



CUSTOMER FOCUSED HEALTH CARE DELIVERY AND SATISFACTION

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Acad Med. 2004 Jun;79(6):511-20.

Teaching communication in clinical clerkships: models from the macy initiative in health communications.

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Medical educators have a responsibility to teach students to communicate effectively, yet ways to accomplish this are not well-defined. Sixty-five percent of medical schools teach communication skills, usually in the preclinical years; however, communication skills learned in the preclinical years may decline by graduation. To address these problems the New York University School of Medicine, Case Western Reserve University School of Medicine, and the University of Massachusetts Medical School collaborated to develop, establish, and evaluate a comprehensive communication skills curriculum. This work was funded by the Josiah P. Macy, Jr. Foundation and is therefore referred to as the Macy Initiative in Health Communication. The three schools use a variety of methods to teach third-year students in each school a set of effective clinical communication skills. In a controlled trial this cross-institutional curriculum project proved effective in improving communication skills of third-year students as measured by a comprehensive, multistation, objective structured clinical examination. In this paper the authors describe the development of this unique, collaborative initiative. Grounded in a three-school consensus on the core skills and critical components of a communication skills curriculum, this article illustrates how each school tailored the curriculum to its own needs. In addition, the authors discuss the lessons learned from conducting this collaborative project, which may provide guidance to others seeking to establish effective cross-disciplinary skills curricula.

Publication Types:

Review

Review, Tutorial

PMID: 15165970 [PubMed - indexed for MEDLINE]

Acad Med. 2004 Jun;79(6):508-10.

Satisfying the patient, but failing the test.

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Communication experts convened in Kalamazoo, Michigan, in 2002 to assess current tools that evaluate physician communication skills. They noted occasional discrepancies between a patient's impression of a physician's skill and the physician's performance as measured by current checklists. The authors explore the reasons for this discrepancy and propose a research agenda to resolve it. They maintain that the patient's evaluation of physician communication skills depends upon the degree to which the patient's reason for seeking care is satisfied. Since current evaluation tools do not incorporate information to which only the patient has access, they can assess neither the meaning of the interview nor the success of the physician from the patient's point of view. The authors conclude that physicians' understanding of how well they are meeting patients' needs may require competencies that are unmeasured or only partially measured by current assessment tools, such as "flexibility" or "improvisational skills." These competencies likely reside in the nonverbal domain. The authors suggest that (1) a new tool must be developed that measures the essence, or meaning, of the visit from the patient's perspective; (2) this tool must incorporate information derived directly from the patient; and (3) research is needed to define those physician and patient behaviors that facilitate meaningful encounters.

PMID: 15165968 [PubMed - indexed for MEDLINE]

Acad Med. 2004 Jun;79(6):495-507.

Assessing competence in communication and interpersonal skills: the Kalamazoo II report.

Duffy FD, Gordon GH, Whelan G, Cole-Kelly K, Frankel R, Buffone N, Lofton S, Wallace M, Goode L, Langdon L; Participants in the American Academy on Physician and Patient's Conference on Education and Evaluation of Competence in Communication and Interpersonal Skills.

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Accreditation of residency programs and certification of physicians requires assessment of competence in communication and interpersonal skills. Residency and continuing medical education program directors seek ways to teach and evaluate these competencies. This report summarizes the methods and tools used by educators, evaluators, and researchers in the field of physician-patient communication as determined by the participants in the "Kalamazoo II" conference held in April 2002. Communication and interpersonal skills form an integrated competence with two distinct parts. Communication skills are the performance of specific tasks and behaviors such as obtaining a medical history, explaining a diagnosis and prognosis, giving therapeutic instructions, and counseling. Interpersonal skills are inherently relational and process oriented; they are the effect communication has on another person such as relieving anxiety or establishing a trusting relationship. This report reviews three methods for assessment of communication and interpersonal skills: (1) checklists of observed behaviors during interactions with real or simulated patients; (2) surveys of patients' experience in clinical interactions; and (3) examinations using oral, essay, or multiple-choice response questions. These methods are incorporated into educational programs to assess learning needs, create learning opportunities, or guide feedback for learning. The same assessment tools, when administered in a standardized way, rated by an evaluator other than the

teacher, and using a predetermined passing score, become a summative evaluation. The report summarizes the experience of using these methods in a variety of educational and evaluation programs and presents an extensive bibliography of literature on the topic. Professional conversation between patients and doctors shapes diagnosis, initiates therapy, and establishes a caring relationship. The degree to which these activities are successful depends, in large part, on the communication and interpersonal skills of the physician. This report focuses on how the physician's competence in professional conversation with patients might be measured. Valid, reliable, and practical measures can guide professional formation, determine readiness for independent practice, and deepen understanding of the communication itself.

