State Health Watch

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THOMSON
AMERICAN HEALTH CONSULTANTS

In This Issue

Many uninsured don't know safety net is available in their community

"Build it and they will come," the saying goes. But for safety net providers and the uninsured, it appears that building it isn't enough. You also have to be sure people know you exist and want them to come.

Many studies have been done on the need for safety net providers. But until recently, no one had looked at the level of awareness of those providers' existence. A study by the Center for Studying Health System Change (HSC) paints a disturbing picture of how well — or not — people understand the help they have available, and what capacity problems could develop if they understood better.

HSC senior health researcher Paul Cunningham tells *State Health Watch* the study found that more than 50% of all uninsured Americans are unaware of a community safety net provider where they can receive lower-cost, affordable health care.

Many of the poorest and most disadvantaged uninsured people apparently do not use or are unaware of the health care safety net, he

*See **Safety net** on page 2*

President to pursue malpractice caps, which proponents say may help stem rising care costs

President George W. Bush, who says he has political capital from his reelection victory over Sen. John Kerry (D-MA) that he intends to spend, will use some of that capital to push for limits to jury awards in medical malpractice cases.

Fiscal Fitness: How States Cope

Citing a RAND Corp. study on California's medical malpractice law, which reduced awards in malpractice trials by an average of 30%, Bush says he intends to push for a nationwide cap on malpractice verdicts.

The push to cap malpractice verdicts, beyond actual economic damages such as the cost of long-term medical care or inability to work, was a major element in the president's campaigning. It was the first health-related item he mentioned in his Nov. 4 post-election news conference at which he reiterated the agenda he wanted to follow for his second term.

"We must confront the frivolous lawsuits that are driving up the cost of health care and hurting doctors

*See **Fiscal Fitness** on page 4*

State Health Watch
The Newsletter on State Health Care Reform

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Safety net

Continued from page 1

explains, including 4.6 million uninsured poor people, 5.7 million uninsured Latinos, and 2.4 million uninsured African Americans. Also, some 7.9 million uninsured are unaware of a safety net provider despite living within five miles of a community health center.

"Even if uninsured people don't have an immediate need for care, awareness of a place to receive affordable care could encourage them to seek timely care if the need arises, instead of waiting until their condition becomes more severe," Mr. Cunningham says.

An HSC Issue Brief on the study findings says the organization's 2003 Community Tracking Study Household Survey added questions to learn from uninsured people about their use and awareness of medical care providers who offer low-cost and affordable care.

Mr. Cunningham says he and his colleagues have done some research into whether having safety net providers makes much difference in terms of the uninsured getting care. "The missing piece," he says, "is whether they're aware of it or use it, even though it's there. And no one's been able to comment on that before."

Taken together, the responses indicate that less than half of the uninsured (48%) — some 18 million people — use or are aware of a safety net provider in their community. "These findings suggest that many uninsured people do not know of an affordable source of care to turn to when they need medical attention, and therefore, they are at elevated risk of going without needed medical care," Mr. Cunningham reports.

Among all uninsured people, awareness of a local safety net provider varies by income, race/ethnicity, health status, and proximity to community health centers. Poor and lower income uninsured people were more likely to know of a safety net provider in their community than uninsured people with higher incomes. Awareness of a local safety net provider also was higher among uninsured racial and ethnic minorities, likely in part, because they tend to have lower average incomes than uninsured whites. Some 57% of uninsured blacks and 53% of uninsured Latinos knew of a safety net provider in their community, compared with 41% of whites.

Awareness of safety net providers varied little by health status and number of chronic conditions, Mr. Cunningham says. Although 52% of the uninsured in the poorest health reported using or being aware of a safety net provider, that was only slightly higher and not significantly different from the 45% of the uninsured in very good or excellent health who used or knew of a safety net provider.

While 64% of uninsured people identify a single place where they usually go to receive medical care, only 45% of uninsured people with a usual source of care reported paying less than full price for their care. The uninsured are more likely to have a safety net provider as their usual source of medical care if they are poor (55%), black (56%), Latino (61%), and live close to a community health center (54%). Also, uninsured people in poorer health are more likely to have a safety net provider as a usual source of care.

Awareness of the safety net other than through a usual source of medical care appears to be much more limited. For those uninsured without a safety net provider as a usual source of care, only 29%

were aware of safety net providers in their community.

Overall, physician offices and clinics/health centers were identified as the most common sources of low-cost care. By contrast, hospital outpatient clinics and emergency departments were much less likely to be identified as safety net providers, although Mr. Cunningham says that other HSC research has shown that the uninsured receive more than half their outpatient care from hospital-based facilities. In particular, he says, only 8% of uninsured people who are aware of safety net providers in their community identified a hospital emergency department as a safety net provider.

