AMERICAN HEALTH CONSULTANTS®

Copublished by The Medical Group Management Association

PATIENT SATISFACTION & OUTCOMES MANAGEMENT™

IN PHYSICIAN PRACTICES

INSIDE

OCTOBER 1999

VOL. 5, NO. 10 (pages 109-120)

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Coordinating care is crucial to better patient trust and outcomes

Patients wonder if there really is a health care 'system'

An elderly patient comes to the hospital with chest pain. She is immediately admitted and scheduled for bypass surgery. Who is in charge of her care? A cardiologist? A cardiac surgeon? A hospitalist? Or her own primary care physician?

Managed care promised to focus a patient's care with one key provider — the primary care physician. But new specialties grew, including behavioral health "carve-outs" and urgent care centers. **(See related articles, p. 112.)**

Coordination of care is now gaining attention as an important factor in both clinical outcomes and patient satisfaction. Patients need to know who is responsible for their care, and they have a right to clear information and prompt follow-up, outcomes experts say.

"The absence of a coordinated health system is one of the most important reasons why people don't trust health care right now," says **Susan Edgman-Levitan**, PA, president of The Picker Institute, a Boston-based nonprofit organization that focuses on health care quality improvement from the patient perspective.

"When you ask consumers about their perceptions of the health care system, universally, they start laughing," says Edgman-Levitan,

EXECUTIVE SUMMARY

Patients have a right to know who is responsible for their care and to receive proper follow-up, outcomes experts say.

- Electronic medical records improve the flow of information and continuity of care.
- Sharing a care plan, or even a medical chart, builds a partnership with patients.
- Hospital discharge planning can begin even before a patient is admitted for elective or scheduled surgery.

Improve coordination of care

Providing better coordination of care may involve a new attitude toward patient care as well as system-level changes. Here are some ideas that emerged from the collaborative on Improving Service in Health Care, sponsored by the Institute for Healthcare Improvement and The Picker Institute in Boston:

To unify and coordinate care in your system as experienced by patients:

- ✔ **Identify a spokesperson** for the medical team: physician and nurse (give patient card with beeper, e-mail, etc.).
- ✔ **Share care plans and clinical pathways** with patients so they know what to expect and when.
- ✔ **Have a "call return" time service guarantee.**

To ensure smooth transitions between care settings and other caregivers:

- ✔ **Share map of the entire process of care** developed from the perspective of the patient.
- ✔ **Check with patient and family** for understanding of referral processes.
- ✔ **Provide 24-hour prescription refill request lines.**
- ✔ **Fax orders and clinical information** between settings. ■

referring to Picker-sponsored focus groups. "Even using the word 'system' is an oxymoron. [They say,] 'There is no system up here. The only person who coordinates care is me. It is not done for me.' There is a tremendous amount of cynicism about health care in general that is, in part, related to that [frustration]."

Coordination of care can involve everything from smooth discharge from a hospital stay to prompt communication about test results. "Patients want to know that things are happening that should be happening," she says.

Technology can play a major role in that smooth flow of information. At Kaiser Permanente in Oakland, CA, policies require hospitalists to notify primary care physicians within 24 hours of admission that their patient is in the hospital. The hospitalist is also responsible for sending a discharge summary to the primary care physician who is expected to contact or visit the patient during the hospitalization.

But each physician still generates a new paper record, which isn't readily available to physicians at other sites. Kaiser hopes to rectify problem with an electronic medical record that includes firewalls, passwords, and other security measures to ensure confidentiality.

"As long as things are paper-based, there's going to be a real problem in moving information around, which is a barrier to continuity of care," says **Mike Ralston**, MD, director of quality demonstration for The Permanente Medical Group in Oakland. "As patients move through these different areas of specialty, information about their care has to move along with them."

At Harvard Vanguard Medical Associates in Boston, a computerized medical record allows urgent care doctors to access records, inform primary care physicians of the encounter, and even schedule follow-up appointments with the patient's regular doctor.

"I don't miss a beat," says **Steven Pearson**, MD, MSc, an internist and urgent care physician. "If patients come in who don't have a primary care provider, I can assign one on the spot and arrange for a follow-up."

While technology provides such benefits, coordination of care also relies on simple aspects of communication. For example, nurses or physicians may share the care plan with the patient or even hand over the medical chart for review, says **Diane Miller**, MBA, director of the collaborative on Improving Service in Health Care for the Institute for Healthcare Improvement (IHI) in Boston.

