey is not anonymous,

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■ Geriatric management program improves patient satisfaction

■ What medical care looks like through the patients eyes

■ Making chronically ill patients your partners in outcomes management

■ Measuring and controlling outcomes in HIV care

Common Causes of Patient Complaints

Patient complaints often have a common refrain. In fact, when researchers from Vanderbilt University Medical Center in Nashville, TN, analyzed 14,000 complaints, they were able to sort them into the following major problem areas:

- ✓ **Billing/payment:** More than one-third of complaints involve questions about bills — confusing statements, excessive charges, or bills from health professionals they never saw.
- ✓ **Care and treatment:** About one-third of patient complaints involve medication errors, adverse outcomes, concerns about delayed admission or quick discharge, and questions about the health professional's competence.
- ✓ **Communication:** About 20% of complaints involve poor communication, feelings that a health professional didn't respond fully to questions, didn't listen, misled them, or criticized care by another health professional or the institution.
- ✓ **Humaneness:** About 10% of complaints involve patients feeling that a health professional was disrespectful — rude, unconcerned, or unprofessional.
- ✓ **Access and availability:** About 10% of complaints involve problems such as long waits, rushed visits, or failure to return phone calls.
- ✓ **Environment:** Patients' frustrations with parking, equipment, or the physical facility (such as cleanliness) may spill over into their impression of their care.

you should contact all patients who respond, he says. "People will write things on there and anticipate a response and never receive one."

In fact, complaints offer the opportunity to turn negative experiences into surprisingly positive ones, says Dewar. "Look at that breakdown [in service] as an opportunity, not a problem. Because if you recover well, you can make people feel even better than they would have if the breakdown hadn't happened in the first place."

Respond quickly to the complaint, he says. If you had a lapse in service, such as an excessive wait, explain why it happened and what you are doing to ensure it doesn't happen again.

In some cases, you may want to reduce or eliminate the patient's fee for the visit. The goodwill you create will far outweigh the lost payment, Dewar says. "What does it cost you to grow your practice and get new business? How

do you even calculate that cost?" he asks, noting that engendering patient loyalty is good business.

Hickson agrees that writing off a bill makes sense when a patient has been inconvenienced. But in the case of a poor outcome, you don't want to seem to be hiding anything by eliminating the bill, he cautions.

□ **Categorize and analyze complaints.**

Individual complaints will seem like isolated incidents unless you have a system of collecting and analyzing them, say Pichert and Hickson.

"What we're finding is too often institutions miss the opportunity to learn about themselves because they don't centralize and analyze the capture of complaints," says Hickson.

□ **One person in the practice can take responsibility for reviewing complaints.**

Pichert and Hickson are developing a Patient Advocates Reporting System (PARS), which includes software to capture patient complaints in narrative form. A trained rater uses descriptive codes to identify the type of complaint.

"One incident report might include more than one kind of complaint," says Pichert. "The patients may start out complaining about a bill they got that they didn't understand. With a little probing, you find out the reason they're complaining is because they didn't get the service they wanted, the nurse was rude, the doctor was rushed, the waiting room was filthy, and [staff] didn't return phone calls the next day for test results."

In PARS, physicians receive biannual report cards listing their complaints over a four-year period compared to their peers. (Codes are used instead of names; the complaints are collected by the medical center's Office of Patient Affairs.) Through a formula that takes into account that physicians may have responded to complaints and improved their performance, recent complaints receive greater weight in the report card than earlier ones.

□ **Identify patterns in complaints and provide feedback to physicians.**

The last step in PARS involves "peer intervention." High complaint-generating physicians receive a visit from a mentor, a fellow physician who has been trained to provide feedback. The report card and coded complaints are used to explain the variation and source of dissatisfaction.

"If you're going to use the data to sit down with physician colleagues and say, 'You've got a problem here,' that sort of encounter has to be based on reliable data," says Hickson.

The encounter also is nonjudgmental, and the

data on high-complaint physicians aren't revealed to administration. "The assumption is you're not a bad apple. You may be caught in a bad system," says Hickson.

Hickson and Pichert have included other medical groups and institutions in their research, as they seek to determine whether the intervention reduces complaints and malpractice actions.

