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INSIDE

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Experts urge use of data for guidance, 'intelligent action'

Displays enhance frequent measurement, trend charts

Pilots have innumerable gauges in a cockpit to receive constant information, but by comparison, physicians are generally "flying blind" when they see patients, two leading outcomes experts say.

Physicians often don't know how many of their diabetic patients have their blood sugar under control. They don't know how long the average wait is. They don't know how many patients wanted a same-day appointment but couldn't get one.

To turn data into a kind of "instrument panel," the Dartmouth-Hitchcock Clinic in Lebanon, NH, has created data walls with charts showing key indicators over time. "We have just really begun to use measures for learning in health care — learning about the processes and the systems," says **Paul B. Batalden**, MD. Baltalden is director of Health Care Improvement Leadership Development at Dartmouth Medical School and one of the first to adapt Edward Deming's principles of quality management to health care.

Recent advances in outcomes management have focused on using performance indicators to report to consumers. But Batalden notes that those retrospective, broad-scale measures don't help physicians in day-to-day decision making.

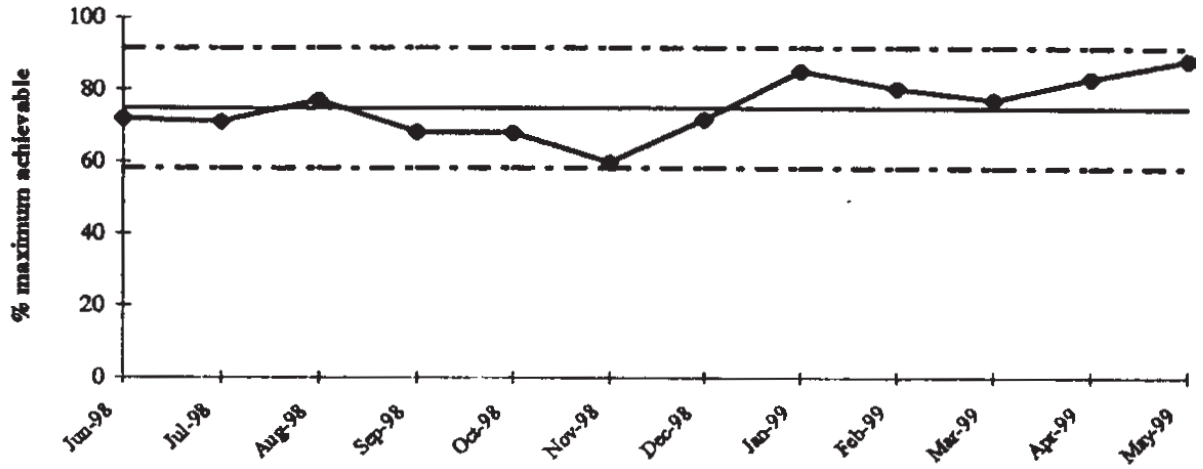
"The purpose of report cards is for judgment and not for learning," says Batalden. "Sometimes there's a belief that the measures used for performance assessment and judgment will be good measures for learning. They can sometimes wake us up or call our attention [to problems],

EXECUTIVE SUMMARY

Tracking outcomes on "control" charts allows medical groups to use data to guide day-to-day decisions.

- Report cards focus on judgment, but "instrument panels" of current data allow guidance, says renowned outcomes expert.
- Continuous monitoring enabled Dartmouth-Hitchcock Clinic in Lebanon, NH, to cut cardiovascular surgery infection rates in half.
- Hand tallies can be as useful as computer-based data.

Rate the Overall Ease and Convenience of Getting an Appointment



Source: Barbara Walters, DO; Carl DeMatteo, MD; Dartmouth-Hitchcock Clinic, Lebanon, NH.

but they often don't guide us about the actions we should consider taking."

His colleague, **Eugene Nelson**, PhD, director of quality education measurement and research for the clinic, helped set up the measurement and analysis that would help various departments guide their care. The key is timeliness and usefulness of the data, he says.

"It's meant to provide them with information that will help them monitor the vital functions of the system they're running," he says. "The purpose of the information is to gain insight and take intelligent action."

Are you hitting your goals?

Outside the office of the chairman of cardiovascular surgery at the Dartmouth-Hitchcock Clinic, charts are updated weekly with new data. They show trend lines such as observed vs. expected mortality and complication rates such as sternal wound infections.

The charts also have lines at the upper and lower control values, a statistical measure that shows whether the variation is within a normal range or a true outlier. For example, if sternal wound infections rose above the upper bar, that could indicate a problem for physicians to investigate immediately. Charts could also include a line for a target goal.

"They've cut their infection rate from the mid-30% range to around the 15% range," says Nelson. "They've looked at a number of quality- and cost-related issues."

