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Physicians must act quickly to regain lost trust from patients

Survey shows sharp drop in trust, rise in consumerism

Patient trust in physicians is eroding dramatically as patients wonder whether doctors, under pressure from managed care, are truly putting their interests first, according to new survey data.

In a national survey of 170,000 households conducted by National Research Corp. (NRC) of Lincoln, NE, just 18.3% of respondents said they had a "very high" level of trust and confidence in their physicians. That was a decline from 26.8% in 1998.

"The error range on this study at a national level is 0.2%," says NRC spokesman **Phil Richmond**. "When you see an eight-point movement in scores, something's going on out there."

Loss of trust may seem an inevitable byproduct of a system that creates restrictions on both doctors and patients to improve cost-effectiveness. But physicians can take steps to reassure patients and rebuild trust, says **David Thom**, MD, PhD, an assistant professor of medicine at Stanford University School of Medicine in Palo Alto, CA, who has conducted extensive research on the issue of trust. "The fundamental issue is to be worthy of the patients' trust — to be competent and to put the patient's interests first," says Thom, who is a family practice physician. "Most physicians do that. But it isn't going to create trust unless you give patients a reason to do so [by demonstrating those qualities]."

EXECUTIVE SUMMARY

Managed care and cost pressures have contributed to a decline in patient trust in physicians, but doctors can take steps to rebuild that trust.

- More than 80% of Indiana consumers said they were "likely" or "very likely" to change providers if they didn't get their needs met, one study found.
- Almost half of consumers believe a doctor's effectiveness is weakened by becoming part of health networks or systems, according to a national survey by National Research Corp. of Lincoln, NE.
- Explaining tests and procedures and involving patients in their care decisions can boost trust.

Survey: Patients will leave if they're unhappy

Consumers assume their doctors are clinically competent, but they judge them on their interpersonal skills, according to a survey and focus groups conducted for the "Indiana Eye on Patients" study. The study was sponsored by the Indiana State Medical Association, the Indiana Hospital & Health Association, and the Indiana University School of Medicine, all in Indianapolis. The telephone survey gathered responses of 1,000 Indiana residents, and 113 consumers participated in 14 focus groups across the state. Here are some of the key findings:

- ❒ About half (52%) of survey respondents described their relationship with their primary care physicians as excellent. However, fewer African-American consumers (39%) had that level of satisfaction.
- ❒ Women and baby boomers (those in the 35 to 54 age range) were more likely to rate their relationship with their primary care physician as poor.
- ❒ When asked how likely they would be to change doctors if they weren't happy with the care provided, 83% of respondents said they would be "very likely" or "somewhat likely" to change. Again, women and baby boomers were the most likely to say they would change doctors if they were unhappy.
- ❒ 37% of respondents said they had changed physicians because they were unhappy with the care they received; two-thirds of those who had changed doctors were women.

Even small gestures can bring a wealth of goodwill, he says. "Probably the most powerful thing a doctor can do to make a patient feel he or she is acting in the patient's interest is to do something above and beyond. [It could be] a follow-up phone call that the patient didn't feel the doctor had to do but the doctor did anyway. Looking up information for a patient. Staying late to see somebody."

While trust may develop over time, with each visit the physician has a chance to shape that relationship,[1] Thom says.

Trust isn't just a feel-good issue. Trust — or the lack of it — lies at the core of an emerging consumerism among patients. More than 80% of Indiana consumers said they were "likely" or "very likely" to change providers if they didn't get their needs met, according to the "Indiana Eye on Patients" study sponsored by the Indiana State Medical Association, the Indiana Hospital & Health Association, and the Indiana University School of Medicine, all in Indianapolis.

"Trust is actually a stronger predictor of whether patients stay with their physicians than satisfaction," says Thom, although he points out that satisfaction and trust are highly correlated. "[Trust] is what matters most in their satisfaction with their relationship with physicians."

Not surprisingly, in focus groups, health care consumers expressed concerns about how managed care affected their relationships with doctors. "People more and more are looking at their health care experience through the prism of their health care coverage," says **B. Lee Zacharias**, president of The Zacharias Group, a public opinion research firm based in New Gloucester, ME. "They perceive that it has changed their relationship with their doctors."

They don't like choosing doctors from a list, and they worry that cost and insurance coverage influences the medical advice the doctors provide, says Zacharias.

The concern about just who is making the health care decisions emerged from American Hospital Association focus groups as well, says AHA Senior Vice President **Rick Wade**.

