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Physicians vs. MCOs: Can they cooperate to improve care quality?

Here's two approaches to investing in physician-driven care

The well-entrenched notion that quality improvement efforts cause more contention than cooperation between health care plans/payers and physicians probably isn't going away completely any time soon. Old attitudes die hard, including those of plans and doctors.

But progress is being made in getting both parties moving in the same direction on issues of quality measurement and improvement. At least some of this progress is due to the actions of the plans themselves; a couple of them are seeing the potential benefits of supporting physician quality improvement efforts through investments of time, staff, resources, and dollars.

In those instances, one plan emphasizes providing physicians with necessary information and staff support. Another has taken the approach of directly funding physician QI. And the common thread linking both approaches is the realization that all health care is delivered by physicians, and their buy-in and involvement from the start is crucial to the success of any quality improvement effort.

Key points

- The notion persists that quality improvement efforts cause more contention than cooperation between health care plans/payers and physicians.
- Some plans are overcoming this by investing a variety of resources in physician quality improvement projects — and involving physicians from the start.
- Aetna U.S. Healthcare Research takes a collaborative approach to physician quality improvement.
- Detroit's Health Alliance Plan has awarded $3.9 million in grants to fund physician quality improvement projects — as drawn up by its physician groups.

One way for health plans to support physician QI efforts is by giving them useful information. But there is more to this than just instituting a one-way flow of practice guidelines and other types of bureaucratic edicts.

"In our experience, collaboration is key," says **Roseanne Waters**, director of operations for Aetna U.S. Healthcare (formerly Prudential) Research Center in Atlanta. "Our interactions with providers have always been positive, in part, because we go to the physicians themselves and ask them what they feel are the key issues they need to get information about," she says. And guided by this input, "We provide them with the scientifically sound information they need to improve the care they are giving."

The Research Center also often combines the role of information provider with that of a support organization in efforts to improve the quality of care provided by physicians, Waters explains. For example, in a still-active study targeting pediatric vaccination coverage levels, "We began by performing the chart reviews for patients under the age of two at seven practice sites, with the objective of providing the physicians and nurses with feedback on their performance in this area."

Feedback and consultation

But rather than merely generate reports on individual and aggregate physician performance, Research Center personnel utilized a collaborative, supportive approach. "We took the results of our chart reviews and presented them [to participating physicians] in a number of small-group meetings," says Waters, "which allowed for in-person discussion of the reviews and the findings."

Based on these discussions, the Research Center then collected a variety of types of information, including national and state-level vaccination coverage data; lists of their pediatric patients not up-to-date on immunizations; and data on how other plans and providers had improved pediatric immunization rates. The information was then distilled and channeled to the physician / nurse group. "This, in turn, led to further discussions on potential interventions that could be used to improve performance in this area," notes Waters, who adds that preliminary study results show much improvement in immunization coverage rates for the subject population.

This kind of collaborative, information provider / staff support approach is effective in all physician quality improvement efforts, adds Waters. "It is a lot more comprehensive than just coming up with performance measures. Instead, we put ourselves in the role of providing the physicians with the information and tools they need to help them identify the best ways to improve, and we are there to give them feedback and consultation as needed."

Health Alliance Plan (HAP), a Detroit-based nonprofit managed care plan serving 500,000 members and 3,000 employer groups, has taken what is widely considered to be a unique approach to improving the quality of care provided by physicians. HAP has awarded grants totaling $3.9 million to affiliated physicians in its largest provider networks to both improve and track the quality of medical care patients receive. The Invest in Quality grant program funds new or expanded programs — as proposed and drawn up by physician groups — that stand to improve the group's performance in clinical measures of quality care.

"We're creating a health care paradigm where physicians and health plans collaborate to make sure members are getting enough medical care," says **Cleve Killingsworth**, HAP president and CEO. "Our vision is that Invest in Quality will spur a new paradigm in health care that reaches beyond the current political debate and demonstrates that physicians and health plans can and do work together to achieve the highest standards of health care."

"There has been a widespread perception that the managers and providers of care have not necessarily been partnering, cooperating, or collaborating on these kinds of quality improvement efforts," says **Ann Waters**, director of quality management at HAP. " My own feeling is that this has been taking place on an informal basis, but maybe not in ways that are readily visible."