"This is surprising, because hospital emergency departments are often considered to be providers of last resort for uninsured people, and about a quarter of all outpatient visits by the uninsured are to emergency departments. While the uninsured may be frequent emergency department users because of the lack of alternatives, and because by law they can't be turned away, these findings suggest that they don't necessarily regard emergency departments as places to receive affordable or lower-cost care," Mr. Cunningham adds.

Uninsured people who have a safety net provider as their usual source of care were much more likely than other uninsured people to identify a doctor's office as a safety net provider (35% to 13%). In contrast, uninsured people who do not have a safety net provider as their usual source of care were much more likely to identify clinics or health centers as safety net providers (55% vs. 37%).

When asked whether any uninsured members of their family used a safety net provider in the last year, less than one-fourth of survey respondents who were aware of safety net providers reported any use by family members. The main reason cited for not using a safety net provider in the previous year, according to Mr. Cunningham, was no need for care (about 60%). Some 20% cited a variety of other reasons, including perceived ineligibility (5%) or convenience issues such as long distance, long waiting times, or inconvenient hours.

Few people explicitly mentioned negative perceptions such as stigma associated with receiving lower-cost care, poor quality care, or concerns about the neighborhood as a reason for not using a safety net provider. About 20% cited other unspecified reasons for not using safety net providers.

According to Mr. Cunningham, increases in the number of uninsured, rising health care costs, and the uncertainty of any major coverage expansions in the foreseeable future mean that most uninsured Americans will continue to rely largely on the health care safety net for medical care. Uninsured people who live in areas without safety net providers are especially at high risk for lacking access to even basic medical care, he says.

Even when safety net providers such as community health centers are present, a large number of uninsured people apparently are unaware of them as places to receive affordable medical care, including many uninsured who are poor and have a high need for medical care.

Avoiding medical debt

If uninsured people are unaware of safety net providers, they may be at higher risk of going without needed medical care or incurring large out-of-pocket expenses and medical debt to obtain that care. Even for uninsured people without a specific need for medical care, awareness of a place to receive affordable medical care could encourage them to seek timely care if the need arises, rather than waiting until a problem becomes more severe and complicated to treat. Thus, Mr. Cunningham says, outreach efforts to increase awareness of safety net providers may be as important to improving access as are current efforts to expand the number of community health centers.

"That more than half of the uninsured are unaware of safety net providers in their communities also may reflect the fact that so few identify hospital-based outpatient settings as sources of lower-cost care," he writes. "While visits to hospital outpatient and emergency departments make up more than half of all outpatient visits by uninsured people, a comparatively smaller number of uninsured identified hospital-based facilities as safety net providers. Since services received in hospital-based settings are usually more expensive than in clinics or private physician offices, the uninsured may not perceive that hospitals are lower-cost sources of care, even if the services are provided at a discounted rate."

Solution lies at the local level

Asked about a potential solution to the lack of awareness of safety net providers, Mr. Cunningham tells *State Health Watch* that he believes more needs to be done at the local level. "Some recent federal programs have been geared to coordination of services and outreach, but it really should be a local effort for organizations to make themselves known and make people aware of the services they provide."

He says he does not believe the lack of awareness means that facilities are underutilized. "If anything, we hear about long waiting room lines and overcrowding. And if more of the uninsured start using the

safety net providers, it could mean some serious capacity constraints."

National Association of Community Health Centers vice president for federal, state, and public affairs Dan Hawkins says community health centers agree that outreach should be a vital part of all safety net providers' essential functions, and says it has been a key part of the community health center model of care since their 1965 founding. "Unfortunately, community outreach staffing at health centers has worsened for the first time in five years. In 2002, health center outreach workers served an average of 6,769 patients per worker, a 23% improvement over 1998 due to rising numbers of outreach workers. However, this trend is starting to change. The number of patients per outreach worker rose to 7,135 with no sign of rebounding any time soon," he continues.

"This is because health centers, like many other safety net providers, are caught in a brutal squeeze between rapid growth both in their uninsured patient loads and the costs for everything they need to provide quality health care, while revenues from virtually every source, including federal grants to support care for the uninsured, are failing to keep pace with inflation. This disturbing news raises deep concern that health centers may be facing a period, similar to what they experienced during the mid-1990s, when their ability to support such key nonmedical services fell dramatically amid revenue losses."

Mr. Hawkins says that unless the trend reverses itself, the association is concerned that vital services such as outreach will continue to decline.

[Contact Mr. Cunningham at (202) 484-5261 and Mr. Hawkins at (202) 296-1890. Download the HSC Issue Brief and other materials from www.hschange.org.] ■

Fiscal Fitness

Continued from page 1

and patients," he said at that news conference.