"That's usually seen as something you don't do, but it opens up a partnership," says Miller,

COMING IN FUTURE MONTHS

- ■ An end to smoking? Project improves counseling, targets quit rates
- ■ A successful self-management program addresses multiple conditions
- ■ Employee satisfaction leads to greater patient satisfaction at Mayo
- ■ How to rebuild patient trust that is diminished by managed care
- ■ Judging the value of alternative medicine in satisfaction and outcomes

Sample Questions on Coordination of Care

The following questions are excerpted from the adult office visit questionnaire developed by The Picker Institute in Boston. They are designed to provide feedback on the patient's experience with care:

- ❒ Did the provider explain what to do if problems or symptoms continued, got worse, or came back?
- ❒ Did someone tell you how you would find out the results of your tests?
- ❒ Did someone tell you when you would find out the results of your tests?
- ❒ If you needed another visit with this provider, did the staff do everything they could to make the necessary arrangements?
- ❒ Did you know who to call if you needed help or had more questions after you left your appointment?

who is director of organizational development at Virginia Mason Medical Center in Seattle.

In fact, sharing clinical pathways and guidelines improves patient satisfaction and gives patients realistic expectations, says Edgman-Levitan, who co-chaired the IHI collaborative. When patients don't know what to expect from a hospital visit and discharge, "there is a cascade of problems that arise," she says. "They don't know they're going to need to set up a series of follow-up appointments, or they don't have the equipment they need for home care."

Patients also need to be completely informed of who is responsible for their care. If a diabetic has questions about the insulin schedule, should she ask her patient educator, physician, or pharmacist? "Some teams developed a glossary of sorts of the different professionals you will see in the course of this illness, what they're responsible for, and who is the final authority," says Edgman-Levitan.

In fact, she knows from her own experience as a breast cancer patient how confusing the team of specialists can be. "From my perspective as a patient, my experience of how my managed care organization manages and coordinates my care is mostly through the approval process for seeing specialists," she says. "It doesn't facilitate my seeing the specialists. It just makes it possible for me to see the specialists."

Truly coordinated care eases patients through their health care experience and even reaches into their home environment, when necessary. At Cedars-Sinai Medical Center in Los Angeles, efforts to create a smooth hospital discharge begin within 24 hours of admission.

A case manager or social worker from the department of case management visits each patient, hands them an information sheet, and provides them with names and phone number of the case manager and social worker who cover that area. "In that brief intervention, you're also able to determine whether this person has discharge-related needs," says **David Esquith**, LCSW, MPA, manager of medical social work.

To improve communication with attending physicians, the department of case management also faxes a sheet to their office briefly outlining the discharge plan. They need only respond if they have questions or concerns.

Just before discharge, a case manager or social worker again visits the patient and discusses any discharge needs, such as transportation, nutrition, psychosocial support, home care, or therapy. In many cases, the staff person simply says, "It did not appear there were any specific needs you would have when you were discharged. From your perspective, has anything changed?"

In cases of elective surgery, such as scheduled cardiac surgery, Cedars-Sinai is working with medical groups to begin discharge planning before the patient even enters the hospital. With extra time to plan, the social workers and case managers can better meet patients' post-discharge needs.

The changes in discharge planning led to a surge in patient satisfaction, Esquith says.

Monitor progress with patient surveys

Medical groups and hospitals can monitor patients' experiences with coordination of care just as they do satisfaction with access or communication, says Edgman-Levitan.

The Picker Institute ambulatory care survey contains questions about coordination of care, including questions about receiving test results and smooth referrals. **(See sample questions, above left.)** "It's as important to send them the normal results as it is to send them abnormal results [of tests]," she says. "That becomes part of your quality control. If [patients] don't hear from you, they will follow up."

For chronically ill patients, coordination is

especially important as different physicians prescribe medications for different conditions. But even the healthy patient should have coordinated preventive care that includes reminders about screening tests or immunizations.

"Continuity is something patients have a right to expect," says Ralston.

[Editor's note: A new collaborative on Improving Service in Health Care will begin in November. For more information, contact the Institute for Healthcare Improvement, 135 Francis St., Boston MA 02215. Telephone: (617) 754-4800. Fax: (617) 754-4848. Web site: www.ihi.org.