How often to collect data and what to collect varies based on the goals of the medical group, he notes. For some measures, such as financial ones, quarterly information might be adequate, he says.

But at Nashua Internal Medicine, which implemented an open access system to allow same-day appointments, daily measurements helped assess progress. Schedulers used a mini-survey with small samples, such as five patients at 10 a.m. and five patients at 2 p.m.

"You can actually see on this morning how many open slots they have at the beginning of the day and how many people didn't get seen when they wanted to be seen," says Nelson. Meanwhile, overall access data, including satisfaction with access and third next available appointment, was plotted on graphs and displayed on the data wall. **(See sample charts, above and p. 99.)**

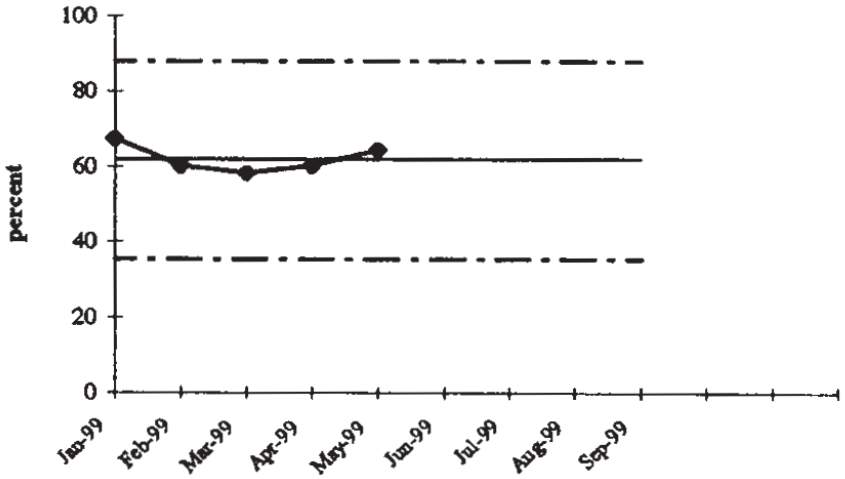
"What we've really learned is that there's no one data element that can truly measure the work that people do," says **Vicki Kahn**, MHA, senior information consultant with Nashua Internal Medicine. "You have to track a number of them."

'Instrument panels' for doctors and patients

For further detailed information, the department uses a patient satisfaction survey that is mailed to randomly selected patients and tabulated in the clinic's central office. That system has a three-month time lag.

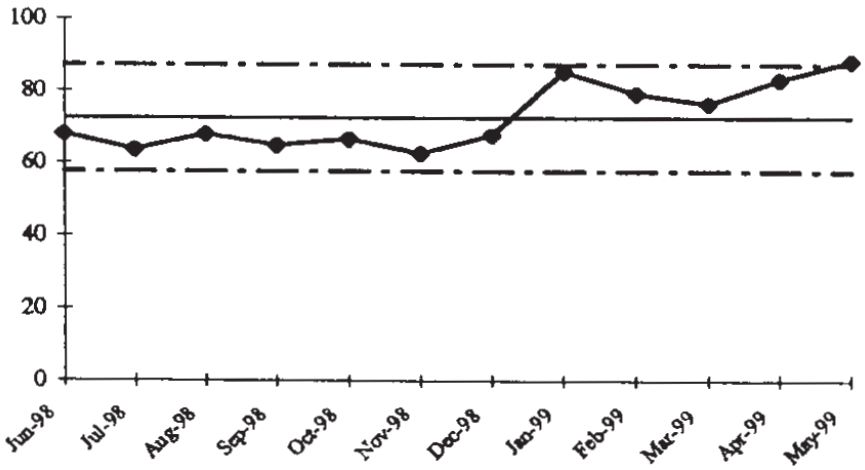
All of the displayed data reflects a team approach, with information from all clinicians. But medical directors, operations managers, and department heads receive the same trend data by

Percent of Patients Receiving Appointment on the Same Day They Requested It



Source: Barbara Walters, DO; Carl DeMatteo, MD; Dartmouth-Hitchcock Clinic, Lebanon, NH.

How Satisfied Was Patient with Length of Time Between Making Appointment & Actual Visit?



Source: Barbara Walters, DO; Carl DeMatteo, MD; Dartmouth-Hitchcock Clinic, Lebanon, NH.

clinician. And soon, physicians will receive their personal "instrument panels," as well.

"What we found is our physicians want to see their individual detail and many of them want to see it against their peer group," says Kahn, who notes that the data are adjusted for such differences as patient age and gender and full-time equivalency of the physician.