With Republicans having increased their majority in the Senate, some political observers say there could be enough support to overcome Democratic-led resistance to limits on malpractice awards.

Suits said to drive up costs

Advocates for capping the jury awards say suits without merit drive up health care costs by forcing malpractice insurance rates up and by encouraging the practice of defensive medicine by physicians who may order unneeded tests or procedures to protect themselves against charges that they didn't provide adequate care.

America's Health Insurance Plans CEO Karen Ignani said such suits are worth $100 billion a year if one factors in the cost of unnecessary tests. "Then there's the whole issue of safety and quality," she added. "Providers are afraid to talk about things that go wrong because they are afraid of being sued."

When Centers for Medicare & Medicaid Services administrator Mark McClellan was an economist and physician at Stanford (CA) University, he and a colleague published research that showed spending for hospital care was lower in states with malpractice caps than in those that didn't have the caps. But other studies have found little or no evidence of a link between costs and liability limits. An analysis of the president's health agenda during the campaign by the Lewin Group put the savings from changes in liability at $37 million over 10 years.

The RAND Corp. study found that California's malpractice law reduced awards in malpractice trials by an average of 30%. Because attorney fees were capped as well as jury awards, the researchers said, the net recovery by injured patients and their families only went down 15%, while payments to plaintiffs' attorneys were cut 60%.

California's Medical Injury Compensation Reform Act (MICRA), enacted in 1975, had two main provisions — it limited to $250,000 the amount of noneconomic damages a plaintiff could recover through a medical malpractice trial, and it limited attorney contingency fees on a sliding scale.

RAND researchers Nicholas Pace, Daniela Golinelli, and Laura Zakaras looked at data from 275 malpractice trials from 1995 to 1999 to determine:

1. how MICRA's caps on noneconomic damages affected the final judgments;
2. what types of cases and claims were most likely to have an award cap imposed following trial;
3. what effect MICRA had on attorney fees;
4. what effect MICRA had on net recoveries for plaintiffs;
5. what the effect on final awards would be if the MICRA cap were adjusted for inflation.

The three said their analysis indicated MICRA appeared to have achieved the California legislature's intended initial result of limiting defendants' expenditures. "Whether such savings have translated into reduced premiums and greater availability of coverage, which were the California legislature's ultimate goals, is beyond the scope of this analysis," they added.

While the study did not go into the adequacy of compensation for plaintiffs, it did identify types of cases and plaintiffs that lose the most under MICRA:

Plaintiffs with the severest injuries, such as brain damage, paralysis, or a variety of catastrophic

losses, had noneconomic damage awards capped far more often than plaintiffs with injury claims, and had median reductions of more than $1 million, compared with a median reduction of $286,000 for injury cases.

Plaintiffs who lost the highest percentage of their total awards were often those with injuries that led to relatively modest economic damage awards (about $100,000 or less) but that caused a great loss to their quality of life, as suggested by juries' million-dollar-plus awards for pain, suffering, anguish, distress, and the like. The plaintiffs sometimes received final judgments that were cut by two-thirds from a jury's original decision.

Death cases are capped more frequently than injury cases (58% vs. 41%) and when they are capped, death cases have much higher percentage reductions in total awards than injury cases, with a median drop of 49% as compared with a 27% drop for injury cases.

According to RAND, the study also suggested that MICRA resulted in a significant change in the economics of attorney representation in malpractice cases. The analysis suggested savings to defendants and their insurers were funded by plaintiffs and their attorneys. The effect of the financial shift on attorney practices is unclear, the report said. Important questions raised by the analysis included whether MICRA has discouraged attorneys from practicing in this field, whether MICRA has changed the way claims are litigated and settlements are negotiated, and whether MICRA has made it more difficult for plaintiffs in malpractice cases to find attorneys who will represent them.

Meanwhile, a report by the Congressional Budget Office (CBO) reviewed a number of studies evaluating state-level tort reform and assessing the relevance of that research for evaluating similar proposals at the federal level.

A number of the studies, the report said, have found that state-level tort reforms have decreased the number of lawsuits filed, lowered the value of insurance claims and damage awards, and increased insurers' profitability as measured by payouts relative to premiums in the short run. But CBO warned the findings should be interpreted cautiously for several reasons: First, data are limited, and the findings were not sufficiently consistent to be considered conclusive. Second, the more persuasive studies were limited in that they analyzed specific types of cases such as claims of bodily injury from auto accidents, making generalizations difficult. And third, because most reforms are often enacted in packages at the state level, distinguishing among the effects of different types of reforms can be difficult.

"The most consistent finding in the studies that CBO reviewed was that caps on damage awards reduced the number of lawsuits filed, the value of awards, and insurance costs," the CBO analysts wrote.