"We've been stunned with some of the results we've seen," Hickson says. "Many physicians are able to review the data, understand what it means, and act in their own way to adjust to patient sources of dissatisfaction."

References

1. Entman SS, Glass CA, Hickson GB, et al. The relationship between malpractice claims history and subsequent obstetric care. *JAMA* 1994; 272:1,588-1,591.
2. Pichert JW, Miller CS, Hollo AH, et al. What health professionals can do to identify and resolve patient dissatisfaction. *Jt Comm J Qual Improv* 1998; 24:303-312.
3. Hickson GB, Clayton EW, Miller CS, et al. Obstetrician's prior malpractice experience and patients' satisfaction with care. *JAMA* 1994; 272:1,583-1,587. ■

Employers seek to reduce variation in medical care

Dartmouth Atlas projects focus on patient choice

Employer groups are targeting variation in physician practice as an area of quality improvement and possible cost savings.

For several years, the *Dartmouth Atlas of Health Care* has reported wide variation in medical care based on Medicare data, but that information alone had little impact on patterns of care. Then in 1997, the Chicago-based Midwest Business Group on Health sought to show that employers could be the catalyst for change.

The 11-state business coalition hasn't proven yet that projects based on Atlas data can reduce variation. But they are heralding the tool as a way to find overuse and underuse of medical services and to focus improvement projects.

Three pilot projects in Muncie, IN; Wichita, KS; and Milwaukee are addressing percutaneous transluminal coronary angioplasty rates that are significantly higher than the national average. (See chart, p. 29.) In about six months, Muncie is

expected to be the first to report data.

"There are two tests that we were trying to pass with this project," says **Jim Mortimer**, president of the Midwest Business Group. "One was to find data that were understandable to employers, so they could find the most appealing opportunities for improving the system. The second test was that the data were acceptable and viewed as valid by clinicians."

While the project encountered some obstacles, including skepticism on the part of physicians, those goals have been met, he says.

Variation in U.S. care 'disturbing'

The variation presented in the *Dartmouth Atlas* makes U.S. medicine seem somewhat arbitrary. Even when adjusted for demographic differences and incidence of heart disease, the number of angioplasties performed varies from two per 1,000 to 14 per 1,000, with a U.S. rate of six per 1,000.

"This variation is reflecting something very disturbing about the way medicine is practiced," says **Megan McAndrew Cooper**, MBA, MS, editor of the atlas, which is produced by the Center for the Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, NH.

"There is very little absolute, shared knowledge about what's best under what circumstances. Physicians are making a lot of decisions on an ad hoc basis, and they don't have an enormous amount of feedback about their own work, what others are doing, and outcomes," she explains.

"What happens to you is more a function of where you live and which doctor you go to for care than it is about some knowledge base about what works or an informed decision by the person affected," Cooper adds.

In fact, she contends that drastic measures to save Medicare from insolvency wouldn't be necessary if the nation addressed differences in use of medical procedures and cost around the country. But those differences aren't decreasing on their own, even with managed care.

"The patterns of variation are very stable over time," Cooper says. "Places with very high bed rates have stayed very high. Everybody's been reduced some, but the rate in reduction in bed capacity is the same in high-rate areas as it in low-rate areas."

The Midwest Business Group on Health saw the same potential to hold back increases in health costs by ensuring their employees receive

National Variation in Angioplasty Rates

Hospital Referral Region Name	Hospital Referral Region State	Medicare Enrollees (1994 plus 1995)	PTCA Procedures per 1,000 Medicare Enrollees (1994-95)
Alexandria	LA	68,176	14.11
Stockton	CA	81,367	14.09
Elyria	OH	59,128	13.60
Salinas	CA	65,778	13.57
Napa	CA	73,922	12.63
United States	US	58,796,484	5.97
Tacoma	WA	117,556	2.82
Tupelo	MS	89,959	2.72
Asheville	NC	182,675	2.32
Buffalo	NY	419,829	2.28
York	PA	97,650	2.13

Source: 1998 Dartmouth Atlas of Health Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, Hanover, NH.

appropriate care. The Robert Wood Johnson Foundation in Princeton, NJ, funded a study by the coalition, the Hospital Research and Education Trust of the American Hospital Association and researchers at Dartmouth.

The first product of the collaborative was a publication, *A Health Care Purchaser's Guide to Using the Dartmouth Atlas*.