The Spine Center has taken the novel approach of using instrument panels to monitor individual patients or groups of patients with a similar diagnosis. Patients answer questions before a visit, and a quickly produced chart shows such items as spine pain, symptoms, functional status, and satisfaction with treatment.

"You can see the change in status from first visit to second visit to third visit," says Nelson.

No computer skills necessary

It may sound onerous to collect, analyze, and present the continuous data. But Nelson insists that the process is not difficult.

The data collection can take place when a receptionist asks patients questions over the phone or when they register, then marks responses on a sheet. Or the practice can use a scannable survey form with outcomes management software.

"Just making a hand-done tally is fine," says Nelson. "That doesn't take any computer programming. If you have four questions you ask people, you can build little bar charts just by hand, one by one. You can do all of this without touching a computer. Or you an do it in a sophisticated way."

In fact, the display of the data is more important than the method of collection, he says.

"Start with a question that you really want to have answered, [such as] 'How many people see their own primary care physician? What's the observed mortality rate vs. the expected mortality rate? How many people have the phone answered in three rings or less?'" he says.

"Provide the answer to that question and use visual methods to answer the question," he says. "You may lay out a clinical process in a simplified version — in six steps — and literally hang the measures off each of the key steps, thereby helping people see how discrete elements in a larger process are performing."

And that is what turns data into an instrument panel that can guide care. ■

NCQA setting standards for PPO accreditation

PPOs will use patient surveys to judge quality

The quest for accountability and quality standards is expanding as the National Committee for Quality Assurance (NCQA) in Washington, DC, launches an accreditation program for preferred provider organizations (PPOs).

Meanwhile, NCQA is shifting some health plan indicators to biennial measurement to make room for more detailed, clinically-oriented measures on diabetes, cardiovascular disease, and other conditions.

Pressure from large employers and consumer organizations, along with a changing marketplace, led NCQA to adapt its program that until now targeted only health maintenance organizations. While 80 million Americans belong to some 650 HMO plans, 89 million are enrolled in 1,034 PPOs.

"Although the number of individuals in managed care is increasing, the number in some kind of PPO or choice plan is increasing at a more rapid rate," says **Gary Krieger**, MD. Krieger is a pediatrician in San Pedro, CA, and a member of NCQA's Committee on Performance Measurement, which guides the development of quality of care measures.

"The consumer public has indicated in so many ways that it does want more choice," he says. "But at the same time, these entities need some standards and parameters of quality."

The PPO program presents some dilemmas in designing a program that assesses outcomes and quality of care. Some standards, such as credentialing and members' rights and responsibilities, can be adapted easily, notes NCQA spokesman **Brian Schilling**. But PPOs don't attempt to manage care through a primary care physician. PPOs would find it difficult, if not impossible, to obtain information through medical record reviews, as health plans do.

"A PPO wouldn't be able to report on its mammography or C-section rate," says Schilling. "They can't give us the kind of performance data that an HMO can. They would have a lot more difficulty getting the information they need from a loosely affiliated network of providers."

Assessing PPOs with modified CAHPS

Instead, NCQA will adapt its Consumer Assessment of Health Plans survey to gauge the patient's experience of care at PPOs. The survey, which is also used by HMOs, will allow a true comparison of the two insurance types, in addition to comparisons among individual payers, says Schilling.

The new PPO accreditation program isn't likely

HEDIS Measures Reported in 2000

- ✔ Childhood immunizations
- ✔ Adolescent immunizations
- ✔ Well-child visits in the first 15 months
- ✔ Well-child visits for ages 3, 4, 5, and 6
- ✔ Adolescent well-child visits
- ✔ Cholesterol management
- ✔ Controlling high blood pressure
- ✔ Beta-blocker treatment after an acute cardiac event
- ✔ Comprehensive diabetes care
- ✔ Management of menopause

HEDIS Measures Reported in 2001

- ✔ Cervical cancer screening
- ✔ Breast cancer screening
- ✔ Prenatal care in the first trimester
- ✔ Follow-up after discharge for mental illness
- ✔ Advice to quit smoking
- ✔ Comprehensive diabetes care
- ✔ Management of menopause
- ✔ Controlling high blood pressure
- ✔ Cholesterol management
- ✔ Initiation of prenatal care
- ✔ Frequency of prenatal care

Source for both charts: National Committee for Quality Assurance, Washington, DC.

to have a significant impact on medical groups, says **Mike Ralston**, MD, director of quality demonstration for The Permanente Medical Group in Oakland, CA. But it does mean that medical groups with that contract with PPOs will find a greater emphasis on patient satisfaction, he says.