"Yet even those finding must be viewed in context. As a whole, the studies provided little systematic evidence that any one type of reform had a significant impact on any of the various outcome measures studied. Few of the findings — except for a reduction in the losses experienced by insurers — were independently corroborated by other studies. Some studies were unable to document any measurable effects from the tort reforms, a result that may be more reflective of the lack of data than of any failure of the reforms."

Many of the studies, CBO said, concluded that tort reform can affect outcomes most closely related to the tort system in much the same way that advocates of changing the tort system would claim. Those studies find that reforms, in general, have decreased the number of lawsuits, reduced awards, and improved the profitability of insurance providers.

But, "moving further away from economic behaviors most directly influenced by torts, the literature is thin," CBO said. "For that reason, the conclusions should be interpreted with caution, especially insofar as they indicate how federal tort reform might be expected to affect the economy."

The Coalition for Affordable and Reliable Healthcare (CARH) — an organization of hospitals, long-term care providers, businesses, health care professionals, and concerned citizens dedicated to working with the administration, Congress, and the media to educate the public about the medical liability insurance crisis and support federal reform legislation — has been calling attention to various studies that back its position.

Wyoming's action is promising

Late in 2004, it praised the Wyoming Healthcare Commission for providing evidence that capping noneconomic damages in medical malpractice cases will reduce malpractice costs.

CARH said the Wyoming study

Correction

A story in the November 2004 issue of *State Health Watch* contained an incorrect Internet address on page 10. To locate the status of federal legislation, the correct link is http:// thomas. loc.gov. We regret any inconvenience caused by the incorrect link. ■

found that capping noneconomic damages at $250,000 could lead to a 15% reduction in malpractice losses.

"Too many Americans can't find quality health care because runaway jury awards are driving malpractice liability insurance costs higher and forcing doctors to shut their doors," said CARH president John Thomas. "This report proves that capping noneconomic damages has a very real effect in lowering overall malpractice costs."

Wyoming is one of 20 states identified by the American Medical Association as a health care crisis state where high malpractice costs are driving doctors away.

Mr. Thomas said average malpractice awards have tripled to $3.5 million since 1994, driving medical liability insurance premiums up more than 500%.

In 2001, he said, 12 juries awarded verdicts higher than $20 million, including a $269 million judgment in Texas The cost of America's tort system is predicted to go from $200 billion in 2003 to $300 billion by 2005.

Critics of caps are pointing to a 2003 filing with the Texas Department of Insurance by medical malpractice insurer Medical Protective that said caps would reduce payouts by approximately 1%.

Medical Protective had supported Texas legislation mandating a $250,000 cap on noneconomic damages in most cases, calling such caps a "critical element [of tort reform] because in recent years we have seen noneconomic damages spiraling out of control."

Insurer not sure caps help

But when the company filed for a 19% rate increase, it said noneconomic damages represented a "small percentage of total losses paid."

The insurance department denied the request and the case moved to an administrative law judge.

Commenting on the filing, the Texas Medical Association said the caps already had helped reduce malpractice insurance rates. The doctors' organization said Texas Medical Liability Trust, the state's largest malpractice insurer, had reduced premiums by 17% after the caps were enacted.

An attorney for Medical Protective said the comment on the role of caps was one small part of the filing and had been taken out of context. Insurance department deputy commissioner Mike Geeslin said information in the filing should not be applied across the industry.

"You're looking at information submitted in a rate filing that is obviously slanted toward trying to justify some sort of rate action," he said.

Finally, a Massachusetts study reportedly has malpractice attorneys wondering why they're still looked at as the bad guys in the liability crisis.

The study showed that malpractice settlements in the state peaked three years ago, but insurance premiums continue to go up.

"These skyrocketing malpractice rates have to be due to something else," noted attorney Mark Breakstone.

"It is a fraud being perpetrated by the insurance industry, which the medical society has swallowed hook, line, and sinker. Doctors should be up in arms with the insurance industry that's gouging them."

Massachusetts Medical Society president Dr. Alan Woodward said the report's conclusions are misleading. While overall payments appear to have leveled off, he said, average individual award amounts have increased since 2001 from $388,800 to $431,000.

"What we still have is a system that's unsustainable going forward," he maintained.

Malpractice attorney Neil Sugarman told the *Boston Herald* he can understand why doctors are upset, given that some are paying 30% more for malpractice insurance. "But the leveling of their ire should not be on the people who get hurt," he continued. "It should be on the people who make the rates."

(Find the RAND study on-line at www.rand.org/publications/MG/MG234/. The Congressional Budget Office study is available at www.cbo.gov.) ■

This issue of *State Health Watch* brings you news from these states:

Learning collaboratives help health centers improve primary care

A Commonwealth Fund study reports that while community health centers deliver primary health care to much of New York City's low income population, the design and delivery of health care services at the centers can be made more patient-friendly.