"All of the hassles with insurance translates into a view of people being much more skeptical about who is on their side and who they can relate to," says Wade, who spearheaded the "Reality Check" studies in 35 states over three years. "They don't feel anyone is their advocate anymore. That's leading to the emergence of a much more independent or aggressive individual who is there on behalf of themselves or someone they care about."

In this climate, even prudent decisions about which tests or procedures are necessary may seem suspect. "The medical establishment has nobody to blame but itself for this problem," says Zacharias. "For years and years, it has told the public more is better when it comes to health care. Now things are changing, and the public is suspicious. They see something taken away from them as opposed to a more judicious use of medical resources."

Meanwhile, frustrations caused by impersonal and inefficient aspects of large group practices can further erode trust, says Zacharias. Patients

often view these medical groups as medical bureaucracies, she says.

"One of the things that frustrates patients more than anything is the phone system," she says. "'Thank you for calling the XYZ Group Practice Association. Press one for this; press two for that; press three for that.' People hate that." Instead of creating efficiency, patients perceive such "improvements" as barriers.

Growing or merging into a large organization isn't a problem in itself, stresses Zacharias. "There are many other businesses in this country that run huge, huge businesses that are very customer-oriented."

In the National Research Corp. survey, people who understood the concept of health systems and networks expressed concerns about the impact on doctors. The survey first asked if the respondent was aware of hospitals, doctors, and health plans in their area that had merged to form large health systems or networks. Among respondents who said they were aware, 44.6% said becoming a part of such systems weakened a doctor's effectiveness.

"I think that clearly indicates that people want their doctors to be able to make decisions autonomously," says Richmond. "They don't want their doctors to have to call a plan and find out if it's OK to pursue a course of treatment."

In the same survey, almost one in four respondents said that doctors were "most interested in making a profit" as opposed to being most interested or equally interested in providing quality care.

Measure trust with patient satisfaction

While physicians can't alter the fundamental shifts in insurance coverage or mergers, they can act to heal their relationship with patients, says Thom. Trust can be measured along with patient satisfaction, and physicians can make changes to respond to the findings, he says.

Based on various scales designed to measure patient trust, Thom recommends adding statements to patient surveys such as:

- I trust my doctor to put my medical needs above all other considerations, including cost.
- My doctor is well-qualified to manage medical problems like mine.
- I have complete confidence that my doctor will always act to provide me with the best medical care possible.

Such questions expand the patient survey into a new realm, says Thom. "Trust is fundamentally different from satisfaction. Trust implies a relationship between two people. Satisfaction is more mechanical in a sense of whether certain things were done or not done. Trust is something that applies over time, while satisfaction applies to a given visit or event."

While trust may seem more nebulous, it can be the focus of improvement efforts. For example, better communication can, in turn, boost trust, notes Thom. Physicians who explain why a test wasn't ordered may reassure patients that the decision was based on need and not cost pressures.

If there is a positive spin on this trend toward more skeptical, less loyal patients, it lies in an evolving consumerism. As patients become their own advocates, they are also more informed and involved in their own medical care.

"I think consumers are going to become more savvy users of health care," says Zacharias. "They're going to question more."

With the vast information now available to consumers via the Internet, patients will be coming to office visits with new expectations. Meanwhile, allowing patients to become partners in their care creates a quick basis of trust even in the absence of long-standing relationships with their doctors, says Thom. "Patients are going to be more comfortable

Patients' Trust and Confidence in Doctors

A national survey by the National Research Corp. calculated scores for trust and confidence in physicians based on a scale of 0 to 100. The national average was 68.5. Here are the cities that had the highest and lowest levels of trust:

Highest

1. Madison, WI	73.4
2. Birmingham, AL	72.7
3. Ann Arbor, MI, and Rochester, NY (tied)	72.4
4. Wichita, KS	71.9
5. Providence, RI	71.9

Lowest

1. Las Vegas	62.6
2. West Palm Beach, FL	64.3
3. Lakeland, FL, and Daytona Beach, FL (tied)	65.2
4. Melbourne, FL	65.7

Source: National Research Corp., Lincoln, NE.

if they feel they are involved. The doctor explains what's going on. They are being listened to. Things aren't being done that they don't understand or [that they] have doubts about.