For more information on Picker surveys and services, contact The Picker Institute, 1295 Boylston St., Suite 100, Boston, MA 02215. Telephone: (617) 667-2388. Fax: (617) 667-8488. Web site: www.picker.org.] ■

Program links primary and psychosocial care

Medical group breaks barriers to behavioral health

When physicians refer patients to a psychologist or other behavioral health specialist, more often than not they never follow through. But by connecting behavioral health with primary care, HealthCare Partners in Torrance, CA, improved successful referrals by up to 80%.

"It's a new system of delivering health care so you're dealing with the biopsychosocial aspects," says **James D. Slay Jr.**, RelD, director of behavioral health and collaborative care. The collaborative was named an Acclaim Award honoree by the American Medical Group Association in Alexandria, VA.

Behavioral health specialists, including psychiatrists, psychologists, and chemical dependency specialists, moved into primary care offices where they have staggered hours. For example, on a Monday morning, a child psychologist may be available, and a specialist in depression may be on site in the afternoon. The specialists have formed links with family practitioners, internists, pediatricians, and OB/GYNs.

The primary care physician can introduce patients to the specialist that they are recommending for referral, and the patient can schedule an appointment at the same office site. The physicians and specialists also can discuss cases, as necessary. Even receptionists have been trained in the collaborative care model, says Slay.

In the case of emergency situations, such as a patient who appears suicidal or homicidal, a handoff occurs on the spot.

"The behavioral health department spends more time in primary care than it spends in the department working traditionally," he says. "It is true coordination in real time — verbal exchange, record exchange, information exchange."

The relationships are enhanced by a monthly collaborative care forum — a lunchtime meeting, which focuses on a biopsychosocial theme such as depression or somatization (a physical ailment that has a psychological origin). Physicians and behavioral health specialists also can bring cases for discussion.

The collaboration breaks down barriers, such as stigma felt by patients who have never sought help for psychosocial issues. And it ensures that patients receive appropriate care, says Slay. "We're reducing the anxiety and resistance of the patient. We demystify the process."

The result, he says, is higher patient and provider satisfaction and better outcomes. Primary care physicians are more likely to refer patients for evaluation by behavioral health. Two-thirds of the patients seen in the collaborative care had never before had behavioral health or mental health treatment.

The program also decreases inappropriate utilization of primary care, Slay says. "By treating people appropriately, according to their real need in real time, you always have a better result." ■

Group makes urgent care extension of primary care

Smooth flow of communication is key to success

Urgent care centers are often a last resort, a place for patients who want to see their primary care doctor but can't get a same-day appointment.

But these centers don't have to serve as a dumping ground for patient overload. Instead, the centers can become an extension of primary care, offering a different solution to access and coordination of care problems, says **Steven D. Pearson**, MD, MSc. Pearson is an internist and assistant

professor in the Department of Ambulatory Care and Prevention at the Harvard Medical School and Harvard Pilgrim Health Care in Boston.

"When urgent care is handled right, as an extension of a primary care practice, I think it actually provides the highest satisfaction and service to patients," says Pearson. "There's nothing happier than patients who find they can get such rapid access — not have to go to the emergency room — and have [their condition] immediately communicated with the primary care physician. To them, it's magical."

At Harvard Vanguard Medical Associates, where Pearson sees urgent care patients, the smooth flow of care relies on both technology and process improvements. The medical group has an integrated computerized medical record system.

Pearson can access a patient's full medical record, including progress notes from the primary care physician. Then he can add his own notes. "When I dictate an encounter, a copy is sent automatically to the primary care provider."

Ensuring patient follow-up

Pearson also can view the primary care physician's schedule and arrange a follow-up appointment for the patient. "If I think the person needs to be seen within a week, I make the appointment for them," he says. "I'm sure it's done. I can tell the patient what time it is."

In cases in which follow-up is especially important, or if there is any question about the possible compliance of a patient with follow-up instructions, the physician can fill out a fluorescent yellow form with the patient information.

An urgent care nurse then taps into the primary care schedule to see if the patient showed up for the appointment. If not, the nurse calls the patient to find out what happened and to make another appointment. "You can't underestimate the importance of having a system to ensure correct follow-up," says Pearson.

Yet no matter how efficient and cohesive an urgent care center is, it is not the first choice of many patients.