A Muncie, IN, health system provides the business coalition's best example of what can be done with data from the *Dartmouth Atlas*. General Motors Corp. worked with the Cardinal Health System to analyze 44 variables, comparing them with 14 other regions that have General Motors sites. They produced a matrix that helped identify problems areas. The team selected angioplasty as an area for study. But in working with area cardiologists, it first had to verify that the Medicare data reflected the pattern of care in the community at large.

When it calculated rates using a state database from the Indiana Hospital Association, the team found the same pattern of variation (although not necessarily the same frequencies). "That validated the findings from the *Dartmouth Atlas*," says Mortimer.

Cardiologists met to discuss and analyze the variation. "When you have physicians from different communities with different practice signatures discussing how they manage patients with a particular condition, they realize there

are different ways of [doing things]," says **David Wennberg, MD, MPH**, senior research associate at the Maine Medical Assessment Foundation in Manchester, which uses statewide Medicare and Medicaid data to address variation. "The data is a way to get conversations rolling."

The project team, which included support from Ball State University in Muncie, IN, and the Indiana Hospital & Health Association, decided to focus on patient awareness as a way to reduce the angioplasty rate.

The Shared Decision-Making videos, produced by the Dartmouth-affiliated Foundation for Informed Medical Decision Making, explain the risks, benefits, and options of various treatments. Studies show that use of the shared decision-making program can reduce the use of invasive procedures to treat heart disease.¹

Docs aren't always enthusiastic

The collaborative between physicians and health care purchasers hasn't been easy to establish in all markets. In Milwaukee, which has an angioplasty rate of 9.1 per 1,000, physicians have been less willing to become involved in the project, says Mortimer.

The project team there is now trying to work with physician leaders, he says.

So far, employers have steered away from any

Want More Information?

For more information on the *Dartmouth Atlas of Health Care*, contact:

- **Megan McAndrew Cooper**, Editor, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, Hinman Box 7252, MML Building, Hanover, NH 03755-3871. Telephone: (603) 650-1820. Fax: (603) 650-1225. E-mail: Megan.Cooper@dartmouth.edu. World Wide Web: <http://www.dartmouth.edu/~atlas>.

For a copy of the *Dartmouth Atlas* (\$350 plus shipping and handling, \$1,100 for the CD-ROM version), contact:

- **The American Hospital Association's Health Forum**, 1 N. Franklin, Chicago, IL 60606. Telephone: (800) 821-2039. World Wide Web: <http://www.amhpi.com/marketplace/dartOrderForm.html>.

For a free copy of *A Health Care Purchaser's Guide to Using the Dartmouth Atlas*, contact:

- **The Midwest Business Group on Health**, 8765 W. Higgins Rd., Suite 280, Chicago, IL 60631. Telephone: (773) 380-9090. Fax: (773) 380-9096. World Wide Web: <http://www.mbgh.org>.

For more information on the shared decision-making program, contact:

- **The Foundation for Informed Medical Decision Making**, P.O. Box 5457, Hanover, NH 03755-5457. Telephone: (888) 634-1532. Fax: (617) 854-7441. World Wide Web: <http://www.dartmouth.edu/dms/cecs/fimdm/>.

Shared Decision-Making videos are offered as a part of patient education and disease management services of:

- **HealthDialog**, 60 State St., Suite 700, Boston, MA 02109. Telephone: (888) 634-1532. World Wide Web: <http://www.healthdialog.com>.

talk about "selective contracting." But Mortimer says he doesn't discount that possibility.

Although the *Dartmouth Atlas* information is purely population-based, physician- or medical group-specific information could be obtained from other databases.

"[Employers] may wind up rewarding the practitioners who are working with them by channeling people in that direction," he says. "They can be more confident that people will get better care. That's the whole idea of quality improvement — better value, less waste, less overuse."

Reference

1. Morgan MW, Deber RB, Llewellyn-Thomas HA, et al. A randomized trial of the ischemic heart disease shared decision-making program: An evaluation of a decision aid. *J Gen Intern Med* 1997; 12(supp):12-62. ■

Integrate QI changes to make them last

Measurement and feedback shouldn't stop

Sometimes, quality improvement seems too easy. You focus on a goal, such as increased preventive services, and suddenly the cholesterol screenings and flu shots increase. But once you turn your attention to something else, will that improvement disappear?