"Involving patients in a partnership will go a long way toward reassuring them and helping them develop some trust," he says. "If you're in a position where you're totally dependent on somebody else and you don't have much information about what they're doing, you're going to be more uncomfortable and have a lower level of trust."

In the course of treatment, physicians also need to be careful not to make promises that they may not be able to fulfill. For example, Thom recalls the case of a patient who thought her family practice physician had promised to deliver her baby. When the doctor had other commitments and wasn't able to be present at the delivery, the patient felt betrayed.

"There's a tendency sometimes to over-promise to people to meet their needs or their demands," says Thom. If you later aren't able to fulfill that, "then they don't know what else you said that you aren't going to be able to live up to."

Reference

1. Thom DH, Campbell B. Patient-physician trust: An exploratory study. *J Fam Pract* 1997; 44:169-176. ■

Some people just hate to wait for docs at all

Satisfaction with wait time varies by city

In Charleston, SC, and Ann Arbor, MI, patients wait an average of 10 minutes to see their doctor. That may not sound too bad, but it depends on your perspective. In a national survey last year by the National Research Corp. (NRC) in Lincoln, NE, Ann Arbor came out on top in satisfaction with wait time while Charleston was at the bottom.

People in different parts of the country may have different expectations, notes **Phil Richmond**, manager of public relations for the NRC. The level of managed care penetration also may affect expectations and satisfaction, he says. "We are getting to the point where managed care is becoming the standard on a national level. It takes some time to get used to."

NRC conducts a national, mailed survey every year, targeting a representative sample of the U.S. population. This year, about 170,000 people responded, representing about 400,000 covered lives. They answered 100 questions related to their health care and health status.

The 1999 results, published in the *NRC Healthcare Market Guide*, revealed some concerns about physician communication and access. Some 18% of respondents rated the amount of time they spent with doctors as fair or poor. One in four (25.9%) gave a rating of fair or poor to the time it took for physicians to return phone calls, and

Percentage of Patients Who Saw the Doctor with No Wait

Best		
1.	Harrisburg, PA	45%
2.	Denver	43.2%
3.	Hartford, CT	42.9%
4.	San Francisco	42.7%
5.	Milwaukee	42.7%
6.	Tulsa, OK	42.6%
Worst		
1.	Miami	25.2%
2.	Memphis, TN	28.1%
3.	Stockton, CA	28.6%
4.	Ventura, CA	29%
5.	New Orleans	29.1%

Percentage of Excellent or Very Good Wait Times

Best		
1.	Omaha, NE	55.6%
2.	Syracuse, NY	53%
3.	Evansville, IL	52.6%
4.	Rochester, NY	52.4%
5.	Spokane, WA	52.3%
Worst		
1.	Daytona Beach, FL	39.0%
2.	West Palm Beach, FL	39.1%
3.	New York City	39.2%
4.	Memphis, TN	39.3%
5.	Fort Lauderdale, FL	39.8%

Source for both charts: National Research Corp., Lincoln, NE.

28% gave a fair or poor to "wait time past appointment." **(For a look at the differences by metropolitan area, see boxes, p. 136.)**

[Editor's note: For more information on the NRC Healthcare Market Guide, *contact the National Research Corp., Gold's Galleria, 1033 O St., Lincoln, NE 68508. Telephone: (800) 388-4264. Fax: (402) 475-9061.]* ■

Medical groups strive to create the 'ideal' office

Open access, strong leadership are key elements

Envision the ideal medical office, a place where patients can call for an appointment and come in the same day. It's an office where staff morale is high and patients feel like partners in their care. There is a steady flow of information allowing physicians to discover inefficient or faulty processes and fix them.

Medical groups around the country are trying to turn that vision into reality through a project sponsored by the Institute of Healthcare Improvement (IHI) in Boston. Rather than trying to address a narrow quality improvement goal, 42 QI teams at 23 health care organizations are trying to become prototypes of a patient-centered and quality-based practice through the "Idealized Design of Clinical Office Practices" project. **(For a list of the principles for clinical office practices, see box at right.)**

"It really is daunting," says **Frank Littell**, MD, an internist with Peacehealth Medical Group in Eugene, OR, and a faculty member with the IHI project. Yet the dangers of not acting were even greater. "The challenge we faced is that like many other integrated delivery systems; the medical group has lost money ever since the development of the integrated system. We had an opportunity to look at the redesign of the medical group."

The first sites began examining their processes in January 1999. They are collecting data every six months and anticipate having significant improvements to reveal within three years, says project manager **Mora Babineau**, MHP.