In 1996, Pearson and colleague **Anna E. Plauth**, MD, MPH, conducted a study of the Harvard Vanguard urgent care; 47% of patients said they were there because they had been unable to get an appointment with their primary care physician. "Among the patients who do come to urgent care, a lot of them said they would have much rather seen their own doctor even if they had to wait a day or two," Pearson says.

The medical group revamped its scheduling system and implemented an open access system, enabling patients to receive same-day appointments. **(For more on open access, see *Patient Satisfaction & Outcomes Management,* February 1999, p. 13.)** A portion of the compensation for primary care physicians is now tied to a measure of how many of their patients they see themselves.

Urgent care is now viewed as a resource, both by patients and physicians, says Pearson. For example, the center can provide intense observation of patients the day after discharge from the hospital. The center also coordinates the administration of an injectable form of medication to treat deep vein thrombosis, providing daily communication to the primary care physician and then transferring ongoing care back to that physician.

"The system is set up to respect and foster primary care," says Pearson. "We, as urgent care physicians, respect the primary care relationship of our patients with their doctors. We try to encourage the patients to get back into the primary care physician's office. All of our systems and our communications flow are structured to assist the primary care practice." ■

Beyond illness: New tool targets child development

PEDS uses parents' concerns to identify risk level

Physicians have made great strides in preventing and detecting pediatric illness, but there is still one significant area that often remains overlooked. Only about 30% of children with serious developmental and behavioral problems are identified before they enter school, when they could benefit from early intervention.

With a new screening tool, clinicians are beginning to address that deficiency. The PEDS (parents' evaluation of developmental status) is a short form that categorizes parents' concerns and allows physicians to identify children who may be at risk for developmental or behavioral problems. In many cases, parents simply can be reassured that their child is developing normally. In other cases, the physician can conduct further screening or provide a referral.

Child health measures move toward completion

NCQA/FACCT field trials ended this fall

The first phase of field trials have ended in the Child and Adolescent Health Measurement Initiative, and a complete set of performance indicators now moves a step closer to implementation.

The field trials focused on adolescent preventive care, early childhood development, and chronic care. Much of the measurement information was collected with a version of the pediatric CAHPS (Consumer Assessment of Health Plans Survey). **(For more information on the initiative, see *Patient Satisfaction & Outcomes Management*, November 1998, p. 125.)**

"We think patient and parent reports are the most reliable source of information about what happened in the context of well-child visits," says **Christina Bethell**, PhD, director of research for the Foundation for Accountability in Portland, OR, which is coordinating the initiative with the National Committee for Quality Assurance in Washington, DC.

"The adolescent is the best source of information about whether he or she received counseling about smoking or alcohol," she adds. "The medical record is not a very reliable source at all at this moment, and the claims data can only tell you they had a visit but not what happened."

Response rates overall for adolescent and parent surveys was about 50% in the field trials, but attaining a good response rate in inner-city and ethnically diverse areas was more challenging, the initiative coordinators found.

Performance measures that target care for chronic illnesses among children must be broad-based because of small sample sizes. For example, measures such as patients' experience with care and provision of education, counseling, and support would combine data from children with different chronic conditions.

"Even large health plans don't have enough children with diabetes or cerebral palsy [to create a large enough sample size for measurement]," says Bethell.

The RAND Corp. in Santa Monica, CA, is developing child health measures based on medical chart review, but that work is in early stages, Bethell says. ■

"We're dealing with the highest prevalence of all [problems] that affect children," says **Frances Page Glascoe**, PhD, associate professor of pediatrics at Vanderbilt School of Medicine in Nashville, TN, and the developer of the PEDS. Glascoe notes that about 18% of children have a developmental problem. "Yet physicians have not approached the detection of developmental problems with nearly the kind of rigor with which they've approached asthma or otitis," she says. "There's every reason for them to want to do more than they're doing."

Development moves into the spotlight

In fact, developmental issues are coming to the forefront in pediatric medicine.

"For a long time in pediatrics, the big problems were infectious diseases and injuries," says **Jeff Brown**, MD, MPH, a pediatrician and director of the general pediatrics division of Denver Health, a system of city and county hospitals and neighborhood clinics. "With vaccines and better antibiotics, we've been able to rein in a lot of those problems.

"There's been a lot of talk about the new morbidities — learning problems, behavioral problems, developmental problems," he says. "As pediatricians, we've been trying to figure out how to identify those problems."