"The medical groups will for the first time have external forces bringing [patient satisfaction] information to evaluate their performance," says Ralston, who is also a member of NCQA's Committee on Performance Measurement. Such information could be become an issue in contract negotiations, he says.

The final standards for the PPO accreditation program will be developed by the summer of 2000, Schilling says. The first surveys will occur about three months after that, he adds.

There is great interest in PPO accreditation, including some PPOs that want to distinguish themselves as quality payers, says Schilling.

"We expect that there will be some large employers who will require PPOs to begin collecting this information," he says.

Measures shift to biennial reporting

In another development, the NCQA will begin staggering the collection of HEDIS effectiveness of care measures. **(See charts on HEDIS measures for 2000 and 2001, p. 100.)** The change will allow NCQA to monitor meaningful changes in performance while allowing the agency to implement new measures, says Schilling.

"Immunization and mammography rates aren't likely to jump or slide a significant amount in a year," he says. Yet annual measurement of a large number of measures becomes a heavy financial burden on health plans.

"When you [look at] the collection of data and the time it takes to analyze and report them, you're almost halfway through the next data collection period," says Krieger.

Yet annual measurement won't halt for all health plans. Federal law requires Medicare managed care plans to report on performance indicators on a yearly basis, and some states and larger employers may require annual reporting as well, says Krieger.

New measures such as "cholesterol management after acute cardiovascular events" initially will be reported every year. One measure proposed for HEDIS 2000, "emergency room visits for people with asthma," has been postponed for technical reasons. ■

HMOs, docs work together to target low-birth weight

'Good health care should not be proprietary'

Competition shouldn't get in the way of better medicine. That conviction led to a collaborative of four Philadelphia-based health plans and about 800 clinicians in a project to improve pregnancy outcomes among Medicaid women.

And while it's still too early to measure the clinical impact of the project, the collaborative approach is already providing much better data than any single health plan could have gathered, says **Richard J. Baron**, MD, FACP. Baron is an internist and president and CEO of Healthier Babies Inc., the nonprofit corporation that maintains the database.

The health plans and providers are all using the same data collection form, which can be used to identify patients at risk for low weight births. Some 90% of providers are sending their forms to the Healthier Babies project, allowing for population-based information and broad interventions, says Baron.

"The core commitment was to gather comprehensive prenatal data on all deliveries in 1999 and to link that with birth outcome information from birth certificates," he says. Armed with data that describes, for example, what percentage of Medicaid patients are smokers, health plans and medical groups can design interventions. The Healthier Babies project plans to target smoking as a risk factor this fall.

Together, the health plans hope to lower the low birth weight rate in the Philadelphia area, which is about double that of the federal "Healthy People 2000" goal of 5% of live births.

Health Partners, a nonprofit Medicaid managed care organization owned by five Philadelphia health systems, spearheaded the Healthier Babies project to identify and intervene with at-risk pregnancies in a five-county area of southeast Pennsylvania. But Health Partners officials quickly realized that one health plan couldn't do it alone. Any single payer would be able to impact only a portion of the physicians' panel.

The three other health plans serving the Medicaid population were willing partners.

"Good health care should not be proprietary," says **Deneen Vojta**, MD, FAAP, senior vice president of medical affairs, and chief medical officer

of Health Partners. "Each HMO has a different flavor about them, and we may go about solving the problem in different ways. But we all agree that we need to solve the problem."

Designing a uniform data form

The first challenge for the collaborative was to create a uniform intake and risk assessment form that could be used for all Medicaid pregnancies. That alone was a daunting task.

Three of the health plans had distinct risk-assessment forms that asked similar questions but in a different format. The providers were also varied, encompassing private practice, academic centers, community health centers, and federally sponsored health centers.

Meanwhile, the concept of creating a database of clinical information to monitor the outcomes of a subgroup of patients was novel for many physicians.

"Everybody's used to standard financial reports of business performance of a practice," says Baron, who was formerly chief medical officer at Health Partners. "But people haven't gotten as good at understanding ways to standardize and work with clinical information at the practice level."

Some physicians wondered if they would be compensated for the extra time required to fill out forms. (Previously, the completion rate of the different health plan forms wasn't high.) But Baron stressed the overriding goal of collaborating for better outcomes. "We're going to need some different kind of effort; we're going to need to mobilize resources you don't have [alone]," Baron told physicians. "This is a team approach."

The Robert Wood Johnson Foundation in Princeton, NJ, provided a $400,000 start-up grant, and Health Partners invested almost twice that much. The form evolved with input from physicians and research of the medical literature.