HAP's Invest in Quality has provided financial support for a number of high-profile quality

COMING IN FUTURE MONTHS

- Home health care: Issues and best practices (2-part series)
- The shift to APGs
- Recruiting and retaining nursing personnel
- Fostering needed organizational change
- New data sources

improvement efforts. Recipients and efforts funded through the program to date include:

❒ **Mercy Oakland Physician Network** (MOPN) in Pontiac/Bloomfield Hills, MI received an Invest in Quality grant for support of a computerized system that simplifies the process physicians use to order medications for hospitalized patients. Instead of the typical, multistep process involving physician order sheets, nurse transcription, and clerical input, MOPN physicians can place a medication order directly into the computer at the point of care, eliminating several steps and reducing the chances for error. MOPN also received funds for a disease management center to improve the treatment of congestive heart failure, pediatric asthma, and adult diabetes.

❒ **Henry Ford Medical Group** (HFMG) in Detroit received grants to support mechanisms that ensure patients receive preventive services in mammography and cervical cancer screening, childhood immunizations, diabetes management, smoking cessation, and beta-blocker usage. A centralized call center will target at-risk patients who need these medical services and contact them for appointments, while automated medical record workflow software will enable HFMG physicians to call up background information and quickly determine which preventive services a patient should receive during office visits. Meanwhile, the HFMG mammography and cervical cancer screening initiative will also address access issues, missed opportunities due to lack of patient awareness, appropriate documentation and triggers, and patient education.

❒ **Providence Medical Group** (PMG) in Southfield, MI, received a grant to implement a project that will increase the diabetic eye exam rate to 65% in an effort to screen for diabetic retinopathy, the leading cause of blindness among American adults. PMG is implementing a system where a project coordinator works with physicians, ophthalmologists, and patients to expedite referrals. Ophthalmologists will generate monthly reports listing referred patients who have had exams, as well as those who either did not schedule visits or did not show up for appointments. After two unsuccessful attempts by the ophthalmologist to schedule and complete the eye exam, the project coordinator will contact the patient directly via certified mail. The coordinator will also audit patient records to ensure that ophthalmologists' reports are received by the physician and kept in the patient's medical records.

All projects funded under the Invest in Quality program originate with physician groups, and have to tie in with positive impacts on HAP's HEDIS scores, according to Ann Waters. "Projects must demonstrate evidence that HAP and its providers do indeed provide the highest — and possibly the benchmark — quality of care available." And by working in partnership with the physicians who provide the care, she adds, "We are making sure that our members receive a standard of care that is both proposed and supported by members of the medical community."

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ADS centers test a new data set to improve care

Tool provides infrastructure for benchmarking

Field-testing is now under way for an assessment tool that will enable performance measurement and help establish benchmarks for adult day services (ADS) centers, a relatively new form of long-term care that is growing in popularity.

Supported by funding from the National Institutes of Health (NIH), Oakland CA-based

Key points

- The adult day services (ADS) center is an approach to the treatment of adults whose ability to live independently is threatened or impaired. In practice, it can be referred to by many names, including adult day support centers, adult day health care, medical day care, day treatment, and Alzheimer's day care programs.
- As a model of care, the ADS concept has taken on many different "flavors" as far as the mix of services it offers in response to community-level needs, which is not an altogether good thing.
- An assessment tool that will enable performance measurement and help establish benchmarks for ADS centers is now being field-tested.

RTZ Associates is rolling out its ADS Data Set for ultimate use in the approximately 7,000 ADS centers located across the country. ADS centers in Alameda County, CA, began using the data set this past summer; it is now being implemented in centers located in Iowa, Arizona, Washington, and Hawaii.

There is a tremendous need for this type of tool in the ADS industry, according to RTZ Associates senior partner **Rick Zawadski**. "At present, ADS centers serve many different types of consumers, making record keeping and measuring success across programs difficult — much like comparing apples and oranges."

"By setting up a standardized data system, we will, for the first time be able to compare clients and programs. The resulting information can be used to improve reimbursement of ADS centers, improve their service delivery systems, and institute policy change," Zawadski adds.

The ADS center model

The ADS center is an approach to the treatment of adults whose ability to live independently is threatened or impaired. In practice, this concept is referred to by many names, including adult day support centers, adult day health care, medical day care, day treatment, and Alzheimer's day care programs. The ADS is a current version of a model of care that Zawadski helped create in California in the early 1970s. These centers can provide a wide range of services (i.e., a continuum of care) stretching from very limited direct services to extensive and intensive medical and rehabilitation therapies, depending upon the needs of the participants being served and the resources available.