Some benefits are readily apparent, Littell says. Initial changes have boosted the morale of staff and physicians and increased patient satisfaction.

Scheduling and access are areas that plague staff, physicians, and patients alike. So the "Idealized Design" practices began by trying to improve patient flow and scheduling, often moving toward "open access" that allows same-day scheduling and attempts to match physician supply with patient demand.

"What are the one or two areas that people are disgruntled about on a daily basis? Their schedules," says Babineau. "People felt they had no time."

So practices greatly reduced scheduling types and, in some cases, added hours. "It also helps

Principles for Clinical Office Practices

What are the components of the "ideal" office practice? While no two offices will be exactly the same, these are the guiding principles identified by the Institute for Healthcare Improvement (IHI) in Boston as medical groups began shaping the "Idealized Design of Clinical Office Practices." The IHI defined the components as "a foundation for our vision of what clinical offices should be."

- ✔ Paramount focus on the clinician-patient relationship.
- ✔ Individualized access to care and information at all times.
- ✔ Knowledge-based care — standard.
- ✔ Opportunity for patient to customize his own care to the extent that each individual desires.
- ✔ Minimal waiting for all involved in the processes of care.
- ✔ Seamless communication of information and coordination of care based upon cooperative relationships.
- ✔ Financial performance sufficient to ensure unhindered viability.
- ✔ Patient and practice management based on real-time data, including measures of process, satisfaction, finance, outcomes, and epidemiology.
- ✔ Continual improvement and waste reduction in all processes and services.
- ✔ Individual health linked to broader community health.
- ✔ A model work environment.

[Editor's note: For more information on the "Idealized Design of Clinical Office Practices" project, 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.]

you when people are in for an appointment to 'max-pack'" by addressing preventive needs even though the patient came in for an acute problem, she explains.

For Peacehealth, open access went hand in hand with another innovative change — to care teams. The medical group moved schedulers and clerks to the back of the office into the doctor-nurse care teams. Each team now has a dedicated scheduler who answers a separate phone number for one team. The nurses and medical assistants have been cross-trained to handle patient phone calls and paperwork.

The changes correspond to a business model called "Lean Thinking," based on a book by the same name written by James Womack and Daniel Jones.

"Most clinics have a lot of inefficiency," says Littell. "Nobody in the front knows what the people in the back are doing. Nobody in the back knows or appreciates what the people in the front are doing. "We decided to combine the front and the back office, to create three teams with three or four providers per team," he says. "The people involved in the delivery of health care should all work together, and that includes the front office."

The change improves patient flow because the cross-trained staff can now support each other.

Test new ideas with leaders' support

Peacehealth has just begun considering other changes using a rapid cycle process of quality improvement that allows the medical group to test ideas and expand or discard them. For example, Peacehealth is creating a software-based registry of diabetic patients to help the medical group track their care.

"Some of us in the group are experimenting with audiotaping the visit and giving it to the patient to improve compliance with instructions," says Littell, who adds that written instructions also are provided.

The medical group also may add some lab capabilities that would allow for "real-time" results to increase efficiency in patient care.

Other IHI project participants are adopting other innovations, but it's still too early to capture many lessons from the practices that seek to redefine how they provide care, says Babineau. "It takes a long time to make change. We're facing that reality as we're heading to our second year."

Yet one fact is clear: Success relies largely on the commitment the project receives, she says. "It's important to have leadership from the CEO level and leadership at the site. We're seeing success where the leadership is coming from the physicians. Putting them back in charge of this work is the right way to go."

IHI also requires the sites to devote a half-time or full-time employee as a project manager. Each quality improvement team sets specific aims, and the project manager coordinates monthly data collection and a monthly report to senior leadership, staff, and IHI.

"If you're really serious about doing this, you need someone who is collecting information, getting your data walls up [to track trends using charts], making sure everyone is staying focused," Babineau says. ■

VA may open surgical outcomes database

Risk-adjusted system covers all major procedures

A vast database of surgical outcomes developed by the Veterans Affairs may soon open up to subscribers from private hospitals.

In a pilot project, three hospitals have been selected to submit data via the Internet to the VA's National Surgical Quality Improvement Program (NSQIP), a risk-adjusted outcomes monitoring system that began in 1991 and now encompasses 123 VA medical centers and more than 700,000 surgical cases. (The three hospitals are the departments of surgery at the University of Michigan in Ann Arbor, Emory University in Atlanta, and the University of Kentucky in Lexington.)