With education of providers and some pressure applied from health plans, the intake, follow-up, and post-partum forms quickly gained acceptance. Healthier Babies now receives about 1,800 forms a week. **(See sample form, inserted in this issue.)**

Intake data from those forms revealed one important risk factor: 18% of the pregnant women were smokers. Healthier Babies plans to coordinate a broad-scale smoking cessation program that targets pregnant women who are members of the Medicaid plans.

Meanwhile, individual health plans are making use of the data in different ways. Health Partners is developing a method to identify low- and high-risk members. "We are reaching out to our high-risk members with an education program to make sure they understand the signs and symptoms of pre-term labor," says Vojta.

The health systems that are part of the health plan also received data and tailored their own interventions. For example, Temple Health System discovered that women missed prenatal care because of transportation problems. So the health system purchased a van and provides rides to enable women to receive the care they need.

Health Partners also identified HIV-positive pregnant members and cross-matched their names with a pharmacy database to see if they were taking AZT. "Women who take AZT and have good obstetrical care markedly decrease the risk of transmitting HIV to their babies," says Vojta.

Medical groups also will receive data on their Medicaid population, risk factors, and subpopulations. "They will understand more about their practice," says Baron. "They'll know what percentage of their women smoke; they'll know their low birth weight rates. They'll understand some relationship between those things."

By working together and using these data, the health plans and providers can truly manage care for better outcomes, says Baron. "It feels like a good opportunity to make a difference in an important public health problem," he says. ■

On-line assessment offers quick route to outcomes

'Dynamic' surveys target questions to patients

Would you use health status questionnaires with your patients if they were quick, accurate — and free of charge?

It's now possible to access health status surveys through a new Web site — www.amIhealthy.com — sponsored by QualityMetric of Lincoln, RI. Patients and physicians can tap into the power of a new "dynamic assessment" method of measuring health status without investing in special software, scanning devices, or consulting services.

QualityMetric, headed by **John E. Ware Jr.**, CEO and developer of the widely used SF-36 health status survey, launched the Web site this summer at a conference of the International Headache Society. Within five days, it received 750,000 "hits," a measure of Web traffic.

The site highlights an interactive Headache Impact Test, which gives patients a percentile ranking for the severity of the symptoms by asking only a handful of targeted questions. Patients also can receive scores for physical and emotional health on a general health survey, also by answering as few as four questions.

The Dynamic Health Assessment (DynHA) system contains a large pool of potential questions but only asks those that are relevant based on prior answers. For example, if the patient answers that he or she isn't limited in everyday activities such as climbing stairs, then the dynamic survey won't ask about moderate activities such as using a vacuum cleaner or bowling.

"For nine out of 10 people, [the survey] will be over in four or five questions," says Ware. "It's just that the questions will be different."

Patients can take the on-line survey at home and bring the results to their physicians. Or, for a fee that is based on their volume of usage, physicians can register and receive more detailed information that can be sent to them electronically.

"Indefinitely, we're going to provide a free public service," says Ware, who originally intended to demonstrate the site at the conference, then continue to work on its design. The development of an interactive headache assessment was sponsored by the Glaxo Wellcome pharmaceutical firm.

"We've already had a number of doctors call up and say, 'What if I had my patients do this and get their scores, would it still be free?' The answer is yes," says Ware.

Docs, patients use on-line health info

The QualityMetric Web site comes as both patients and physicians are using the Internet in unprecedented numbers. About 60 million Americans went on-line to search for health and medical information in 1998, according to a study by Louis Harris & Associates. Another study, by Healtheon Corp., found that 85% of physicians use the Internet and a third communicate with patients via e-mail.

Yet Americans are also concerned about privacy and confidentiality. The site allows users the option of registering or remaining anonymous — and two-thirds chose not to register, even though the site ensures their privacy.

Essentially, this version of outcomes management involves a partnership between the physician and patient. Physicians who subscribe to the registry can arrange to have survey results sent directly to their electronic records database. They will be able to receive additional information, such as consistency scores, that show whether the patient gave consistent answers to the short series of questions and more detailed analysis of questions and answers. But patients must give permission first.

The Diamond Headache Clinic in Chicago is set up for the transmission of scores, which then become a part of the patient's chart. But many patients choose to bring in their own reports, says associate director **Merle Diamond**, MD, FACEP. "Privacy is a big issue for patients," she says.

Feedback reports tell percentile

Yet beyond that hurdle of privacy, the interactive health assessment is a tool that helps patients define their symptoms and track their own progress. The brief feedback report tells patients their percentile ranking. For example, it will say that only four out of 10 people are more bothered by headaches than they are.

After taking a new medication, the patients can take the survey again and see how their percentile ranking has changed. The general health surveys give similar reports on overall physical and emotional health.