According to the California Association for Adult Day Services (CAAD), ADS centers:

- **are designed for adults who are frail and/or physically, cognitively, or emotionally impaired** with conditions such as heart disease, cerebrovascular disease, Parkinson's disease, diabetes, arthritis, Alzheimer's disease or other related dementia;
- **emphasize keeping each participant at their highest degree of independence and well-being;**
- **offer a daytime program with some combination of psychosocial, health, and/or rehabilitative services** in a setting that is enjoyable, emotionally supportive, and relatively informal;
- **bring participants together in a group to promote socialization**, provide peer support, and strengthen participant self-esteem and motivation for self-care, as well as control costs.

Generally speaking, clients usually spend some four to six hours a day at an ADS center, according to Zawadski. "In some instances, the center simply provides people with a brief respite from caring for a elderly, frail family member," he explains. "But for many, the center is a place where the client can receive the therapeutic regimens [such as occupational and/or physical therapy] and support services [such as meals and assistance with personal care] they need to stay out of a nursing home."

From the cost standpoint, ADS centers compare favorably with other care alternatives for the frail and elderly. A day at an ADS center is usually around half the price of a home health care visit, according to Zawadski. Meanwhile, the annual cost of three to five days a week at an ADS Center is also about half that of full-time nursing home care.

Generally, in California, says Zawadski, a day at an ADS center costs $64, which includes all services. A nursing home day is more than $100, which does not include therapies and other specialized services that are typically included at the ADS Center. However, the typical ADS customer uses the center three to five days a week; the typical nursing home patient is a seven-day a week customer.

The relatively low cost of the ADS model of care has led to its increasing popularity nationwide. "The ADS center as a phenomenon has taken hold in many communities," says Zawadski. And, at the same time, the model has taken on many different

CADCare 4.0 Core Data Set

The CADCare 4.0 Core Data Set

Assessment Components Include:

Medical Assessment: Assessment items include diagnosis identification, severity ratings, ICD-9 Codes, medication, allergy, and vital signs tracking

Sensory/Motor Skills Assessment: Sensory ability, communicative ability and limb use ratings with adaptive equipment.

Functional Assessment: Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as assessed with adaptive devices.

Cognitive/Psychosocial Assessment: Cognitive ability assessment, psychological, social and behavioral characteristics assessment, DSM-IV codes, Mini-mental score.

Financial Assessment: Client monthly and annual income, monthly expenses, funding eligibility.

Housing Assessment: Accessibility, resources, and safety assessment of client's current residence.

Support Assessment: Assessment of client's informal and formal support networks.

Source: RTZ Associates, Oakland, CA.

"flavors" as far as the mix of services it offers in response to community-level needs — which is not an altogether good thing.

"Depending on the location, the services offered by the ADS center can vary widely," says Zawadski. "Some facilities are basically social centers with an activities director, while others may provide some monitoring of people who are cognitively impaired and need to be protected," he notes. "Still others may offer extensive therapeutic services. But they all go under the ADS center name."

The impact of these operational/service disparities is twofold. Funding sources for these centers, which include Medicaid, private-payer, and special-purpose (such as Alzheimer's care) programs, are confused by the wide disparity of activities and costs associated with ADS centers, leading to the model being "under-recognized," says Zawadski.

"Moreover, people in the field think that there is no real way to measure what ADS centers are doing and that it's impossible to compare what they do with other services," he says. And at the same time, "We also don't know how to compare across different programs, which we need to be able to do to improve quality."

RTZ Associates' ADS Data Set was developed to help remedy these situations. Designed for use in paper-based systems or with RTZ's proprietary enterprise software program (CADCare), the ADS Data Set will create a repository of information that can be used to compare how these centers assist clients with different types of disabilities. With room for data that cover client characteristics, activities, outcomes, billing, scheduling, coordination of services, contact monitoring, and medical reports, the system "tracks everything that can happen within a center with a client," says Zawadski. **(See box, p. 124.)**

Data elements within the system have been selected from appropriate elements found in the Health Care Financing Administration's Long Term Care and OASIS home health care data sets, reports Zawadski, along with those from the Administration on Aging's National Aging Program Information System. "We took elements from all these tools, and added some we felt were missing that applied to the operation of ADS Centers," he says.

By using elements from these established data sets, "We think we have created a tool that is not only easy to use but also one that can be used to link up with these other sets, and allow ADS providers to demonstrate outcomes using terminology that is familiar to traditional acute and long-term care providers," he says.