The VA database is unique not only in its size, but in its scope as well. The centers report data on 50 preoperative variables, 43 operative, and 40 postoperative variables for each patient. Virtually all major surgical procedures are assessed, including the subspecialty areas of general surgery, orthopedics, cardiac surgery, urology, neurosurgery, otolaryngology, noncardiac thoracic, and plastic surgery.

"We had been literally bombarded by questions from various providers in the private sector regarding the feasibility of using the VA models in their own private institutions," says **Shukri F. Khuri**,

MD, FACS. Khuri is a cardiac surgeon who is chairman of the NSQIP and chief of surgery at the Boston VA Health Care System. "We feel this is quite applicable to the private sector."

The NSQIP has already set up a secure Web site to capture the data from private institutions. While the data will be compared to national VA benchmarks, the private information will remain separate, with confidentiality assured, says Khuri, who is also vice chairman of the department of surgery at Brigham and Women's Hospital in Boston and professor of surgery at Harvard Medical School.

"The NSQIP will be purely a repository," Khuri says. "The data are owned by the institutions that enter data into it. If an institution wants to release it's own data, that's a different story."

Criticism prompted outcomes system

The VA's quality improvement program grew out of a storm of criticism and a congressional mandate in the mid-1980s, when the news media published high mortality rates from cardiac surgery that were not adjusted for severity of illness.

The VA had no risk-adjustment model, and there were no national benchmarks for mortality rates or risk adjustment. They had no data to refute the negative assertions.

Congress demanded proof of improved quality, and, after some false starts, by 1990, the VA recognized the need for a comprehensive response. The National VA Surgical Risk Study focused on cardiac surgery performed at 44 medical centers and sought to validate a model of risk adjustment.

That risk-adjustment model, which has been expanded to include non-cardiac surgeries, forms the foundation of the NSQIP system, says Khuri.

"The risk-adjusted observed-to-expected ratios in mortality and morbidity were indeed reflective of the quality of care," he says. "If an institution was a high outlier — with statistically significant higher mortality than that expected — then it is very likely one would find suboptimal surgical care.

Without a valid system of risk-adjustment, comparisons among hospitals would be meaningless, notes Khuri. "If you do not risk adjust, you can err almost 60% in judging the outlier status of an institution. You have a 60% chance of mislabeling them [as high or low outliers]."

Of course, collecting quality data is also vital to such a project. The VA ensured the integrity of its data collection by requiring a full-time nurse reviewer at every institution. The nurse collects the forms that are filled out on every patient preoperatively or postoperatively and inputs the information. The nurse transmits data periodically to a central data center.

Collecting data from administrative records or even retrospectively from medical records is inadequate, says Khuri. "If you really want to do proper risk-adjustment, you need to collect data on a prospective basis and have a dedicated nurse."

In the early days of the cardiac project, different centers devoted different resources to the data collection, recalls **Jeannette Spencer**, RN, MS, CS, the national coordinator of NSQIP who is based at the West Roxbury (MA) VA Medical Center. When the VA began requiring a full-time nurse reviewer, "the compliance skyrocketed from 70% of data collected to 99%."

The quality of the data also improved with special training of the reviewers. "All of them had to utilize the same definitions," she says. "They were able to collect the data from each institution more accurately and more reliably."

The three private hospitals that are now joining the project are required to devote a nurse to the data collection effort.

If NSQIP eventually is expanded to include subscriber hospitals around the country, that requirement will remain, says Khuri. The expense of the dedicated employee is more than worth it, he says. "The cost for the VA for 123 centers, mostly salaries for these nurses, is no more than $5 million. If you calculate that per case captured, you're talking about $32 per operation. This is a cost which is less than two prolene sutures."

Database leads to better outcomes

Since 1994, the VA medical centers have reduced 30-day mortality from major surgery by 9% and morbidity by 30%. While Khuri and his colleagues acknowledge that surgical advances and other factors may contribute to the improved outcomes, they see clear evidence that NSQIP has paid off.

Chiefs of surgery receive annual reports and some less detailed information quarterly. High outliers receive help in identifying quality improvement goals and processes.

The low outliers become benchmark institutions. "We have gone to the low outliers and

asked them to come up with lists of processes or structures that the surgeons felt were aspects of good practices of care," says Khuri. "We felt it was our job to disseminate these as good practices."