The interactive survey selects questions based on a person's prior responses from a collection of dozens of possible items. For example, patients with mild headaches will receive questions geared toward that, while questions about the impact of severe symptoms would be eliminated. That provides the benefit of a long survey without the burden, explains Ware.

For headache sufferers, the DynHA gives expression to their symptoms, says Diamond. "We have a number of measures that are available to distinguish the most disabled patients," she says. "But for patients who are moderate or have episodic symptoms, we haven't had a way to measure outcomes."

Patients now can take the health assessment as often as they like in the comfort of their own home. They become more involved in monitoring their health and treatment, says Diamond.

"I have patients coming in my office who say, "When I take my medicine this way, this is the result I get. When I don't use it properly, I get these results,'" she says. "They can see little changes in efficacy."

Ultimately, making health assessment more accessible empowers patients, says Ware.

"We're giving consumers proof that they do or don't have substantial burden associated with their health problems," he says. "They can take that to their doctors and talk about it." ■

Consumers have a voice in this medical group

Advisory panel ensures patient perspective

Getting the patient perspective means more to Hill Physicians Medical Group in San Ramon, CA, than asking questions on a survey or gathering an occasional focus group.

Hill Physicians has formed a consumer advisory panel with patients and patient/employer representatives. The panel, which meets quarterly, gives input on everything from the design of a new newsletter to the method of conducting patient satisfaction surveys.

Soliciting consumer opinions about possible business decisions is nothing new in other consumer-oriented industries. But it is a rarity in health care.

"We saw the consumer advisory group as a way to validate some of the things we thought were really important [to consumers] and to test new business strategies," says **Rosaleen Derington**, vice president of corporate services at Hill Physicians.

Good food, lively talk

The dinner meetings evolve into lively discussions, a form of input that is far removed from the cold statistics of patient satisfaction rankings. While the surveys provide a barometer of how patients feel about their experiences, the panel offers immediate feedback, notes Derington.

"You're getting emotion; you're getting passion; you're getting people who are excited — or not — about topics," she says.

"It's real-live people you're interacting with," she says. "You have a responsibility to give feedback and take seriously what they say and see what can be done to try to effect change."

Hill Physicians formed the panel with representatives of some of its major customers — health care purchasers such as the California Public Employees' Retirement System and Chevron. But the medical group also opened it up to interested patients. The panel includes a woman with four children who have significant health needs, and a retiree.

"The board is made up of people with a lot of different perspectives," notes panel member **Diane Johnston**, managing partner of Kenzler & Associates in Alamo, CA, a consulting firm that specializes in customer contact. "It's a very robust cross-section of people."

Creation of the panel follows the general advice that Johnston gives medical groups and other consumer-oriented businesses: "Anything you can do to better understand your customers — both internal and external — in advance of a problem, puts you light-years ahead of your competition.

"People moving in and out of programs is very costly," says Johnston. "The idea is to get a customer, treat him very well, and to leverage off the experience. The only way that's done is to look at ways to continually improve your interaction with them."

Including physicians on such a panel is also very important, says Johnston. "We don't [usually] hear the voice of all these different customers," she says.

Patient newsletter, survey on agenda

Every meeting has an agenda and a two-hour time frame. Derington tries to run a tight meeting so the participation doesn't become burdensome to members.

"We try to do some ongoing education," she says. "If there's anything unique happening in our business, we send them articles and newsletters. We try not to overwhelm them but to send them information to think about and mull over."

For example, Derington previewed a new medical group newsletter with the panel. "We spent an hour asking them, 'What did you think of the materials? Would it get past the trash can and into your house? Do you find it to be of value? What are topics you would like to address?'" she recalls.

"We're trying the best that we can to put knowledge in their hands and let them be a vital part of

the decision-making process," she says.

The medical group also asked the panel about patient satisfaction surveys and discovered that the consumers greatly preferred mailed rather than on-site surveys. "There was a lot of dialogue about the different options," recalls Johnston.

Panel members also air their feelings, positive and negative, about their experiences in the office. They want a smoother, even seamless visit, with greater efficiency and less confusion about coordination of the care and insurance issues, says Derington.

Everyone's time is important

"We heard about the doctor's timeliness," she says. "They are important people, too, and they can't be sitting around for 20 or 30 minutes when the doctor is late."

The panel has met only three times, but it has found its place in the medical group. "It's already forming into a partnership," says Derington. "The consumers bring something to the table. The management brings something else. That partnership needs to stay strong."

Now that consumers have a voice in the inner workings of the medical group, they seem to have no lack of topics. "I think we'll have a long agenda for years to come," says Derington. ■

End long waits with patient flow analysis

Free software tracks patient-staff contact

Consider these typical situations: long waits in the reception area, more waiting time in the exam room, delays in getting lab results, delays in finding patient charts.