And in what should be a boon to benchmarking efforts, ADS providers also will be able to share collected outcome data over the Internet, "creating a living database for ADS managers, researchers, advocates, and policymakers to study and evolve the role of ADS in the long-term health care continuum," says Zawadski. Individual participating centers will receive confidential reports of their outcomes and will be able to compare their performance against other centers. "And at the program level," he notes, "providers will benefit by being able to anonymously compare their center's performance to state and national averages."

RTZ's development of the ADS Data Set has been assisted by two phases of funding over four years by the NIH's Small Business Innovation and Research program. The company also manages an extensive Web site that provides information on long-term care services for individual caregivers and the industry at large.

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Study quantifies diabetes management outcomes

DAP connects docs, patients, and information

The sponsors of a recently concluded diabetes disease management pilot study hope that the results of their work will bring primary care providers the tools and information they need to provide better diabetes care.

The 17-month study was a joint effort by two major health care concerns:

1. Diagnostics Division of The Roche Group, the international pharmaceuticals company, whose products include the Accu-Check blood glucose monitoring system.

2. Sierra Health Services, a Las Vegas-based health care services company that operates HMOs, indemnity and workers' compensation insurers, PPOs, and a multispecialty medical group.

The focus of their efforts was on improving

Key points

- Diabetes mellitus currently affects some 16 million Americans, and more than 150,000 people die from diabetes and its complications each year.
- Studies show that many, if not all, of the complications of diabetes can be slowed or even prevented by better management on the part of the health care team and the patient.
- A 17-month study by Roche Diagnostics and Sierra Health Services examined the impact of expediting the availability of patient and treatment-option information on patient outcomes.

the methods of managing patient populations with diabetes mellitus. According to the Diabetes Quality Improvement Project (DQUIP) diabetes mellitus currently affects some 16 million Americans, and over 150,000 people die from diabetes and its complications each year. "The annual cost of diabetes has been reported to be nearly $100 billion," according to DQUIP, making it "one of the deadliest and most costly diseases known." The coalition includes the American Diabetes Association, the Foundation for Accountability, the Health Care Financing Administration, and the National Committee for Quality Assurance (NCQA), the American Academy of Physicians, the American College of Physicians, and the Department of Veterans Affairs.

Most of the morbidity and mortality of diabetes is due to the complications associated with the disease, according to a recent DQUIP statement, including blindness, kidney failure, nerve damage, and cardiovascular disease. "Studies show that many, if not all, of the complications of diabetes can be slowed or even prevented by better management on the part of the health care team and the patient. Improved blood glucose control, regular eye examinations, and reduction in cholesterol and blood pressure are some of the practices that have been unequivocally shown to reduce complications and the heavy personal and financial toll of the disease."

Roche Diagnostics has historically invested heavily in medical research activities at the consumer, physician, and managed care plan levels, according to **Ron Peyton,** the company's director of managed care and health management. And Sierra wanted to improve its approach to diabetes care.

When the two organizations joined forces in late 1997, the result was the Diabetes Advantage Program (DAP). "We worked with Sierra to put together a comprehensive health management approach to improve diabetes care among its population. What we wanted to do was build a program that combined risk stratification and patient education, along with software reporting and tracking tools, to assist Sierra in better meeting patient needs," he explains. "At the same time, we also wanted to enable Sierra to better meet the various managed care benchmarks that are being applied to the treatment of diabetes through NCQA, DQUIP, The Health Care Financing Administration, [the Joint Commission on Accreditation of Healthcare Organizations], and others."

"Overall, we wanted to improve the quality of patient outcomes in terms of HbA_{1c} levels, lipid levels, and blood pressure management," says **Linda Stutz**, manager of health management development for Roche Diagnostics. In addition, "We wanted to increase the level of patient satisfaction with Sierra's diabetes care program, as well as with the overall level of service from the health plan."

And, importantly, "We wanted to create a program that would not increase the workload of the primary care physician," says Stutz, "but, in fact, could increase his or her ability to deliver quality care within the existing outpatient clinic setting." This final point is an important one, she notes, because research has shown that 90% of all diabetes care is done by primary care physicians, as opposed to specialists.

Program's care standards set by physicians

Although approximately 600 total Sierra diabetes patients were enrolled in the DAP, only about 250 of them were "academically enrolled" and included in the actual study, according to Peyton. This latter group met the study's inclusion / exclusion criteria: ages 21 to 75, no major health risks, no end-stage renal disease, and no current involvement in any other studies. Other enrollees, who did not necessarily meet these criteria, came on board "due to physician excitement about the program," he notes.