The result, says Khuri, is a system that can monitor outcomes and provide models of success. "We think we have a system that can compare quality of care using risk-adjusted outcomes, which also provides the tools with which one can enhance and improve the quality of surgical care," he says. ■

QI target: Talk to patients about smoking

New forms, training increase cessation counseling

As at most clinics and doctors' offices, physicians at Fallon Community Health Plan in Worcester, MA, didn't routinely and persistently encourage their patients to stop smoking. Those that did advise their patients to quit weren't likely to record those comments in the medical record.

But with a quality improvement project that provided physician education, new documentation tools, and feedback on performance, Fallon improved both counseling and documentation during routine visits from 18% to about 50%.

After training physicians on counseling techniques and revamping the documentation tool, Fallon increased the documented counseling of smokers during routine visits from 18% to about 50%. One clinic site — an OB/GYN office — made a commitment to the project and achieved a documented counseling rate of 100%. The project encompasses the Fallon Clinic, with 275 physicians at 33 sites, and the affiliated University of Massachusetts Group Practice, with about 400 physicians. Fallon Community Health Plan also has a network of 3,000 affiliated physicians.

"By chipping away at this, we expect to impact the prevalence of smoking and ultimately to save the system a lot of money," says **Christine Micklitsch**, FACMPE, MBA, director of physician education and services, citing statistics that show $750 per year in excess medical costs for smokers.

There's another incentive as well. The HEDIS effectiveness of care indicators of the National Committee for Quality Assurance in Washington, DC, which accredits health plans, includes a measure on physician counseling on smoking cessation. In 1998, Fallon had the highest rate nationwide of members who said they had been counseled by physicians on smoking, says Micklitsch.

Are they ready to change?

Changing behavior is a challenge, both for patients and their physicians. Despite years of health warnings, smoking remains pervasive. A 1997 survey of adult members of the Fallon health plan found that 39.5% said they smoke "every day or some days" and 32.3% smoke every day. Nationally, the prevalence of adult smokers is 23.5%.

The Fallon program focuses on stages of change — providing patients with information based on their readiness to change.

"The basic theory is that in order to change any behavior you have to be ready to change," says **Emily Eaton**, MEd, physician education specialist at Fallon. We all have things we know we should change, but we're not ready to. That means we're precontemplative."

For example, a precontemplative patient may say, "I know smoking's bad for my health, but I enjoy it too much to quit." A contemplative patient may say, "I've thought about it. I know I should quit, but I'm not ready now."

"We want physicians to give different messages at the different stages," says Eaton. "The goal is to move them to the next stage. You are never going to get a precontemplative person to quit smoking. If you get them to change stages, that's a major accomplishment."

A physician may provide a brochure with smoking cessation information and may tell a precontemplative patient: "I know you're not ready. However, you need to know you should quit. If you'll read this information, we'll talk about it the next time you come in."

Without the tools and training on stages of change, physicians can become discouraged about their potential influence on patients' smoking habits, says Eaton. "I think physicians are uncomfortable [talking about smoking cessation] because it's a very difficult conversation to have." Eaton was a smoking cessation counselor for many years.

How do patients feel about being gently nagged by their doctors to give up smoking? Not bad at all, Fallon found in a telephone survey that asked patients how they felt about

their doctor's questions and comments about smoking.

"People were very pleased about being asked by their doctors about their smoking stages," says Micklitsch. "The evidence we got from that telephone survey helped us to tell [physicians] that it wasn't something that would be an annoyance to patients, but that patients saw it as a positive thing that physicians should be doing."

The intervention itself can be brief and still have significant impact, says Eaton. One study found that physician counseling raised the one-year quit rate from 2.5% to 4%.

What should doctors say?

Yet physicians themselves need resources. Fallon revised the progress notes sheet placed on medical charts to include checkoff boxes that ask "smoking vital sign" information, including smoking status, whether the patient has tried to quit, and if the physician provided smoking cessation counseling. Based on the question, "Have you considered quitting?" the physician can mark the patient's stage as precontemplative, contemplative, or action (ready to quit).

"Now it's in front of them all the time," says Micklitsch. "It's just like blood pressure, height, weight. If it's in front of you, you feel obligated to do it."

During the pilot project, physicians received regular reminders and feedback on their documentation rates every five or six weeks. Once that level of feedback slackened, so did the documented counseling. The overall rate dropped to about 40%, and the internal medicine department even dropped to 27%.