Publication Types:

Consensus Development Conference

Review

Review, Tutorial

PMID: 15165967 [PubMed - indexed for MEDLINE]

AIDS Read. 2004 May;14(5):220-4.

Advanced-access scheduling increases quality, productivity, and revenue.

Valenti WM, Bookhardt-Murray J.

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PMID: 15198080 [PubMed - indexed for MEDLINE]

Am Fam Physician. 2004 May 15;69(10):2310.

What people want from their family physician.

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The public wants and is satisfied by care provided within a patient-physician relationship based on understanding, honesty, and trust. If the U.S. health care system is ever to become patient-centered, it must be designed to support these values and sustain, rather than fracture, the relationships people have with their primary physician.

PMID: 15168951 [PubMed - indexed for MEDLINE]

Am Fam Physician. 2004 May 1;69(9):2255-6, 2259.

The right to know--but at what cost?

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University Medical Center, Washington, DC, USA.

PMID: 15152971 [PubMed - indexed for MEDLINE]

Am J Health Promot. 2004 May-Jun;18(5):370-7.

Factors underlying variation in receipt of physician advice on diet and exercise: applications of the behavioral model of health care utilization.

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PURPOSE: To identify factors associated with receipt of physician advice on diet and exercise, including patient sociodemographic characteristics, health-related needs, and health care access, using Andersen's model of health care utilization. **DESIGN:** A cross-sectional analysis was performed using data from the 2000 National Health Interview Survey (NHIS). **SETTING:** NHIS data were collected through personal household interviews by Census interviewers. The overall response rate for the 2000 NHIS adult sample was 82.6%. **SUBJECTS:** Subjects were a representative sample of the American civilian, noninstitutionalized population aged 18 and older. After eliminating missing data and respondents who reported they did not see a doctor in the past 12 months, sample sizes for physician advice on diet and exercise were $n = 26,255$ and $n = 26,158$, respectively. **MEASURES:** Using the 2000 NHIS, the prevalence of receipt of physician advice on diet and exercise was assessed. Multiple logistic regression analyses were performed to examine the associations between receipt of physician advice on diet and exercise and potential predictors, adjusting for all covariates. **RESULTS:** By self-report, 21.3% and 24.5% of respondents received physician advice on diet and exercise, respectively. Being middle-aged (adjusted odds ratio [AOR] = 1.14, 95% confidence interval [CI], 1.0-1.29 for diet; AOR = 1.55, 95% CI = 1.33-1.79 for exercise) and having a baccalaureate degree or higher (AOR = 1.78, 95% CI = 1.52-2.08 for diet; AOR = 1.75, 95% CI = 1.47-2.07)

were associated with a higher likelihood of receiving physician advice on diet and exercise. African-Americans (AOR = .78, 95% CI = .67-.92) and foreign-born immigrants (AOR = .57, 95% CI = .38-.86) were less likely to receive physician advice on exercise. The prevalence of physician advice was higher for persons who chose hospital outpatient departments as a usual source for care (AOR = 2.36, 95% CI = 1.66-3.36 for diet; AOR = 2.39, 95% CI = 1.68-3.4 for exercise) than for adults with other types of usual care sites. Poorer self-rated health status (AOR = 5.2, 95% CI = 4.12-6.57 for diet; AOR = 2.63, 95% CI = 2.04-3.38 for exercise) and obesity (AOR = 2.32, 95% CI = 2.02-2.66 for diet; AOR = 3.01, 95% CI = 2.46-3.69 for exercise) was positively associated with the likelihood of receiving physician advice on diet and exercise. **CONCLUSIONS:** Effective strategies to increase receipt of physician advice should include efforts to improve access to regular source of care and patient-physician communication. Sociodemographic factors remain independent and important predictors of who obtains such advice.

PMID: 15163138 [PubMed - indexed for MEDLINE]

Am J Hosp Palliat Care. 2004 May-Jun;21(3):196-202.