At least some of this excitement may have been due to the large role participating Sierra physicians played in setting the standards for the program. "We brought the physicians together so that they could establish exactly what their standards of care are for diabetes," says Peyton. "We

asked them to put these standards in terms of what factors they felt were most important to monitor." Those factors included HbA_{1c} levels, lipid levels, and blood pressure, as well as foot condition and complications of diabetes such as retinopathy and nephropathy.

The various factors were then rank-ordered by the physicians to provide a stratified classification system for placing diabetic patients in categories for high, medium, and low risk of serious complications. The physician group then determined what they felt were the appropriate medical responses, coming up with definitions of appropriate treatment / intervention options for diabetes patients within each risk category.

These options, or "standing orders" for each risk category, were entered into a computer software program specially designed for the DAP, according to Peyton. Meanwhile, the clinical characteristics and / or lab profiles of participating diabetes patients were entered into the same program. A designated staff person — called a tracker — was charged with the responsibility of getting diabetes patients in for appropriate lab testing as well as entering all data into the software program.

Constructing 'a better world'

Having a physician-generated risk classification system, individual patient lab profiles, and standing orders for treatment / intervention linked within a computer database created what Peyton calls "a better world" for both physicians and diabetics in the DAP study.

Once brought into the program, each patient received a report stating where they were on the risk continuum and what course of action they should follow, according to Peyton. And at the same time, physicians got reports for each patient stating lab results and where they fell in terms of risk, along with the standing orders / recommendations for appropriate treatment — as formulated by the participating physicians at the beginning of the program. And in the DAP study, these events occurred before any patient / physician encounter took place — a situation that is not the norm in today's health care environment.

For a patient, a visit to a physician's office is typically a starting point, kicking off a series of events including observation, testing, diagnosis, and treatment. But, "in the better world we have constructed with Sierra, by the time the diabetic patient hits the physician's office with a complaint, explains Peyton, "the lab profiles, the results of previous examinations, and the standing orders are already there."

In short, there's magic in having the physician, the patient, and the necessary knowledge all in the same room at the same time, he says. "There's no time lag, no waiting for test results." Freed from basic patient information gathering, "Physicians become empowered to try to find out what is unique about this patient and can expend their efforts on creative thought on how they can uniquely intervene."

The Roche / Sierra DAP concluded in October. A preliminary look at the results showed that the program had positive impacts on meeting Health Plan Employer Data and Information Set requirements, as well as on patient and physician satisfaction levels. At press time, the official results from the first six months of program operation were slated for presentation at the 35th annual meeting of the European Association for the Study of Diabetes (EASD) in Brussels in late September. Full results are scheduled for tabulation and release in early 2000.

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Check out marketplace with these data sources

New facts and figures are now available

Maybe your benchmarking efforts require you to put together some comparative data on the costs of treating various maladies in a hospital setting. Maybe you need to get a handle on recent trends in the nursing home industry. You may be heading up your organization's marketing effort to penetrate the over-65 segment of the population and need to know more about the characteristics of Medicare beneficiaries. Or, you may need some MSA-level (Metropolitan Statistical Area) data on HMO penetration.

If you fall into any of the above categories, you're in luck. There is a source of new and / or recently updated data (or maybe one you've just

missed) out there that can help fill at least some of your information needs. Check below for details on a number of data products now available, including content, contacts, and pricing information:

The Medicare beneficiary population is often described in homogenous terms, yet those covered by the program vary significantly in terms of their health, income, supplemental insurance status, and medical service use. Produced by the Henry J. Kaiser Family Foundation, *The Faces of Medicare* is a new publication that profiles the groups within the Medicare population, providing basic information, trends, and data on six sets of beneficiaries that include:

1. healthy retirees, who represent less than 10% of the total Medicare population, but sometimes are portrayed as typical of all seniors;

2. under-65 disabled beneficiaries, whose disproportionately high rates of health and cognitive problems are compounded by low incomes;

3. racial and ethnic minority beneficiaries, who by 2025 will account for one in three Medicare beneficiaries;

4. beneficiaries with cognitive impairments, now nearly one in four Medicare beneficiaries, who face unique challenges navigating the health care system;

5. low-income elderly and disabled, who remain among the most vulnerable;

6. women, who constitute more than 56% of Medicare beneficiaries but nearly 70% of Medicare's poor.

Health care professionals designing service delivery systems targeted at Medicare beneficiaries will want to be familiar with the data *Faces* provides on each of these groups, which includes information on general demographic characteristics, health service use, insurance coverage rates, long-term care needs, and special issues.