Short-lived gain caused simply by bringing a problem to light is called the "Hawthorne effect." To make lasting improvements, medical groups must make outcomes measurement and feedback an integral part of their business, says **Lloyd Provost**, MS, statistician with Associates in Process Improvement in Austin, TX.

That begins with the design of the improvement efforts, which should include a testing phase to allow input from the staff and physicians, says Provost, who works with the Boston-based Institute for Healthcare Improvement on its quality improvement collaboratives.

"In a lot of new collaboratives, we show [QI] teams some of our change ideas," he says. "They'll say, 'We already do that or we already tried that.' Someone sent a memo out to doctors that said, 'Start using this procedure.' Nobody's really using it; nobody really tried it."

Careful design of the QI project and ongoing measurement can make the difference between failure and success, he says.

Test out ideas first

Provost believes in quick quality improvement cycles. He teaches the stages of Plan-Do-Study-Act, in which teams develop, test, and implement change. They can go through these steps in a week.

But the teams are not rushing toward permanent change. They're looking for evidence that the new processes work and asking for feedback.

They generally run several cycles before finding something that works.

“Unless we give organizations a chance to test and adapt and modify the changes they’re supposed to implement, then the implementation will be shallow,” Provost says.

For example, a quality improvement team might ask several physicians to reduce the number of appointment types in their schedules for a week as part of an effort to improve access. The scheduling change occurs manually; the regular computer codes stay the same for everyone else.

In the “act” stage of the test, participants decide if they need yet more tests. “Do we abandon the change? Do we modify it to make it work better? Do we run another cycle?” asks Provost.

By the time the team decides to adopt a change, “we’ll have people who are seriously planning on implementing it instead of conforming to whatever it is, and after the pressure is off, going back to what they want to do,” he says. “It’s a commitment rather than just compliance to what the rules are.”

Teams continue to meet

Sustaining change is a constant issue for Lovelace Health System in Albuquerque, NM, which began a disease management/quality improvement project in 1993 with multidisciplinary teams studying different conditions. Six years later, 10 of the “Episodes of Care” programs have been fully implemented and about 10 more are being developed. The teams still meet, though less frequently, and physicians receive regular reports showing their key indicators compared with their peers.

“Right now, we’re re-appraising each of those efforts and seeing where we want to go,” says **Maggie Gunter**, PhD, vice president and executive director of the Lovelace Clinic Foundation, a research institute affiliated with the health system. “How do we maintain measurement and feedback at some level to make sure we don’t lose the gains? Which additional ones do we want to include? Which are of strategic importance to our membership and employers?”

Gunter says she found computer-based records help provide “ongoing reinforcement.” Software was designed in-house that allows physicians to call up notes and lab results for a patient, as well as care guidelines and reminders.

“We are always thinking, ‘How do we make it

easier for the physician to change?’” says Gunter. “It’s that integration into the daily workflow of the physicians that makes their life easier.”

How do you make change a part of the “infrastructure” of the practice?

First, during implementation, you need to consider every process that is affected, says Provost. For example, you may need to rewrite job descriptions, change forms, or set up new procedures.

When you begin to train your staff and physicians, be sure you integrate the information into new employee training, as well. “If you don’t change any training program, then a lot of changes that are people-focused . . . are likely to disappear,” he says. “A question to ask, as you set up measures and process documentation, is ‘How easy would it be to backslide?’”

Make key measures a part of your review of your business, just as you look at financial information. In an effort to improve access, some practices began measuring their daily demand for appointments, based on the number of patients who called to schedule a visit.

“That’s a fundamental change in thinking,” says Provost. “Once people see the insights they get from that, they make that measure a permanent part of their business.” ■

Ask just a few questions to gauge health status

Computer-based system makes assessment easy

Gauging patients’ functional health status will become as commonplace in physician practices as measuring their blood pressure, predicts **John E. Ware Jr.**, PhD, a pioneer in the field of health status assessment and president of QualityMetric in Lincoln, RI. But first, he acknowledges, it must be as quick, easy, and accurate as well.