Fallon now has a tobacco advisory council that includes physicians, nursing managers, and administrators. It is drafting a practice guideline on counseling for smoking cessation. With a guideline in place, the push for greater counseling gains a new importance. Continuous monitoring and feedback also accompanies guidelines, says Eaton.

Meanwhile, the Fallon Community Health Plan patient satisfaction survey now includes a question about counseling on smoking cessation. That item, among others, will be linked to a performance incentive plan, says Micklitsch.

"We're trying to tie all the pieces together," she says. "We give them to tools to use, we teach them how to use them, then we reward them for using them. The patients get the benefit." ■

Future visions: Outcomes in the millennium

New consumerism, technology will boost field

A decade after the birth of the accountability movement in health care, outcomes management remains in its infancy. Great strides have been made in developing quality measures and patient-oriented surveys, but incorporating those into daily practice is a challenge. Several leaders in the field of health care quality spoke to *Patient Satisfaction & Outcomes Management* about their vision of the future:

PSO: Many medical groups still don't know much about their patients, such as how well diabetic patients are controlling their hemoglobin or how many patients suffer from asthma. With all the talk nationally about health care quality, do you see an evolution beginning in the average medical office?

Mark Zitter, MBA, president of The Zitter Group, a San Francisco-based education and communications company that focuses on outcomes and managed care:

"I don't think we're seeing a lot of change in the smaller or medium-sized groups that don't have a lot of incentive to do something about [outcomes management]. Most of the larger groups are realizing they have to do something with this. We still have more medical care that we can deliver than payers want to pay for. The most palatable way [to determine appropriate care and cost] is to tie it to quality or outcome. As more and more organizations get the information systems in place, they can really manage what they're doing. The places that can do that have an enormous advantage over everyone else."

PSO: In other industries, quality-based comparative information (such as *Consumer Reports*) feeds a consumer demand. That hasn't happened so far in health care, where consumers rely heavily on interpersonal relationships to select their physicians. Will that change? What will drive the change in health care consumerism?

David Lansky, PhD, president, Foundation for Accountability, Portland, OR:

"It will change because the world is changing.

It is unstoppable. In information-rich western nations, people are demanding information to make decisions. Every market except health care has become dominated by the decisions of consumers. It seems unlikely that this would be the one area where people would have no power to get what they want.

"If you believe, as I do, that outcomes are an expression of what people care about, once people have political and economic power to express their needs, they will use this information to make sure their needs are met. People don't currently articulate their health care needs in the same words and concepts that we outcomes researchers use. We have to create a bridge between where people are today in the health care experience and the concepts of quality and outcomes that the gurus think are important. I think building that bridge is very doable. People care about the things we want to measure, but no one has given them information to say that's how you should decide about where to go.

"There's a huge amount of education that needs to occur before there will be public demand for outcomes information. I think it will be a 15-year or 30-year time frame. The analogy we often use is to the environmental or smoking awareness movement. It took a generation to change widely held assumptions in the public mind."

PSO: Gathering and analyzing outcomes information is still quite expensive and time-consuming, often requiring a staff person devoted to the task. How will changes in technology make it cheaper or easier for small group practices to take part in outcomes management?

Eugene Nelson, DrS, professor of community and family medicine, Dartmouth Medical School, Hanover, NH, and director of quality education, measurement, and research, Dartmouth-Hitchcock Health System, Lebanon, NH:

"Technology will change not only the practice's ability to measure outcomes and track them, but will fundamentally change the nature of the doctor-patient relationship. For example, at the Spine Center at Dartmouth-Hitchcock Medical Center and the Nashua Internal Medicine practice that's part of the Dartmouth Hitchcock Clinic, feed-forward information is becoming integral to the flow of the patient and the practice of medicine.

"When patients come in to be seen, they either complete at that time or have already completed a full functional, clinical and expectations health assessment. [The Value Compass tracks] clinical status, functional status, their expectations of care, their satisfaction of care, as well as cost-related information. The clinician and patients can plan their next step around the care regimen that matches the changes in outcomes that have been observed and the patients' current status. You can very quickly understand and hone in on areas that could very easily be missed otherwise.

"Today's technology has been scannable forms and laptops. Today and tomorrow, [the major tool] will be the Internet so the patient and the physician have the capacity to have a shared medical record. Part of the medical record can have modern, quantitatively-based measures of health status and health outcomes.