The beneficiary-level profiles provided by *Faces* are complemented by state and regional data offered in a companion Kaiser Foundation publication, *Medicare State Profiles: State and Regional Data on Medicare and the Population It Serves.* Although Medicare is a national program, there are substantial variations across states and regions in terms of beneficiary characteristics, health needs, and utilization of Medicare-covered services, according to this report. Likewise, there are also considerable differences in Medicare spending and the emergence of Medicare managed care. In a single resource document, *Medicare State Profiles* presents state by state demographic data on the Medicare population, along with information on health service utilization, spending, and Medicare HMO penetration. It also provides regional data on the distribution of beneficiaries by poverty level, self-reported health status, and insurance coverage.

The Faces of Medicare (www2.kff.org/content/1999/1481/) and *Medicare State Profiles: State and Regional Data on Medicare and the Population it Serves* (www2.kff.org/content/1999/1474/) are both available at no cost on the Kaiser Family Foundation Web site (www.kff.org). You'll need Adobe Acrobat Reader to access the documents. Other publications on Medicare are available on the Foundation's Medicare Policy Project Web site (www2.kff. org/sections.cgi?section=medicare).

AHCPR hospitalization, nursing home data

Hospital Inpatient Statistics, 1996 is the latest in a series of statistical publications from the U.S. Agency for Health Care Policy and Research (AHCPR) showing why Americans are hospitalized, how long they stay in the hospital, the procedures they undergo, and the charges for their stays. In short, "This in-depth profile of inpatient care answers many key questions about how specific conditions are treated in hospitals and the resulting outcomes," says AHCPR administrator **John M. Eisenberg**, MD. "It contributes to the evidence base needed to develop effective strategies for improving the quality and value of health care."

The most common reasons for hospital admission in the United States, based on 1996 data, are births (3.8 million admissions), followed by coronary atherosclerosis (1.4 million), pneumonia (1.2 million), congestive heart failure (990,000), and heart attack (774,000), according to *Inpatient Statistics.* Meanwhile, the most expensive conditions, or diagnoses, among those treated in U.S. hospitals in 1996, were spinal cord injury ($56,800), infant respiratory distress syndrome ($56,600), low birth weight ($50,300), leukemia ($46,700), and heart valve disorders ($45,300). These figures are expressed as average charges for the entire stay.

In the length of stay arena, patients stayed in the hospital an average of five days overall. But stays involving premature birth, with problems such as low birth weight and slow growth of the fetus, averaged 23 days. Stays because of infant respiratory distress syndrome averaged 22 days, and patients with spinal cord injuries remained hospitalized an average of 16 days.

Inpatient Statistics estimates are based on all-payer data from AHCPR's Nationwide Inpatient

Sample **(see NIS database update section, below)**, which approximates a 20% sample of U.S. community hospitals. The database is part of the Healthcare Cost and Utilization Project (HCUP), a federal-state-industry partnership to make high-quality hospital data available for research purposes.

Meanwhile, for professionals and practitioners active in the development and/or operations of nursing homes, AHCPR's *Nursing Home Trends, 1987 and 1996*, provides comparative information about nursing homes and their residents for these two points in time. It features findings from AHCPR's 1996 Medical Expenditure Panel Survey (MEPS) and the 1987 National MEPS Institutional Population Component. Highlights include:

- From 1987 to 1996, the proportion of nursing home residents 85 and older rose from 49% to 56% for women, and from 29% to 33% for men.
- The numbers of nursing homes and nursing home beds both increased by almost 20% from 1987 to 1996, from 14,050 homes/1.48 million beds in 1987 to 16,840 homes/1.76 million beds in 1996.
- The number of nursing home residents needing help with three or more activities of daily living such as bathing, dressing, transferring, feeding, and toileting, increased from 72% in 1987 to 83% in 1996.
- In 1996, the most common type of special care unit was for treatment of Alzheimer's and related dementias.
- Between 1987 and 1996, there was a trend toward incorporating assisted and/or independent living beds within traditional nursing home facilities. The proportion of these beds rose from 6.9% in 1987 to 11.3% in 1996.

Both *Inpatient Statistics* (AHCPR Publication no. 99-0034) and *Nursing Home Trends* (AHCPR 99-0032) are available at no charge. Contact AHCPR by mail at the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547; or, by phone at (800) 358-9295. The agency's Web site is http://www.ahcpr.gov.