Ware promises to bridge that gap with the computer-based Dynamic Health Assessment System (DynHA), produced by QualityMetric. The system allows patients to answer just a handful of questions but provides a precise score on physical and mental health functioning.

Basically, DynHA functions as a customized questionnaire for each respondent. The questions are selected from a large pool (perhaps hundreds

of potential health status items) based on the patient's previous answers. For example, a patient who says she can easily walk a mile would not be asked if she can walk around the block. That means an end to long, cumbersome paper forms without sacrificing the statistical precision that those lengthy questionnaires provide.

"If they're a high-scoring patient, we ask high-scoring questions," he explains. "If they're a low-scoring patient, we ask low-scoring questions. The computer picks the questions that are appropriate for that particular patient. It stops as soon as it knows the score at the preset level [of statistical precision]."

Ware says he envisions the DynHA System as a tool for outcomes management of individual patients, for disease management programs, and for use in clinical trials. Glaxo Wellcome of Research Triangle Park, NC, is sponsoring the first disease-specific version for migraines. That tool and the generic version will be available later this year.

Health status tools slowly catch on

The concept of measuring outcomes from the patient's perspective is slowly gaining acceptance. Last year, managed care organizations used a Health of Seniors assessment tool to measure a sample of Medicare patients. In two years, those organizations will report whether the population's health improved or declined. (See ***Patient Satisfaction & Outcomes Management, January 1999, p. 9.***)

But health status assessment surveys such as the SF-36 and SF-12, developed by Ware, haven't been widely used in physician practices, even though software vendors offer touch screen, scanning, and faxed reports.

"Doctors aren't thinking this way," he says. "It's not on their radar screen. We have a major challenge to educate the physician community that just as they monitor the organs of your body, they need to monitor you overall."

Yet existing health status surveys have drawbacks as individual outcomes management tools. "Short forms were designed to reduce the burden [of long questionnaires], but they added a margin of error that really didn't allow physicians to make certain decisions at the patient level," says **Ralph Perfetto**, MBA, chief operating officer of QualityMetric. "It's like a blood pressure cuff that gave you the blood pressure, plus or minus 25."

With DynHA, the precision depends on the

number of questions in the item pool — the total number of potential questions the computer considers asking a respondent. Ware is including questions from a wide range of health status assessment and quality-of-life surveys. "We expect that the item pools [of possible questions] will continue to grow and improve" even beyond the initial development, says Perfetto.

The initial emphasis in item development is on physical functioning, mental health, and social role disability, or how illness is affecting the patient's ability to function in social roles such as working or interacting with friends and family. The dynamic assessment will provide scores for other domains of the SF-36, such as vitality or pain. "We're putting a very high priority on disability as a generic concept and a disease-specific concept because it's so economically and socially relevant," says Ware.

System offers easy connections

How can you gauge a patient's health status without taking up valuable time during an office visit? Solving that question is an important part of making the assessment useful to individual physicians, says Ware.

The DynHA System will be available through a password-coded Internet site, he says. It also could be connected through interactive voice recognition systems, in which patients call a number and answer questions over the phone.

"We've got to make this very simple, very practical to get it into clinical practice at a large scale," says Ware. "This isn't something that's going to happen while the doctor and patient are together. It's a result, a lab result, in front of the doctor when he or she sees the patient."

Managed care organizations have expressed interest in the assessment system, which could be used as a part of a disease management program, says **Lisa Bowen**, QualityMetric's vice president of business development and marketing. The results would be forwarded to physicians, who could then gauge the effectiveness of treatment for chronic illnesses.

Health status assessment promises to empower patients, but they will need to learn about their new role, says Ware.

"Patients are used to going to the doctor to find out how they're doing," he says. "Now they're going to go to the doctor and tell [him or her] how they're doing. They need to be prepared for their new authority."

[Editor's note: For more information about the DynHA system, contact Lisa Bowen, Vice President, Business Development and Marketing, QualityMetric, 640 George Washington Hwy., Lincoln, RI 02865. Telephone: (401) 334-8800. E-mail: Lbowen@Qmetric.com. World Wide Web: <http://www.qmetric.com>.] ■

GPIN offers QI support for med group leaders

Closed network is now accepting new members

For quality improvement efforts to work, they need the full support and encouragement of top leadership. But where can medical group leaders get their support?