Hospice referral decisions: the role of physicians.

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In our study, we collected and evaluated the opinions of physicians in the Lowcountry of South Carolina (Berkeley, Charleston, and Dorchester counties) regarding their referrals to hospice programs and the extent of influence that their patients and families had on the decision. The research questionnaire was sent to 362 physicians who made referrals to hospice (53 percent response rate) and to 337 physicians who did not make referrals (40 percent response rate). Results revealed that medical doctors take the initiative in referrals. They felt that late referrals were due to reluctance on the part of the patient and the patient's family to admit that death was imminent. No differences were found in age, sex, medical specialty percent of terminally ill patients per practice, or initiative taken. However when the age and sex of physicians were evaluated,

a statistically significant difference was found; females younger than 45 years of age were more likely to make referrals than younger males. Younger physicians were more likely to perceive that the family's reluctance to admit that death was near was a barrier to hospice referrals.

PMID: 15188919 [PubMed - indexed for MEDLINE]

Am J Hosp Palliat Care. 2004 May-Jun;21(3):191-5.

Telehospice in Michigan: use and patient acceptance.

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Telehospice, the use of telemedicine technologies to provide services to hospice patients, offers an innovative solution to the challenges of providing high-quality, cost-effective end-of-life care. Specifically, the technology allows caregivers to transmit video images of patients, which provide off-site nurses with the information they need to assist the caregiver. Our telehospice project was conducted in urban and rural Michigan between 2000-2002 and collected data from 187 patients receiving telehospice services in their homes during this study. Overall, nurses were the primary providers of telehospice services and initiated the majority of routine televisits. Often, patients who described themselves as "overwhelmed" at the time of enrollment declined telehospice. However, patients were extremely satisfied with telehospice and often expressed frustration that nurses did not use the telehospice equipment more frequently.

PMID: 15188918 [PubMed - indexed for MEDLINE]

Am J Obstet Gynecol. 2004 May;190(5):1484-8.

Resident physician attire: does it make a difference to our patients?

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OBJECTIVES: This study was performed to examine the preferences of patients regarding physician attire, and if their perception of physician competence was influenced by the physicians' clothing style. **METHODS:** Patients attending the obstetrics and gynecology clinic in which residents provided the majority of direct patient care were invited to participate in this study by completing a questionnaire. Patients were first asked to respond to 3 questions about their preference regarding physician attire. They were then asked to examine a series of photographs illustrating a variety of physician clothing styles worn by a model. Patients were asked to respond to 2 questions: 1). If your doctor is dressed in this outfit, would that make you more or less comfortable talking to your physician?, and 2). If your doctor is dressed in this outfit, would it make you feel more or less confident in his/her abilities? **RESULTS:** The majority of the respondents expressed no preference for their physician wearing a white coat (60%/110/183), or they did not respond that a physician's dress influenced their comfort level (63%/111/179) or the confidence (62%/114/181) they had in their physician. However, for both male and female physician models, the comfort level of patients and their perceptions of physician competence were the highest in response to images of physicians dressed in scrubs with a white coat, and least for casual dress. **CONCLUSION:** Resident physician attire makes a difference to patients. Our patients prefer the white coat with surgical scrubs. Casual clothing is less well liked by our patients.

PMID: 15167876 [PubMed - indexed for MEDLINE]

Arch Phys Med Rehabil. 2004 Jun;85(6):943-50.

Community integration and satisfaction with functioning after intensive cognitive rehabilitation for traumatic brain injury.