Denver Health used the PEDS in a pilot project and just began using them throughout the clinics. At a minimum, Denver Health expects pediatricians to administer the PEDS by the time a child is 2 and again between the ages of 2 and 4. Brown advocates using the PEDS at every well-child visit up to school age.

"It's quick and easy," he says. "You don't need any extensive testing devices — dolls, blocks, cubes, bells [as in other, child-oriented screening tests]."

The PEDS relies on parents' reports of "concerns" about their child's development. Scoring instructions alert physicians to items that relate to behavior (such as having tantrums or refusing to go to bed) and to development (such as difficulty being understood).

The PEDS is based on research that identified risk categories based on parents' observations. That makes it far more accurate than off-the-cuff conversations in which physicians might incorrectly dismiss parents' comments, says Glascoe.

Even the wording is crucial. "If physicians ask, 'Do you have worries about your child's

development?' most parents will say no," she says. "Only 50% of parents know what the word 'development' means."

PEDS asks about concerns about "your child's learning, development, and behavior." **(See sample questionnaire, inserted in this issue.)** About 43% of all parents will list no concerns. Another 20% have nonsignificant concerns, mostly behavioral, such as comments about children who are willful, whiny, or aggressive. Only 5% and 7% of these children, respectively, have undetected disabilities, says Glascoe, although physicians may want to provide parent education resources. "If parents only have a behavioral concern and that's it, there's almost no chance that there's have a developmental problem," she says.

Parents crave the reassurance that their child is developing normally, says Brown. "'Your baby is OK.' What mother doesn't want to hear that? It's an incredible boost."

Almost one in four parents will have a single significant concern about their child's development. These children are at moderate risk; 29% of them have detected disabilities. They need further screening, advises Glascoe.

"Pediatricians don't have to do the screening on their own," says Glascoe, who notes that in conjunction with federal guidelines, states offer free screening for children ages 0 to 3. *(For more information, see the Web site, www.nectas.nc.edu.)* Public schools offer screening of children older than 3.

When parents have more than one significant concern, their children are at high risk. About 70% have either undetected disabilities or below-average skills in language, intelligence, or school achievement. Glascoe advises referring them for diagnostic testing such as speech-language evaluation, or psychological testing.

With early intervention, children with developmental problems are more likely to graduate from high school and less likely to have antisocial behavior, Glascoe says.

PEDS useful in performance assessment

The PEDS also has become a tool for population-based measurement and accountability. The Foundation for Accountability (FAACT) in Portland, OR, and the National Committee for Quality Assurance in Washington, DC, included the PEDS in the Child and Adolescent Health Measurement Initiative as a way of determining whether health plans and providers are "Promoting Healthy Development." **(For more information on the initiative, see related article, p. 114.)**

The PEDS identifies risk levels, and patient-based surveys could determine whether physicians provided any follow-up, says **Christina Bethell**, PhD, FACCT's director of research.

"Follow-up" could be as simple as asking patients to return in six months or scheduling a hearing check, she says. "This tool is designed to encourage health plans to move more into early detection of problems," says Bethell.

[Editor's note: For more information or to order copies of the PEDS forms and the manual ($30 plus shipping and handling for manual plus 100 forms), contact Ellsworth & Vandermeer Press, 4405 Scenic Drive, Nashville, TN 37204. Telephone: (615) 386-0061. Fax: (615) 386-0346.] ■

Accountability produces results, says NCQA report

Plans reporting HEDIS have high satisfaction

Health plan accountability received a boost from the most recent analysis of performance indicators, with plans that publicly reported their figures fairing better than those that collected HEDIS data but declined to report the results.

The third annual *State of Managed Care* report, released by the National Committee for Quality Assurance (NCQA) in Washington, DC, also showed a link between higher HEDIS scores and high patient satisfaction. Plans in the top quartile of HEDIS effectiveness of care indicators had consistently higher ratings of satisfaction with care, service, access, plan, and provider.

"This is tremendously important," says NCQA spokesman **Barry Scholl**. "What it means is that employers, who are vitally interested in high satisfaction rates, now have a really clear reason to choose plans that are delivering high clinical quality. The data can't be disputed. Across every single measure of care, the plans that perform best on HEDIS also have the highest satisfaction scores."