Those inefficiencies lead not only to lower patient satisfaction, but to frustration for physicians and staff. With software available free of charge from the Centers for Disease Control and Prevention (CDC) in Atlanta, medical groups can record and analyze patient flow to pinpoint and fix problem areas.

"Patient Flow Analysis [PFA] allows you to go in and assess where the backlogs are occurring in the system," says **Julie Ellmore Jones**, MBA, MHA, a consultant with Gates, Moore & Co. in Atlanta and a specialist in patient flow. Jones is a scheduled speaker for the annual conference of the Medical Group Management Association, Oct. 17- 20 in San Diego.

"The problem might be that you get the patients worked up, but you don't have enough exam rooms," she says. "Maybe the problem is with the lab and the workup process. A lot of times it is related to the time of day.

"You want to keep the physician moving from exam room to exam room," says Jones. "You don't want a physician outside tapping his toe wondering, 'Why isn't my patient ready for me?'"

First developed for family planning

CDC first developed a patient flow tool in the 1970s to help family planning clinics control their personnel expenses. While cost is still an element, the current analysis is much more complex, says **William Boyd**, MA, public health adviser in CDC's division of reproductive health.

Current software allows users to define up to 15 distinct services performed by staff or clinicians, such as taking a medical history or performing a physical examination. But the updated Window-based version, due to be completed by the end of this year or early 2000, will expand that potential to 625.

Looking at who is providing certain services can sometimes reveal simple changes that would add efficiency, says Boyd. "It may be that there are two staff people taking a complete medical history or two staff people taking a blood pressure check."

The software also analyzes patient compliance with their appointment time — whether they are on time, early, or late. While the current program uses 15-minute intervals (a patient who is 15 minutes late would still be considered on time), the new version will allow users to set their own parameters, Boyd says.

The sophistication of the patient flow analysis will continue to improve, says Boyd. "We expect to come up with annually new versions of PFA," he says.

Collecting the data is fairly simple, but it requires a commitment to accuracy, says Jones. A form is attached to the patient chart, and every employee who comes into face-to-face contact with that patient records the start and stop times of that contact. Staff and clinicians also have codes and a form on which they record the times

they are available to work with patients and when they are on break or unavailable.

"Every single person in the office participates, from the check-in clerk to all physicians," Jones says. "The [rare] exception might be an office manager who has no patient contact whatsoever."

It helps to have someone who can monitor the data collection, she says. "In the beginning, there are a lot of mistakes. People forget to document their time. You have to monitor the forms at first and find the people who are making mistakes. If you don't have good data, there's no point in doing this."

Where did the time go?

The analysis tells medical groups how much time staff or clinician spent in face-to-face time with a patient, and what percentage of the patient's time in the office was spent with face-to-face time with someone.

For example, in one analysis Jones conducted for a pediatric medical group, patients spent 79 minutes in the office, with 36% of it in face-to-face contact with clinicians or staff.

"We're not going to be able to eliminate wait time altogether, [but] it should be 50% to 70%," she says. "As long as [patients are] in face-to-face contact with someone, [they] feel they are being cared for."

In the group, physicians spent 40% to 68% of their time in face-to-face contact with patients. "You want them to be spending 80% minimum of their time in face-to-face contact," she says.

Delays could be related to poor scheduling, or it could be inappropriate staffing, says Jones. For example, sometimes the addition of a medical assistant can actually save money for a practice by allowing greater productivity, she says.

Jones customizes the CDC software to fit the practice's needs and uses the analysis to craft recommendations. She stresses that she isn't simply looking at speed as a measure of productivity. "You get a lot of fear from the staff [who think] you're measuring how quickly they're doing things," she says. "We want them to do things at their normal pace. I try to go out of my way to assure them that I'm not here to assess their job. I'm trying to make things easier for them."

[Editor's note: For a information packet and free patient flow software, contact William Boyd, Public Health Adviser, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, at (770) 488-5130. E-mail: wab2@cdc.gov.] ■

Inpatient data available on line from AHCPR

Benchmarking just became easier with a new interactive on-line service from the federal Agency for Health Care Policy and Research in Rockville, MD.

The service, accessed through www.ahcpr.gov, provides inpatient information on length of stay, total charges, discharge status, mortality, and other indicators. Users can search for various conditions, disease groups, and procedures, and can select patient or hospital characteristics.