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OBJECTIVE: To evaluate the effectiveness of an intensive cognitive rehabilitation program (ICRP) compared with standard neurorehabilitation (SRP) for persons with traumatic brain injury (TBI). **DESIGN:** Nonrandomized controlled intervention trial. **SETTING:** Community-based, postacute outpatient brain injury rehabilitation program. **PARTICIPANTS:** Fifty-six persons with TBI. **INTERVENTIONS:** Participants in ICRP (n=27) received an intensive, highly structured program of integrated cognitive and psychosocial interventions based on principles of holistic neuropsychologic rehabilitation. Participants in SRP (n=29) received comprehensive neurorehabilitation consisting primarily of physical therapy, occupational therapy, speech therapy, and neuropsychologic treatment. Duration of treatment was approximately 4 months for both interventions. **MAIN OUTCOME MEASURES:** Community Integration Questionnaire (CIQ); and Quality of Community Integration Questionnaire assessing satisfaction with community functioning and satisfaction with cognitive functioning. Neuropsychologic functioning was evaluated for the ICRP participants. **RESULTS:** Both groups showed significant improvement on the CIQ, with the ICRP group exhibiting a significant treatment effect compared with the SRP group. Analysis of clinically significant improvement indicated that ICRP participants were over twice as likely to show clinical benefit on the CIQ (odds ratio=2.41; 95% confidence interval, 0.8-7.2). ICRP participants showed significant improvement in overall neuropsychologic functioning; participants with clinically significant improvement on the CIQ also showed greater improvement of neuropsychologic functioning. Satisfaction with community functioning was not related to community integration after treatment. Satisfaction with cognitive functioning made a significant contribution to posttreatment community integration; this finding may reflect the mediating effects of perceived self-efficacy on functional outcome. **CONCLUSIONS:** Intensive, holistic, cognitive rehabilitation is an effective form of rehabilitation, particularly for persons with TBI who have previously been unable to resume community functioning. Perceived self-efficacy may have significant impact on functional outcomes after TBI rehabilitation. Measures of social participation and subjective well-being appear to represent distinct and separable rehabilitation outcomes after TBI.

Publication Types:

Clinical Trial

Controlled Clinical Trial

PMID: 15179648 [PubMed - indexed for MEDLINE]

Benefits Q. 2004;20(2):49-59.

Defined contribution health plan to consumer driven health benefits: evolution and experience.

Patterson MP.

Today, the idea of placing more choice on employees "consuming" health care and giving them more responsibility and incentive to control health care costs and

utilization is alive and thriving in the form of consumer-driven health care. This article examines the evolution of consumer-driven health benefits--including the experience of the first generation of "defined contribution" health care participants (i.e., retirees) and the results of different approaches employers have taken to early consumer-driven plan designs. The author then describes what's needed to answer the question: "Can consumer-driven health care control health cost?"
PMID: 15146754 [PubMed - indexed for MEDLINE]

Benefits Q. 2004;20(2):43-8.

Consumer-driven health care: tangible employer actions.
Beauregard TR.

In response to double-digit health care cost increases, leading employers are aiming aggressive strategies at changing participant and provider behaviors--strategies that go well beyond the narrow idea of a new cost-sharing design. This article describes the elements of a comprehensive consumer-driven health care strategy and provides examples of tangible consumer-driven health care initiatives in the areas of design, pricing, contracting, support and public policy.

PMID: 15146753 [PubMed - indexed for MEDLINE]

Benefits Q. 2004;20(2):23-31.

Consumer-driven health plans: design features to promote quality improvement.
Meyer J.

New Directions for Policy, Washington, D.C., USA.

The most prevalent form of consumer-driven health plans (CDHPs) presents risks in terms of the cost, quality and appropriate use of health care. This article identifies those risks and shows employers how they can reduce them without compromising the overall cost-control potential of CDHPs. A good CDHP strategy should work on both the demand and supply sides of the market.

PMID: 15146750 [PubMed - indexed for MEDLINE]

Benefits Q. 2004;20(2):15-22.

Consumer-driven health care: the future is now.
Bachman RE.

Given that managed care seems to have run its course, employers are forced to deal with escalating health care costs by reducing benefits and lowering pay--or are they? Why not bring the power of the responsible, informed consumer to health care? Consumer-driven health care offers a new, economically rational direction that can simultaneously address the needs of both employers and employees. This article reviews the factors leading to the need for consumer-driven health care and describes the characteristics and benefits of its current and next generations of development.

PMID: 15146749 [PubMed - indexed for MEDLINE]

Benefits Q. 2004;20(2):7-14.

The consumer-driven approach: defining and measuring success.
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Employers' reluctance to implement consumer-driven health plans (CDHPs) is at least in part due to their not understanding how to define and measure the success of CDHPs. To assist employers, the authors define potential points of success for CDHPs in the areas of consumer engagement, consumer financial considerations and employee health and productivity. They then offer ways of measuring success in those areas, as well as in the area of employer cost control. By taking a carefully considered approach to the decision of whether to offer a CDHP, employers can grasp potential opportunities to control health care costs.