NIS database update

Also from AHCPR, the Nationwide Inpatient Sample (NIS) Release 5, featuring data on hospital inpatient care, conditions, services, and costs, is available on CD-ROM. One of several databases and software tools developed as part of the AHCPR-sponsored HCUP, NIS is the largest all-payer inpatient care database available in the United States and is used by a variety of researchers and policymakers to identify, track, and analyze trends in health care utilization, access, charges, quality, and outcomes.

The latest block in a historical database that stretches back to 1988, NIS Release 5 was initially released this past spring. It contains 1996 data covering approximately 6.5 million hospital stays at some 900 community hospitals in 19 states, approximating a 20% stratified sample of U.S. community hospitals. By integrating data from statewide health data organizations, the NIS is a uniform, multistate database that promotes comparative studies of health care services. It will support health care policy research on a variety of topics including:

- use and cost of hospital services;
- medical practice variation;
- health care cost inflation;
- analyses of states and communities;
- medical treatment effectiveness;
- quality of care;
- impact of health policy changes;
- access to care;
- diffusion of medical technology;
- utilization of health services by special populations.

Additionally, NIS includes hospital identifiers that allow linkages to the American Hospital Association's Survey of Hospitals database, as well as county identifiers that permit linkages to county-level information in the Health Resources and Services Administration's Area Resource File.

For more information about the NIS database or other HCUP products, visit the AHCPR's Web site (http://www.ahcpr.gov/data/hcup/) or contact the agency by e-mail at hcupnis@ahcpr.gov. To order the NIS Release 5 (as a set of six CD-ROMs with accompanying documentation) for $160, contact the National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161. Telephone (800) 553-6847 or (703) 605-6000. Or, you may order on-line at http://www.ntis.gov/fcpc. When ordering, refer to PB number 99-500480. Previous releases featuring 1993, 1994, and 1995 data are also available for $160; Release 1, a 26-CD set featuring data from 1988 through 1992, is available for $322.

A new database combining comprehensive hospital data with the latest managed care information is now available from the American Hospital Association's (AHA) Health Forum and InterStudy, a supplier of managed care data.

The Duet Database provides health care decision

makers and researchers with a wide variety of information about hospitals and managed care at the MSA level. It contains hospital data from the AHA's annual survey, along with Inter-Study's MSA level data on the HMO industry from its semi-annual National HMO Census.

According to its developers, the database is designed for penetration research, competitive analysis, and utilization studies in the managed care arena; hospitals can use the database to research similar or benchmark markets to understand how managed care will affect utilization and revenue.

The Duet Database is available on CD-ROM in both Microsoft Access and ASCII formats. Buyers can choose to purchase hospital data or managed care data only for $1,800. The total database sells for $3,000. The database is slated to be released twice annually. Managed care inquires should be directed to InterStudy Publications at (800) 844-3351; hospital inquires to the Health Forum at (800) 821-2039. To order, call (800) AHA-2626. ■

NCQA issues 2000 accreditation standards

New standards designed to streamline health plan oversight processes and operations are part of the 2000 Surveyor Guidelines for the Accreditation of Managed Care Organizations (MCOs), the document used by National Committee for Quality Assurance (NCQA) surveyors and health plan personnel to prepare for and conduct accreditation surveys.

NCQA's 2000 Accreditation standards introduce a number of important new requirements related to internal and external appeals processes, access to behavioral health care, and continued access to providers who leave or are dropped from a plan's network.

Based on comments to the draft version of the guidelines, NCQA has made a number of changes to its 2000 Accreditation program, many of which are designed to streamline the oversight process and/or health plan operations. Changes include:

❒ **Allowing health plans to skip the internal appeals process**, and instead — with the member's permission — send appeals directly to a third-party independent review organization. Health plans and consumers alike have expressed concerns that adding an independent third-party appeal on top of existing requirements for two-level internal appeals might make the whole process too long.

❒ **Requiring MCOs to have a strategy to improve the quality of medical record keeping**, rather than simply requiring biennial review of medical records.

❒ **Focusing follow-up practitioner site visits on problem offices**, rather than on all high-volume primary care physicians every two years.

Meanwhile, NCQA has also released its 2000 Standards and Surveyor Guidelines for the Accreditation of Managed Behavioral Health Care Organizations (MBHOs), a much updated version of the standards that further refines NCQA's requirements for managed care organizations and MBHOs. Like its MCO accreditation standards, NCQA's MBHO standards introduce new requirements for internal/external appeals processes and continuity of care. The new standards also cover items such as pharmaceutical management procedures.