The source for the data is the 1996 Nationwide Inpatient Sample of the Healthcare Cost and Utilization Project (HCUP), and the database contains information from about 6.5 million hospitals stays at more than 900 hospitals in 19 states. ▼

COMING IN FUTURE MONTHS

- NCQA findings on the quality of managed care in 1999
- Key strategies for improving coordination of care
- How one medical group eased the hand-off between primary care and behavioral health
- Avoiding the access problems that spill over into urgent care
- VA surgery database leads to reduced mortality, morbidity

'Empowered' patients called happier

Giving patients information on their rights as patients leads to greater satisfaction, according to a recent study by Press, Ganey Associates in South Bend, IN. In surveys of about 250,000 patients at 525 hospitals, 85% of those who had been informed about their rights were satisfied overall with their care, compared to 81% of those who hadn't received that information. The difference was considered statistically significant.

The study provides further evidence that patients want to be empowered with information, says **Marilou Marosz**, manager of corporate communications for Press, Ganey. "More and more providers are developing brochures that explain what is going to happen (in their treatment) and what to expect," she says. ■

SourceKit

• **Centers for Disease Control and Prevention**, Atlanta. William Boyd, Public Health Adviser, Division of Reproductive Health. Telephone: (770) 488-5130.

• **Dartmouth Hitchcock Clinic**, Lebanon, NH. Vicki Kahn, Senior Information Consultant. Telephone: (603) 629-1153.

• **Diamond Headache Clinic**, Chicago. Merle Diamond, Associate Director. Telephone: (773) 878-5558.

• **Gates, Moore & Co.**, Atlanta. Julie Ellmore Jones, Consultant. Telephone: (404) 266-9876.

• **Healthier Babies Inc.**, Philadelphia. Katherine Lupton, Operations Manager. Telephone: (215) 985-2517.

• **Hill Physicians Medical Group**, San Ramon, CA. Rosaleen Derington, Vice President, Corporate Services. Telephone: (925) 362-6640.

• **QualityMetric**, Lincoln, RI. John E. Ware Jr., CEO. Telephone: (401) 334-8800. Web site: www.Qmetric.com.

• **National Committee for Quality Assurance**, Washington, DC. Brian Schilling, Spokesman. Telephone: (202) 955-5104. Web site: www.ncqa.org. ■

CALENDAR

Partnering for Uniformity — Outcomes 2000 — Oct. 3-6, Boston. The Fourth Annual Disease Management Congress sponsored by the National Managed Health Care Congress, P.O. Box 102713, Atlanta, GA 30368-2713. Telephone: (888) 882-2500. Fax: (941) 365-0157. Web site: www.nmhcc.org.

Legacy and Perspectives: A Journey to the 21st Century — Oct. 17-20, San Diego. The 73rd annual conference of the Medical Group

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Complementary and Alternative Medicine: Practical Applications and Evaluations First Annual Conference — Oct. 15-17, San Francisco. Sponsored by the Stanford University School of Medicine in Palo Alto, CA, and the Center for Alternative Medicine Research and Education of Beth Israel Deaconess Medical Center in Boston. For more information, contact Professional Meeting Planners, 5 Central Square, Suite 201, Stoneham, MA 02180. Telephone: (800) 378-6857. Fax: (781) 279-9875. E-mail: kbates@ pmp meeting.com.

Improving Care for People with Chronic Conditions — Oct. 28-29, Dallas. Sponsored by the Institute for Healthcare Improvement, 135 Francis St., Boston, MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. World Wide Web: http://www.ihi.org.

Conflict and Change: How Quality Enters the Coverage Decision — Nov. 4-5, Plymouth Meeting, PA. A Health Technology Assessment Information Service conference sponsored by ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462-1298. Telephone: (610) 825-6000, ext. 5439. Fax: (610) 834-1275. Web site: www.healthcare.ecri.org/taconf.html. ■

CME questions

1. "Instrument panel" reports, such as those at Dartmouth-Hitchcock Clinic in Lebanon, NH, rely on what type of data?
   A. annual ratings based on clinical and survey data
   B. retrospective review of medical charts
   C. control charts with frequent data collection, such as daily, weekly, or monthly
   D. instrument panels can be created with any type of data

2. The National Committee for Quality Assurance in Washington, DC, moved to biennial reporting of many HEDIS effectiveness of care measures because:
   A. the agency is cutting its costs
   B. the change allows for the addition of new measures
   C. data aren't available every year
   D. health plans were unable to collect the information

3. Hill Physicians Medical Group in San Ramon, CA, created a Consumer Advisory Panel to:
   A. promote the medical group among consumers
   B. comply with health plans requirements
   C. address consumer complaints
   D. test new business strategies and receive better customer feedback

4. In Patient Flow Analysis, a data collection form tracks:
   A. face-to-face contact between patients and staff members or clinicians
   B. face-to-face contact between patients and physicians only
   C. non-patient-related activities, such as dictation and break time
   D. medical diagnoses and treatment