There often are delays in access to care, according to researchers Pamela Gordon and Matthew Chin, making it difficult to get an appointment. Inefficiencies in patient flow also are common, they wrote, resulting in office visits that are needlessly long.

To help the community health centers improve, the nonprofit Primary Care Development Corp. (PCDC) implemented a learning collaborative model at four New York City community health centers. "Using PCDC's methods, each center made dramatic improvements in key operations: getting patients in and out of the center quickly; offering appointments with the patient's primary care provider on demand; enhancing revenue collections; and attracting and retaining patients," Ms. Gordon and Mr. Chin wrote.

The researchers said a successful implementation model is based on clear, simple, and effective principles, with five strategic principles applying to all collaboratives:

1. Build a high-functioning team.
2. Cultivate leadership support and involvement.
3. Track data and map the process from the patient's perspective.
4. Open lines of communication.
5. Use the expertise of PCDC coaches and program leaders.

The four models are shown here:

- **Redesign the patient visit program.** The redesign reduced the cycle time 40% from 68 minutes to 41 minutes, with a 58% increase in productivity from 2.85 patients per hour to 4.5 patients per hour. Ms. Gordon and Mr. Chin said the Jerome Belson Health Center serves a developmentally disabled population, which made the task of reducing patient cycle times even more challenging than usual. "Even so," they said, "the principles of redesign successfully transformed an overcrowded waiting room that was far from user-friendly into an environment where the patient comes first, and providers and staff are highly productive." Redesign principles include: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the expected; and do today's work today.
- **Redesign the patient visit process.** At Union Health Center, PCDC said the key to reducing backlog and meeting demand was to measure the third-next-available appointment time. Union patients commonly had to wait as long as 15 days before they could schedule an appointment. After the seven-month redesign, patients received appointments in one day or less, a 93% decrease in appointment scheduling time. And the patient no-show rate dropped as staff and patient satisfaction levels increased. Redesign principles include: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand for visits; and balance supply (provider time) and demand (patient visits) daily.
- **Improve efficient revenue collection.** The Brownsville Multi-Service Family Health Center undertook an effort to collect revenues efficiently through the entire collection process. The center serves a low-income community living predominantly in public housing. Its challenge was how to sustain revenue while meeting its clients' overwhelming needs. As a result of changes made through the learning collaborative process, average weekly cash receipts increased by 46%. Reimbursement per visit rose 55%, from $78 to $121. Ms. Gordon and Mr. Chin said the case study also documents how the work of the learning collaborative improved employee morale and encouraged high performance throughout the organization. Another significant result of the effort was the adult medical care unit increased patient visit volume by 5% after several years of decline. Ten revenue maximization principles identified in the redesign are: Do it right the first time; collect money due at the point of service; eliminate lag times between service and billing; manage claim rejections; redesign bad processes; encourage teamwork; leverage technology; share data; establish good internal control systems; and maintain appropriate staffing.
- **Improve marketing and customer service.** This case study provided insight into how the South Bronx United Health Plan (UHP) health center adapted highly targeted marketing practices and increased and sustained

patient volume in a very competitive environment. UHP had conducted an extensive media campaign for a new facility, which had generated much interest. But it realized it needed help in understanding the process of marketing without relying on expensive consultants. UHP enrolled in PCDC's Marketing and Customer Service Learning Collaborative. PCDC helped UHP understand the importance of a two-pronged approach to community outreach — creating an in-house marketing division able to customize outreach efforts to narrowly defined populations ,and creating and maintaining employee and customer satisfaction. Marketing principles that were applied included situational analysis, marketing objectives, marketing strategies, marketing tactics, and evaluation. Eight customer service principles are leadership commitments, service defined from a patient perspective, service standards, continuous improvement, internal communication, ongoing communication, reward and recognition, and patient satisfaction measures.

Re-engineering patient throughput, provider paneling, and patient scheduling is at the heart of the PCDC collaborative approach, according to Ms. Gordon and Mr. Chin. "Overhauling these processes is the key to enhanced health care success, provider and customer satisfaction, and operating efficiency," they said.

"The end result is the delivery of patient-centered care. Patients are very satisfied with these changes. They are able to access their primary care provider on the same day instead of next week or next month and are able to complete the visit in less than one hour instead of the typical two to four. For staff, the days run more smoothly. Employees are able to work at their highest level. People are able to go to lunch and the clinic closes on time. Ultimately, clinicians have better support for their work and can focus on building relationships with patients," the researchers explained.