In fact, amid the success of HEDIS, two state-based organizations are working toward quality measurement at the medical group and even

The Value of Publicly Reported Data

The latest quality of care data released by the National Committee on Quality Assurance in Washington, DC, showed a significant advantage for health plans that consistently report data for public review. Here are some of the results:

Measure	3-Year Public Reporters	First-Year Reporters
Adolescent Immunization Status	67.9%	42.9%
Advising Smokers to Quit	66.1%	59.9%
Antidepressant Medication Management	55.0%	52.1%
Beta-Blocker Treatment	85.0%	72.8%
Breast Cancer Screening	76.1%	68.9%
Cervical Cancer Screening	75.4%	64.7%
Chicken Pox Vaccination	52.6%	49.8%
Childhood Immunization Status	72.8%	58.0%
Cholesterol Screening	63.6%	55.3%
Eye Exams for Diabetics	49.4%	38.0%
Mental Health Follow-up	76.1%	63.3%
Prenatal Care in the First Trimester	87.7%	78.6%

individual physician level. **(See related article, p. 117.)**

This year's Quality Compass database includes information from 247 managed care organizations on 410 health plan products covering about 70 million Americans. Another 112 managed care organizations provided data for national averages and benchmarks.

Measurement produces quality improvement

Perhaps the most important conclusion that outcomes experts draw from the NCQA data is a link between measurement and quality improvement.

Those plans that have publicly reported HEDIS for three years showed the greatest improvement. For example, diabetic eye exams rose from 45% in 1996 to 49% in 1998, while beta-blocker use after heart attacks rose from 70.5% to 85%. In 1998, first-year reporters had a rate for diabetic eye exams of 38% and beta-blocker use of 72.8%. **(See chart, above.)**

Performance measurement leads to a commitment to quality improvement, says **James Marks**, MD, MPH, director of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention in Atlanta.

"Those that reported for several years show, on average, steady improvement," says Marks. "That means that a commitment that's characterized by persistent management attention can make a difference, can lead to improved quality. For those that are new to the process, we can hope that they'll show the same improvement over time."

Quality of care indicators also may encourage plans and medical groups to work together on common improvement goals, says Marks. For example, health plans may provide resources for patient education and self-management that can ultimately improve outcomes.

"Patient education on self-management can substantially improve how well people take care of their condition," says Marks.

Other findings from the NCQA *State of Managed Care* report include:

- The greatest gains occurred with relatively new measures. For example, the average reported rate for beta-blocker use after heart attack rose from 62.5% in 1996 to 79.9% in 1998. The average rate for chicken pox vaccine rose from 40% in 1996 to 51.9% in 1998.
- On a scale of 1 to 10, 71.7% of managed care plan members gave their physician or other provider a rating of 8 or higher. In the highest performing plans — those in the 90th percentile — 77.9% of members gave those high ratings.
- Health plan performance varied widely among regions of the country and within regions. New England health plans outscored other regions in nine out of 12 measures, while the South Central region recorded the lowest averages.
- More than 85% of the data in Quality Compass was audited by independent auditors in accordance with NCQA standards. ■

Will 'accountability' work for medical groups, docs?

Expanded projects seek more feedback, less burden

Recognizing that health plan ratings give only a limited picture of health care quality, nonprofit groups in California and Massachusetts are looking for ways to expand measures to hospitals, medical groups, and even individual physicians.

The California HealthCare Foundation, based in Oakland, launched its Quality Initiative, in part, to explore performance measurement and accreditation at the medical group level. This year, the foundation and the California Hospital Association sponsored a survey project to measure the quality of the patient experience at 140 hospitals statewide. The foundation will publicly report results after giving hospitals a year to conduct quality improvement.

"Publicly reporting the data [alone] stimulates improvement," says **Ann Monroe**, MA, director of the Quality Initiative. Medical groups also could benefit from the feedback of a measurement system, she says. "Without that kind of common metric across [medical groups], quality improvement activities are driven not by what standardized measurement shows as your areas of improvement, but what you think is important."

Meanwhile, organizations such as the California Health Care Foundation are concerned about lessening the burden and expense of data collection, both for medical groups and health plans.

That concern prompted the Massachusetts Health Quality Partnership in Boston to study the feasibility of a collaborative that would allow health plans to jointly sponsor a patient survey about care provided by individual physicians. Physicians would receive their own results but the data would not be publicly reported, says **Gina Rogers**, a founder and now a consultant with the Health Quality Partnership.