The 2000 MBHO Accreditation standards also mark the full implementation of several monitoring standards that were not previously scored in the areas of quality management, utilization management, credentialing, and members' rights and responsibilities.

NCQA's Surveyor Guidelines for MCOs and MBHOs are effective for surveys conducted between July 1, 2000, and June 30, 2001. They are now available from the NCQA Publications Center. For more information, contact the center at (800) 839-6487, or visit the NCQA Web site at http://www.ncqa.org. ■

Aging boomers to cause health care havoc

Often described as the demographic "pig moving through a python," the baby-boom generation has always exerted a huge influence on American society and institutions. And according to a new book from the Indianapolis-based

United States Postal Service

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Hudson Institute, when members of this cohort start to reach their "golden years" in the early 2000s, their sheer numbers will force permanent changes in the nation's health care delivery system — changes that will not necessarily be for the better.

In about 100 pages of very readable text, *Health Care 2020: The Coming Collapse of Employer-Provided Healthcare*, co-authored by William Styring III and Donald Jonas, details how social, political, and demographic trends will affect the financing and methods of organization of the health care delivery system in the United States. When the 76 million-strong "boomer generation" enters the new millennium, "They will be retiring in droves, straining employer health plans, as well as

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bankrupting Social Security and Medicare," Styring said in a news release announcing the book's publication.

Meanwhile, in the realm of health care treatment and delivery, "The emphasis will be on cheaper care for the elderly, such as home health care," said Jonas, who adds that "kidcare" programs "will suffer as more and more money is spent on the elderly majority population."

The ratio of elderly / retiring boomers to younger / working "baby bust" individuals will hit the 3-to-1 mark in 2020, down from today's 4-to-1 level, according to Styring and Jonas. This ratio will further decline to around 2-to-1 by 2030. By then, if post-boomer workers are called upon to pay for all the health care their elders demand (and indeed subsidized for the generation that preceded them), the United States will experience societal strains "as powerful as this country has seen since the slavery question erupted into a civil war."

"The bioethics debate will become a bombshell," according to the authors. "The young may get the upper hand and decide the very old have a bioethical 'duty to die,'" they note. And worst of all (depending on your age and / or point of view), "They may refuse to pay for every conceivable medical procedure that might be of benefit for the now-geezer boomers."

Nonetheless, Styring and Jonas do not view the future in entirely bleak terms. "The baby boomers will cause a serious rethinking of what most of us have come to think of as the natural state of affairs. Employment-based insurance will shrink and the tax exclusion, which drives it, will be repealed.

Medical Savings Accounts will be prevalent. Seniors' entitlements will be reneged upon. The possibility of war among the baby boomers and baby busters is quite real, although we think that will not happen. And the Busters will wind up with a raw deal, but not one with which they cannot live."

The Princeton, NJ-based Robert Wood Johnson Foundation (http: / / www.rwjf.org), the nation's largest philanthropy devoted exclusively to health and health care, funded the research and production of *Health Care 2020*. The Hudson Foundation (http: / / www.hudson.org) is a public policy research organization that develops solutions and forecasts trends for governments and businesses. *Health Care 2020* is available for $16.95 per copy, with a 25% discount for orders of 25 or more. To order, call (800) HUDSON-0, or (317) 545-1000. ▼

Nutritional assessment cuts hospital costs

Assessing hospital patients for nutritional deficiencies not only helps reduce the incidence of post-operative complications and re-infection, but can also cut total hospitalization costs, according to data presented at the American Association for Clinical Chemistry's 1999 annual meeting.

The nutritional assessment process includes taking a complete medical and dietary history from patients, as well as clinical testing of pre-albumin and albumin levels to detect evidence of protein-calorie malnutrition (PCM). Characterized by depletion of muscle, visceral protein stores, and body fat, PCM's clinical manifestations include increased morbidity and mortality, impaired wound healing, and compromised immune response.

Detecting and addressing PCM early in the hospitalization process (optimally at admission) "increases the chances of a positive outcome for patients, as well as reducing overall length of stay," according to **Elia Mears**, director of Laboratory Services at the Leonard J. Chabert Medical Center in Houma, LA. Data presented by Mears shows that the nutritional assessment program instituted at the center in 1995 reduced the facility's readmission rate by close to 4% during its first year of operation, at the same time generating some $600,000 in savings attributed to reductions in length of stay.

For additional information, contact Mears at (504) 873-1339, or via e-mail at MearsEli@CMC.LHCA.State.LA.US. ■