The Group Practice Improvement Network (GPIN) in Detroit provides one such resource for informational programs, networking, and sharing of best practices. While GPIN has limited its membership to about 58 of the country's large group practices (those with 50 or more physicians), it is currently accepting new members, says executive director **Beth Anctil**, RN, MSN. "GPIN's focus is really around leadership skill building. What do the leaders need to know in order to affect change or improve outcomes?"

GPIN was formed in 1993 with the sponsorship of the Institute for Healthcare Improvement in Boston, the Medical Group Management Association in Englewood, CO, and the American Medical Group Association in Alexandria, VA.

Recently, GPIN has focused on helping medical group leaders cope with rapid change in health care. A new initiative will explore "creating idealized practice systems," such as improved access, demand management, incentives and compensation, clinical outcomes, and electronic medical records.

This initiative poses the question, "What are core components of having an efficient office practice?" says Anctil.

In fact, that is a question that GPIN members have wrestled with for some time. As a forum for quality improvement, GPIN has allowed members to share their successes — and challenges. For example, Ochsner Clinic in New Orleans, which has about 450 physicians and 28 sites in southeastern Louisiana, developed an open access protocol in some clinics based on the experience of other GPIN peers, says executive administrator

David Posch, MS, chairman of the GPIN steering committee.

"We want to move away from the notion of pre-appointed patients to a process of open access, [that] if you call, you get seen today," he says. "We've increased the number of appointments that are available on a same-day basis."

Ochsner Clinic also has applied principles learned from companies outside health care that presented at GPIN conferences, Posch explains. For example, the organization has adapted 10 dimensions of customer service from Sears Roebuck and Co. In particular, Sears emphasized the importance of employees understanding of the mission and goals of the company — "to look at your employee relations climate as part of your customer service initiative," he says.

Along with sharing ideas, GPIN offers practical advice, says Posch. "Through the workshops, we spend a fair amount of time learning about the tools and techniques of continuous quality improvement, as well as methods supporting leadership's role with regard to nurturing change within an organization," he says.

[Editor's note: For more information about the Group Practice Improvement Network, contact Beth Anctil, Executive Director, GPIN Administrative Offices, Henry Ford Health System, 1 Ford Place, 3A, Detroit, MI 48202-3450. Telephone: (313) 874-4746. Fax: (313) 874-3921. World Wide Web: <http://www.gpin.org>.] ■

Guide lists C-section rates of state's doctors

Docs have input into risk-adjustment, accuracy

A new consumer guide in Virginia provides the risk-adjusted cesarean rates of 622 physicians in the state, making it one of the most comprehensive physician "report cards" yet issued.

Virginia Health Information (VHI), a non-profit health care information organization in Richmond, used hospital discharge data to obtain raw cesarean rates. A panel of physicians, nurses, and researchers then identified 46 factors that affect the rates, including hypertension, pre-eclampsia, and fetal distress.

"The model allowed us to compare a physician's actual rate of cesarean delivery with what you

would have expected given the conditions reported by the provider,” says **Michael Lundberg**, VHI’s executive director. “They can have a 35% rate and be within the expected range if they have patients with these conditions.”

VHI sent the data to the physicians and hospitals and gave them an opportunity to make corrections — for example, if a cesarean actually was performed by someone else or if a patient had a condition that hadn’t been noted. Physicians also could provide their office address, medical school information, and board certification for a listing.

Few physicians voiced concerns about the guide or argued with its results. That was because of the open process that involved physicians at every step, says Lundberg.

The guide, released in December, shows whether physicians’ rates were above, below, or

at the expected rate of cesareans. It also lists the average charges for vaginal and cesarean deliveries, and the average length of stay for vaginal deliveries for each physician.

The guide provides detailed information on care, cost, service, and staffing in Virginia hospitals, such as whether they have a neonatologist on staff and how many birthing rooms they have.

“The guide was designed as an important reference for anyone considering having a child,” says Lundberg.

[Editor’s note: For a free copy of Obstetrical Services: A Consumer’s Guide, contact Virginia Health Information, 1108 E. Main St., Suite 1201, Richmond, VA 23219. Telephone: (877) 844-4636. Fax: (804) 643-5375. World Wide Web: <http://www.vhi.org>.] ■



On-line database offers hundreds of guidelines

AHCPR site allows guideline comparisons

Physicians have easy access to hundreds of clinical practice guidelines with the debut of the National Guideline Clearinghouse on the World Wide Web.