Balancing the need for accurate and valid data with the cost and burden of data collection is a delicate task. A recent article in the *Journal of the American Medical Association* highlighted the large sample sizes that are needed to distinguish quality differences among physicians. **(See *Patient Satisfaction & Outcomes Management*, August 1999, p. 87.)**

Health plans currently survey members about their experiences with physicians, but often, the plans don't capture a large enough sample size to make comparisons valid. "If you really want to use a survey like this to compare [performance] at a physician level, you have to [have] an awful lot of surveys," says Rogers. "No one plan can afford to do that at the physician level."

A collaborative effort would improve the validity and usefulness of the surveys by creating a much larger pooled sample size. The surveys would include questions about preventive care, the patient's opinion of the doctor's technical competency, and doctor-patient communication, Rogers says.

Because the collaborative would simply involve a new method of collecting information that individual health plans already measure, the concept has not garnered opposition. However, it is still in formative stages. "Our mission right now is to have an improved set of information flowing about the physician to the health plan," she says.

Finding relief from data burden

For medical groups, the expense and burden of collecting quality-related information can become overwhelming when they must fulfill redundant demands from different entities, Monroe says.

To address that concern, the California Health Care Foundation is considering whether to cultivate a new physician organization accreditation program. Such accreditation ended when the Medical Quality Commission in Seal Beach, CA, disbanded in 1998.

"Medical groups are inundated with inspections, audits," says Monroe. "We have medical groups that have 50 audits a year — from every health plan for every line of business, HMO regulators, state health departments. It's a lot of duplication and repetition."

The California HealthCare Foundation also is working in partnership with the Pacific Business Group on Health (PBGH) in San Francisco to expand the scope of the Physician Value Check Survey, a patient survey that is used to measure and report the quality of medical groups. For example, the foundation is sponsoring a statewide public information campaign to inform consumers about how to judge health care quality and where to find information on medical groups, hospitals, and health plans.

Monroe also would like to see even more groups join the voluntary project. The Physician Value Check Survey now covers 63 medical

groups, including most of the large medical groups, says **Cheryl Damberg**, PhD, PBGH's director of research and quality. California has about 300 medical groups, many of them with just a few physicians.

Currently, neither the foundation nor the business coalition plans to collect data at the individual physician level. While in some states, a medical group may have little identity for consumers, in California, many medical groups have taken on some responsibilities of managed care organizations, such as credentialing or utilization review. "For our purposes, it is an appropriate unit to hold accountable," Damberg says. ■

Does managed care bring low cost, high quality?

Study suggests it does, but experts are wary

Can lower costs actually go hand in hand with higher quality? Has managed care achieved that goal?

A study by Health Risk Management (HRM) in Minneapolis suggests there is a relationship between low cost and high quality. But outcomes experts caution that the question is far from settled.

"Over and over again, we find studies that show in any [payer] structure we look at there's vast amount of room for improvement," says **Robert H. Brook**, MD, vice president of Rand in Santa Monica, CA, and director of Rand's health program. "Right now, we can't say managed care has improved quality substantially. Neither can we say that fee-for-service was so good that it couldn't be changed."

In the QualityFIRST Index of HRM, states with high quality rankings also had low per capita health care costs, while the reverse was true of states that ranked in the bottom 10 or 25 for quality. The low-cost, high-quality states also tended to have higher than average penetration of managed care. **(See chart, at right.)**

The states were rated based on 46 indicators, including economic measures (such as unemployment, lack of health insurance, and poverty), population health (such as overweight, violent crime, air pollution, and smoking), and outcomes (such as preventable hospital admissions, complication rates, and self-reported health status).

"We're trying to show states, health plans, and consumers how their states stack up against other states in very specific areas that other surveys may not cover," says **George Ryan**, HRM director of information services. "We feel it's a unique study." The report includes mini-profiles of states, highlighting their strengths and weaknesses as revealed by the indicators.