"The technology is moving very, very quickly. I can be on vacation or business travel in Boise, ID, and you might be my physician in Chicago. I can contact you via e-mail. Using the Internet, shared medical records, e-mail, and not far off, desktop-based interactive video, you can see what this can do to two-way communication and the doctor-patient relationship."

PSO: Physicians have been fearful of comparative information that may be misinterpreted or based on faulty data. Their concerns have been justified in some cases, particularly when improper sampling techniques are used. Yet consumers are most interested in the quality of care delivered by their physician, rather than by medical groups or health plans. Will physicians eventually be rated in report cards? Could such a trend actually become a harmful byproduct of "accountability" demands?

William F. Jessee, MD, president, Medical Group Management Association, Englewood, CO:

"Physicians have good reason to be wary of the process because good data (i.e. valid, reliable data on use, cost, quality, and patient outcomes) are exceptionally hard to generate and even harder to evaluate. The major problems stem not so much from sampling as from using data collected for very different purposes [usually for billing] for profiling and from the use of inadequate case-mix adjusting techniques to ensure comparability of patients across each physician's patient panel. Second, there is a real and growing demand for this type of profiling on the part of the public third-party payers (Medicare, Medicaid, indemnity insurance, and managed care plans) and employers.

"Physician group report cards are already being used in some settings and individual physician profiling is increasingly common. While this trend is likely to accelerate, there is a growing awareness that there is a need for substantial improvement in the quality of the data generated for these purposes, and for advancement in the tools and technologies used to create such profiles. CRAHCA and MGMA have been engaged in several initiatives to improve the "State of the Art" in provider profiling.

"The lessons learned from our four-year Physician Profiling Study are being applied through our PSPA [Physician Services Practice Analysis] software. The Profiling Study data are also being analyzed to inform decisions on the design and development of new systems that can provide truly valid and comparable profiles. Data validity, reliability, and comparability must be thoroughly evaluated well before any publicly used profiles or report cards are constructed." ■

HMO hospital quality varies around U.S.

The quality of care provided by HMOs varies substantially around the country, with HMOs in some regions using higher-quality facilities and other using lower-quality hospitals, according to a study by RAND of Santa Monica, CA.[1]

The researchers used expected-to-actual mortality rates for cardiac bypass surgery as a measure of hospital quality. In California, where health care markets are dominated by managed care, the HMOs directed patients to hospitals with lower-than-expected mortality rates. In Florida, where managed care is less established, users of the traditional Medicare program were more likely to receive treatment from hospitals with lower mortality rates than Medicare HMO patients.

Reference

1. Escarce JJ, Horn RL, Pauly MV, Williams SV, et al. Health maintenance organizations and hospital quality of care for coronary artery bypass surgery. *Med Care Res Rev* 1999; 56:340-362. ▼

More than half of patients don't take medicine

Less than half (43%) of patients take their medication as prescribed, and it's worse for those with asthma (34%), back problems (36%), depression (28%), and migraines (28%), according to an

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on-line survey by Harris Interactive of Rochester, NY. The study included responses from more than 10,000 chronically ill adults.

Insurance coverage influenced compliance with medication use. Not surprisingly, those without coverage for prescriptions were less likely to have them filled, the study found. ■

SourceKit

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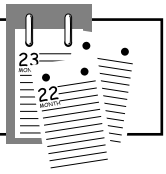
CALENDAR



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CME questions

1. According to a national survey by the National Research Corp. in Lincoln, NE, how many respondents said their level of trust and confidence in their physician was "very high"?
   A. 12%
   B. 18%
   C. 25%
   D. 34%

2. As medical groups began envisioning the "ideal clinical office practice" as a part of a project coordinated by the Institute for Healthcare Improvement in Boston, what was the first area of focus for many of them?
   A. diabetes care
   B. care teams
   C. open access and scheduling
   D. productivity measures

3. Which of the following formed an important foundation of the National Surgical Quality Improvement Program of the Veterans Affairs since its inception?
   A. input from the private sector
   B. congressional guidelines
   C. claims databases
   D. risk-adjustment methods

4. When physicians affiliated with Fallon Community Health Plan in Worcester, MA, counsel patients to quit smoking, their immediate goal is:
   A. to alter the patient's "stage of change," from precontemplative to contemplative or action
   B. to convince all smokers to quit
   C. to identify smoking-related health problems
   D. to raise awareness about the dangers of smoking

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1999 Index

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