New guidelines are coming on-line every week, and the Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, plans to make 3,500 guidelines available within the next four years. The site (<http://www.guideline.gov>) includes comparative charts showing who sponsored the guidelines, what type of evidence was used, and major areas of agreement and disagreement.

This information can be used as a starting point as medical groups seek to reduce variation among physicians, create disease management programs, and monitor outcomes and performance, says **Yank D. Coble**, MD, a Jacksonville, FL, endocrinologist who is a member of the board of trustees of the American Medical Association.

“This provides a unique way for us to very

rapidly get guidelines and scientific information developed by credible organizations and feel confident we’re getting current information,” he says.

Coble served on a panel that developed the clearinghouse. Both the AMA and the American Association of Health Plans worked on its development.

AHCPR stopped creating its own clinical practice guidelines in 1996, after a period of political turmoil for the agency that included opposition to one of the guidelines and threats from Congress to severely cut the agency’s budget. Meanwhile, guideline users were most interested in the scientific evidence analyzed by the agency, says **Karen Migdail**, spokeswoman for AHCPR.

AHCPR changed its focus and set up evidence-based centers around the country, which release reports on various medical conditions. The clearinghouse accepts guidelines from a wide range of organizations and requires them to be based on scientific evidence. ECRI, a health services research organization in Plymouth Meeting, PA, maintains the clearinghouse.

While the site is geared toward clinicians, patients may begin to use it to learn about their conditions. Coble says he will print out guidelines for patients who are interested in more extensive information. But Coble stresses that the material just sparks conversation — both among physicians and between physicians and patients.

“While it’s educational, we wouldn’t want to mislead a patient into thinking they should base their treatment on this,” he says. “These are guidebooks, not cookbooks.” ▼

Child measurement initiative tests surveys

The Foundation for Accountability (FACCT) in Portland, OR, began testing new measures for child and adolescent health. Field trials in nine sites around the country will involve telephone and mail surveys in the areas of "Promoting Healthy Development," "Adolescent Risk Reduction," and "Living With Illness."

The survey includes six screening questions added to the pediatric version of the Consumer Assessment of Health Plans to identify children with chronic conditions. ▼

Are you using evidence tools in clinical practice?

The Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, wants to know how research findings and evidenced-based tools can be used in clinical practice.

The agency is funding up to \$2 million in grants for projects that show the impact of evidence-based tools on outcomes and cost and strategies to create behavior change in various health care settings.

The Request for Applications, "Translating Research into Practice," is available on AHCPR's Web site (<http://www.ahcpr.gov/funding/>) or from Equals Three Communications, 7910 Woodmont Ave., Suite 200, Bethesda, MD 20814-3015. Telephone: (301) 656-3100. ■



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Editorial Questions

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CALENDAR

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CME questions

1. A study of 14,000 complaints at Vanderbilt University Medical Center found that:
 - A. a small group of doctors generates most complaints because they lack technical competence
 - B. a small group of doctors generates most complaints, but they don't differ in competence from other doctors
 - C. complaints are evenly divided among practitioners
 - D. the same patients complain over and over again
2. An employer-physician collaborative in Muncie, IN, is seeking to reduce variation in angioplasty care by:
 - A. setting strict criteria for angioplasty
 - B. setting a quota on angioplasty
 - C. cutting reimbursement for the procedure
 - D. using a shared decision-making video
3. According to Lloyd Provost, MS, statistician with Associates in Process Improvement in Austin, TX, what is one failure medical groups make in designing their quality improvement initiatives?
 - A. they don't include a testing phase and modify their intervention to meet staff and physician needs
 - B. they don't put enough emphasis on the quality improvement intervention
 - C. they don't have enough leadership to implement quality improvement
 - D. they don't choose the right indicators to monitor their quality improvement
4. The Dynamic Health Assessment System, developed by QualityMetric in Lincoln, RI, is a quick but accurate way to measure health status because:
 - A. it uses information from patient charts
 - B. it allows users to scan questionnaires
 - C. it bases questions on the patient's previous answers
 - D. it isn't any faster than the standard methods of measuring health status