"Transforming the dismal patient experience into one that is satisfying for both patients and health care workers takes effort. Health centers must permanently change their individual and collective work behaviors: the way they treat patients, the engineering of work processes, the ability to work together in teams, and the use of technology. Problems arise because an organization's leadership often views the collaborative journey as a consulting engagement."

Pamela Gordon
Matthew Chin
Researchers
The Commonwealth Fund
New York City

All PCDC collaborative participants use the same collaborative model, which has three different stages. At each stage, elements of the collaborative are introduced and implemented.

PCDC cautioned, however, that the path through the stages is not linear but rather is more like a spiral, with each collaborative stage overlapping the stage that comes before it and also the one to follow. The work of one stage spills into and informs the work of the other stages.

"Rather than following directions that take them from point A to point Z," the researchers said, "participants also move forward in an elliptical path that is marked by their growing awareness of what works and what does not what at their particular health center. With this awareness comes an ability to use tools to make and sustain permanent changes in productivity, efficiency, and attitude."

The first step of the pre-work stage is to form a team from multiple disciplines within the center and start to gather the baseline patient tracking data that will be the basis upon which all improvements are measured. Teams participate in three learning sessions facilitated by PCDC staff and nationally recognized leaders in the collaborative field being worked on.

Two action periods take place between the three learning sessions. During the action periods, teams run through rapid tests of change in highly controlled situations. These sessions use the plan, do, study, act cycle method that leads to a final redesign model that is completed over a period of three full days. Once the process is finalized, the methods are passed on to non-team personnel.

Transform how people work

According to the evaluation, collaboratives do more than simply fix particular operations problems. They transform the way people work, expand the boundaries of responsibility, and instill a sense of accountability to patients.

PCDC contended it is very important to engage health center leadership in the process. Organizational leaders are inspired when they experience the change process through the perspective of

their newly motivated staff, officials said. Senior leadership must be involved if the collaborative team is to be successful over the long run.

Teams with weak organizational leadership frequently reach their goals. But without consistent, engaged leadership, few teams can sustain success.

PCDC said it is difficult to tell if gains delivered by learning collaboratives can be maintained. Data collection often stops shortly after a collaborative ends, and there is no strong evidence that supports sustainability of the gains long-term.

Sustaining gains is a problem

"PCDC has often observed that when a collaborative ends, there is little focus on sustaining the initiative," the report said.

"Inevitably, the improvements do not last. Teams are consistently able to make breakthrough changes and completely overhaul existing processes, but if they do not build in accountability for ongoing measurements, the improvements are lost. . . . Health center leaders must recognize that they should take steps to preserve these gains, even after the collaborative concludes."

Ms. Gordon and Mr. Chin said a model familiar to many people that is able to extend involvement without creating dependency is Weight Watchers.

The program is based on three simple principles — eat less, move more, and drink eight glasses of water every day. The principles are easy to understand, but often quite difficult to follow.

Likewise, principles for redesigning the patient visit and advanced access are simple and easy to understand, but hard to follow. For redesigning patients' visits, the principles are: Don't move the patient; eliminate needless work; increase clinician support; communicate directly; exploit technology; monitor capacity in real time; get all the tools and supplies you need; create broad work roles; organize patient care teams; start all visits on time; prepare for the unexpected; and do today's work today.

For advanced access, the principles are: Do today's work today; work down the backlog; reduce appointment types and times; develop contingency plans; reduce demand for visits; and balance supply (provider time) and demand (patient visits) daily.

Ms. Gordon and Mr. Chin suggested that those who participate in a learning collaborative need ongoing support after the process every bit as much as Weight Watchers participants do.

"Perhaps, the problem lies in the way a collaborative is described as a framework for learning a new method," they wrote.

"Instead, it should be recast as a process used by a community of participants to make lifelong behavioral changes. Transforming the dismal patient experience into one that is satisfying for both patients and health care workers takes effort. Health centers must permanently change their individual and collective work behaviors: the way they treat patients, the engineering of work processes, the ability to work together in teams, and the use of technology. Problems arise because an organization's leadership often views the collaborative journey as a consulting engagement. Leaders demand solutions that require little effort or time on the part of management. Despite their health center's participation in the collaborative, many leaders never learn how to initiate and sustain change," the researchers said.

PCDC said it understands that gains achieved through the collaborative process are fragile and are almost certain to unravel if left unattended because the organization's transformation is incomplete.

The solution, it noted, is to make a health center's leadership responsible for anchoring the new culture in the organization.

First, management should communicate to employees frequently and clearly that the new methods and new ways of measuring results are not part of the organization's culture. And second, management should implement clear, consistent systems for defining, measuring, and sharing key results. "These two actions by management form the foundation of a strong organizational culture," the report said.