Outcomes experts agree that managed care has the potential to lower costs while raising quality. But whether it has or not may never be known, says Brook. "It's very, very hard to change a

Link Between Quality and Cost

The 1999 QualityFIRST Index published by Health Risk Management in Minneapolis showed that states ranking high on quality indicators also had lower per capita costs, while low-ranking states had relatively higher costs. Here are the rankings and cost figures:

Top 10

Quality Rank	State	Per Capita Health Care Costs
1	Minnesota	$228
2	Hawaii	$227
3	Wisconsin	$218
4	New Hampshire	$235
5	Vermont	$218
6	Massachusetts	$315
7	Connecticut	$274
8	Washington	$230
9	Maine	$221
10	Iowa	$222

Bottom 10

Quality Rank	State	Per Capita Health Care Costs
41	Kentucky	$253
42	Texas	$253
43	Alabama	$218
44	New Mexico	$223
45	South Carolina	$231
46	Oklahoma	$315
47	Tennessee	$295
48	Arkansas	$248
49	Louisiana	$317
50	Mississippi	$255

Average of top 10 states:	$239
Average of top 25 states:	$246
Average of bottom 10 states:	$260
Average of bottom 25 states:	$268

nonmanaged system. The potential to produce good is there [in managed care]. "I don't think that potential has been realized in most current organizations," says Brook, who is professor of medicine and public health at the University of California at Los Angeles. But there's very little evidence that it produced lower quality than what was there before it took over."

One difficulty arises in the definition of managed care. There's tremendous variability in contracting arrangements and competitive forces in different markets, says **Neill F. Piland**, DrPh, research director of the Center for Research in Ambulatory Health Care Administration of the Medical Group Management Association in Englewood, CO.

"Are you comparing the same kind of contracting managed care organizations?" he asks. "There's a tremendous difference between a closed panel HMO and a preferred provider organization or point of service organization. The incentives offered are tremendously different."

Providing disease management and preventive care can save money in the long term, but they require a substantial investment to implement, notes Piland.

In fact, Brook asserts that too much attention is paid to small differences between payment systems while health care in general is plagued with significant overuse and underuse. "We ought to hold both managed care and fee-for-service accountable for providing a quality product that it isn't currently," he says. "Both areas have a lot of waste, and both areas fail to do a lot of things that people need." ■

NEWS BRIEF

AHCPR searches for new ways to define quality

The Agency for Health Care Policy and Research (AHCPR) in Rockville, MD, is looking for new ways to define quality inpatient care.

As part of its Evidence-based Practice Center program, researchers will identify indicators related to pediatric admissions, chronic medical conditions, and hospital admissions that could have been avoided with appropriate primary care interventions.

The indicators will become part of AHCPR's HCUP Quality Indicator database. A team from the University of California at San Francisco and Stanford University will conduct the work.

AHCPR announced other evidence-based practice center assignments, including the efficacy of behavioral dietary interventions to reduce cancer risk and the diagnosis and management of osteoporosis. ■

Patient Satisfaction & Outcomes Management™ is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Co-publisher is Medical Group Management Association, Web site: www.MGMA.com. Application to mail at periodical rates is pending at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient Satisfaction & Outcomes Management™**, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6:00 Monday-Thursday, 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $329. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $197 per year; 10 to 20 additional copies, $132 per year. For more than 20 copies, call for more information. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $55 each. (GST registration number R128870672.)

This continuing medical education offering is sponsored by American Health Consultants®, which is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association.

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CME questions

1. According to Susan Edgman-Levitan, PA, president of The Picker Institute in Boston, when patients receive treatment from several specialists and a primary care physician, how should they know who is ultimately in charge of their care?
   A. The primary care physician is always in charge.
   B. Chronic disease specialists take precedence over others.
   C. The medical team should tell the patient who is responsible for overall care and who to contact with questions.
   D. The patients are ultimately in charge of their own care.

2. To break down barriers for patients who could benefit from behavioral health care, HealthCare Partners in Torrance, CA, created a collaborative that:
   A. linked primary care and behavioral health in the same office space
   B. gave primary care physicians special training in psychotherapy
   C. provided phone referral services
   D. increased the use of psychological screening tools

3. According to Frances Page Glascoe, PhD, associate professor of pediatrics at Vanderbilt School of Medicine in Nashville, TN, how many children have some kind of developmental problem?
   A. 3%
   B. 7%
   C. 18%
   D. 25%

4. The 1999 *State of Managed Care* report of the National Committee for Quality Assurance in Washington, DC, showed what connection between quality of care indicators and patient satisfaction?
   A. Health plans with high quality ratings also had high patient satisfaction.
   B. Health plans that stressed preventive care showed greater satisfaction with access to care.
   C. Health plans that improved on quality indicators showed a proportional improvement in patient satisfaction.
   D. There was no connection between quality indicators and patient satisfaction.