(More information is available from The Commonwealth Fund online at www.cmwf.org.) ■

Software helps plan infectious illness treatment

In the face of a bioterrorism attack or even a major flu outbreak, state, county, and local health departments will be expected to act quickly to bring vaccinations and other medical care to all who need it.

The speed at which health care facilities treat patients in such an event can be the difference between life and death for thousands or even millions of people.

Now, those agencies have help coming in the form of RealOpt, a software program created by a Georgia Tech professor. Based on a clinical model developed by the Centers for Disease Control and Prevention (CDC), Eva Lee, PhD, a professor of industrial and systems engineering at Georgia Tech, wrote the program to help health departments organize the most efficient plan for treating infectious illness, whether natural or a man-made outbreak.

The program was tested by county health departments in Georgia and North Carolina last fall and is to be made available free to health departments all over the country.

Officials say the program is a big step in preventing the spread of something like influenza or small pox. In the event of an outbreak or bioterror attack, they say, local health departments truly have only a matter of days to vaccinate or isolate just about every man, woman, and child in a city or metro area. And while the departments have plans in place, the RealOpt software program can give them a good indication of how their existing plan would perform in an actual outbreak, factoring in possible panic and even language barriers, and what changes could be made to make it run as smoothly as possible.

Ms. Lee tells *State Health Watch* that greatly improving a health department's efficiency in such an emergency could mean the difference between vaccinating 20,000 people at one location and only being able to get to 10,000, thus greatly limiting or even preventing the disease's ability to spread outside the affected area.

Until actually faced with an emergency, it may be hard for health departments to determine how many doctors and nurses will be needed, how long it will take for frightened citizens to come to a center, how long for them to complete required paperwork, and how infected patients can be separated from those who are still healthy.

Recognizing that local health departments needed guidance on what human resources would be required to treat the affected population, the CDC created a model to assist in the effort. Ms. Lee, who also is an associate professor at Emory University's Winship Cancer Institute, assembled a Georgia Tech team to use the CDC model as a guide to build a more powerful program.

She tells *State Health Watch* that RealOpt can be used to prepare for a possible outbreak as well as for emergency reassignment of health care workers within a clinic and between clinics during an actual outbreak. By determining their preparedness, she says, health departments will have a thorough estimate of what resources and funds they will need to treat their communities before an actual outbreak occurs.

Many variables analyzed

The program takes many variables associated with an emergency health care facility's treatment of a very large group of people and, through simulation and optimization, pinpoints the most efficient way to move patients through the facility.

Using the program, a health department can determine the most efficient facility layout, the number of health care professionals needed in various areas, the number of vaccinations needed, and the time it will take to treat patients.

Processing data in real time

In addition to being used as a planning tool, RealOpt also can be used to process data in real time during an emergency. Thus, as patient flows fluctuate, the program can direct reallocation of a facility's resources in a fraction of a second, sending additional doctors or nurses where they are needed or more attendants to a paperwork processing area.

Ms. Lee says the real-time processing of her program is a significant advantage compared to commercial scheduling systems that are available and can take several hours to process inputs and generate a response. Run time for RealOpt is within a minute, she says.

She describes it as "extraordinarily detailed" in the many factors it considers when optimizing a patient flow pattern.

There will be chaos

Asked about a recent study that predicted severe psychological and emotional problems in citizens during a bioterrorism attack, Ms. Lee says she agrees there would be chaos, although she thinks that rather than people refusing to come to a health center or get vaccinated, the problem will be that everyone

will want to come in at once.

"Terrorists could come to a health center," she cautions. "Security is a huge risk. How people will respond is a very big issue."

When centers go through a practice drill, she points out, it is not as easy to see what problems will arise as it is with a computer simulation.

According to Ms. Lee, she and her team already are at work on the next phase of the project, expanding the scope of the program to include an even more complex problem — how to quickly and efficiently get thousands or even millions of patients to treatment facilities. That effort will work out the best locations in which to establish emergency care facilities based on roads and population density. Facilities could include anything from a school gym to a football stadium. That phase should be ready for testing in the spring.

The final phase of the program will include simulations of the spread of infectious disease through the population and within treatment clinics.

[Contact Ms. Lee at (404) 605-7173.] ■

Should hospitals guarantee poverty care?

While the Mississippi Hospital Association protests that the idea would be disastrous for its members, attorney Richard Scruggs said a lawsuit settlement being negotiated with North Mississippi Medical Center involving free and reduced medical care could become a national model for the level of service hospitals should provide.

Mr. Scruggs suggested hospitals provide free care to anyone with income up to 200% of the federal poverty level.

Applying a sliding-fee scale

He also said hospitals should apply a sliding payment scale discounted off the Medicare payment rate for those between 200% and 400% of poverty.

For a family of three, the poverty level is $15,670, making the 200% level $31,340 and the 400% level $62,680.

According to state officials, half of Mississippi's 1 million households come under the 200% level.

The Medical Center only would say that it was looking at Mr. Scruggs' proposal to make sure that it can afford it and that it doesn't have any unintended consequences.

Former Mississippi attorney general Mike Moore, who represents the hospital, said the best deal "would be one where the hospital can continue its mission and the uninsured are treated fairly."

While Mr. Scruggs and other attorneys have sued some 450 hospitals and the American Hospital Association claiming that the facilities charge the uninsured "sticker prices" while giving discounts to those covered by private or government insurance programs, North Mississippi Medical Center is the only one to consider a settlement rather than go to trial.

Could affect 50% of patients

Mississippi Hospital Association president Sam Cameron said one hospital in his state looked at Mr. Scruggs' proposal and determined that it would cover 50% of the hospital's patient population.

He said that if hospitals adopted such a model, small employers would drop health insurance for their employees, and some employees would drop their coverage so they could obtain free medical care.

Mr. Scruggs said his proposed settlement also calls on hospitals to use a kinder, gentler approach to collecting fees from the uninsured.

"They're entitled to sue and garnish, but not get liens on houses," he told the Jackson, MS, *Clarion-Ledger.*

Mr. Cameron told the newspaper that government regulations require hospitals to be uniform in their approach to all patients, permitting hospitals to file suit when necessary.

Although Mr. Scruggs said many nonprofit hospitals don't provide enough charity care, sometimes amassing large cash reserves amounting to hundreds of millions of dollars, Mr. Cameron contended that the American Hospital Association had determined the nation's 5,000 hospitals provided more than $22 billion in uncompensated care last year.

"Nonprofit hospitals have more cash than all the states combined, yet they're not providing service that left them free of taxation," Mr. Scruggs said. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Study shows increase in uninsured workers

TALLAHASSEE, FL—The percentage of working people without health insurance in Florida increased over the past five years, mostly because they couldn't afford rising premiums, a new state study has found. Nearly 20% of the state's working age population is without health insurance, compared to about 17% five years ago, according to a study by the state Agency for Health Care Administration.

Of those, more than half went without insurance for a year or more, and 63% blamed unaffordable premiums. State officials point to one bright spot: The number of low-income Floridians with insurance increased, primarily because of state-subsidized programs such as Healthy Kids. The study was intended to provide lawmakers with information as they move to overhaul Medicaid, the state-federal insurance program for the poor, and search for ways to make health insurance more affordable.

—*St. Petersburg Times,* Nov. 18, 2004

Health plan premiums for poor may cease

PORTLAND, OR—A 20-month-old requirement that the state's poorest pay premiums for Oregon Health Plan coverage may be lifted, if members of the Legislative Emergency Board approve. Oregon Health Plan officials petitioned for the change. Last year, the state imposed premiums of $6 to $20 for coverage under the health plan's standard plan designed for single adults and couples with incomes below the poverty line. Once the premiums were imposed, enrollment fell from nearly 100,000 to a little more than 50,000.

The falling enrollment helped ease the Oregon Health Plan's tightening budget. But it also defeated the purpose of the plan, which was to extend health care coverage to the state's poorest residents. The premium "systematically worked to erode enrollment among people who are most vulnerable," said Ellen Pinney, director of the Oregon Health Action Campaign, an advocacy group for the uninsured.

Under the proposal that Department of Human Services director Gary Weeks advanced, Health Plan members making less than $77 a month for a single person and $112 a month for a couple would no longer pay the $6 premium. Premiums for those with higher incomes would be kept in place.

Ending the $6 premium for the poorest Oregonians would reduce state revenues only slightly, Mr. Weeks said. It would require the Oregon Health Plan to drop about 250 more Oregonians from coverage to make up for the loss.

—*Corvallis Gazette-Times,* Nov. 18, 2004

University receives disparities grant

MOBILE, AL—The University of South Alabama's Center for Healthy Communities has received a $1.2 million grant from the National Institutes of Health to address health care disparities in minority and underserved populations in the area. Programs to be funded include a church-based exercise project, home-monitoring of certain medical conditions for inner-city residents, and a summer enrichment program for minority high school students to help them become competitive applicants for careers in biomedical sciences, according to Martha Arrieta, associate director of the Center for Healthy Communities.

The three-year grant is from the National Center on Minority Health and Health Disparities' Project EXPORT, whose awards "support the development of resources and infrastructure . . . as a prelude to initiating full-scale health disparities research, community outreach and training aimed at eliminating health disparities." That means institutions receiving the grants can test health interventions and programs, and the results become public knowledge and can be duplicated, Ms. Arrieta explained.

—*Mobile Register,* Nov. 18, 2004