PMID: 15146748 [PubMed - indexed for MEDLINE]

BMJ. 2004 Jun 5;328(7452):1343. Epub 2004 May 19.

What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study.

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OBJECTIVE: To obtain feedback from patients receiving palliative care and their relatives from various ethnic backgrounds about their experiences of the disclosure process and their satisfaction with information sharing during the illness. DESIGN: A qualitative study with semistructured single interviews.

SETTING: Perth, Western Australia, and Winnipeg, Manitoba, Canada.

PARTICIPANTS:

72 participants registered with palliative care: 21 patient-family dyads in Perth and 14 dyads and 2 patients in Winnipeg. RESULTS: Participants described their experiences in great detail. The analysis indicates that in information sharing the process is as important as the content. The timing, management, and delivery of information and perceived attitude of practitioners were critical to the process. This applied to information interactions at all stages of the illness. Main content areas mentioned related to prognosis and hope. Hope can be conveyed in different ways. Secondary information from various sources is accessed and synthesised with the primary information. All patients, regardless of origin, wanted information about their illness and wanted it fully shared with relatives. Almost all patients requested prognostic information, and all family members respected their wishes. Information was perceived as important for patient-family communication. Information needs of patient and family changed and diverged as illness progressed, and communication between them became less verbally explicit. CONCLUSIONS: Information delivery for patients needs to be individualised with particular attention to process at all stages of illness. Patients and families use secondary sources of information to complement and verify information given by health carers.

Publication Types:

Multicenter Study

PMID: 15151964 [PubMed - indexed for MEDLINE]

Caring. 2004 May;23(5):56-7.

Common customer service mistakes and how to avoid them.

Ferris MT.

PMID: 15239184 [PubMed - indexed for MEDLINE]

Geriatrics. 2004 May;59(5):38, 41-2.

Sharing the diagnosis of Alzheimer's disease: methods and expectations. Breaking news to patients requires patience and sensitivity to their needs.
Samuels SC.

Department of Psychiatry, Mount Sinai School of Medicine, New York, USA.
PMID: 15152735 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Jun;39(3):643-64.

Determining personal care consumers' preferences for a consumer-directed cash and counseling option: survey results from Arkansas, Florida, New Jersey, and New York elders and adults with physical disabilities.

Mahoney KJ, Simon-Rusinowitz L, Loughlin DM, Desmond SM, Squillace MR.
Graduate School of Social Work, Boston College, Chestnut Hill, MA, USA.

OBJECTIVE: To assess Medicaid consumers' interest in a consumer-directed cash option for personal care and other services, in lieu of agency-delivered services. DATA SOURCES/STUDY SETTING: Telephone survey data were collected from

four states from April to November 1997. Postsurvey focus groups were conducted in four states in 1998. Early implementation experiences are drawn from three states from 1999 to 2002. STUDY DESIGN: Participants (N=2,140) were selected for a structured telephone survey interview from a probability-sampling frame of current Medicaid consumers in Arkansas, Florida, New Jersey, and New York. Key variables include interest in the cash option, demographic and background characteristics of consumers, as well as previous experience and training needed. Postsurvey focus groups were also conducted with current Medicaid consumers. DATA COLLECTION/EXTRACTION METHODS: Interviewers read the telephone

survey from computer screens and entered responses directly into the database of the Macintosh Computer Assisted Telephone Interview software. Data were analyzed using SPSS 10.0 (<http://www.spss.com>) for Windows. PRINCIPAL FINDINGS: Cash option interest was positively associated with experience hiring and supervising workers, more severe levels of disability, having a live-in caregiver, living in Florida, and minority status. Age of the client was also a significant factor.

CONCLUSIONS: There is significant interest in the cash option, although interest varies among subgroups of consumers. Future research should continue to evaluate interest in the cash option among different groups of consumers, as well as actual experience with the option when the Cash and Counseling Demonstration and Evaluation (CCDE) evaluation findings are completed.

Publication Types:

Multicenter Study

PMID: 15149483 [PubMed - indexed for MEDLINE]

Healthc Exec. 2004 May-Jun;19(3):50-1.

Patient-friendly billing. High-quality service doesn't stop when patients leave the hospital.

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PMID: 15146730 [PubMed - indexed for MEDLINE]

Hosp Health Netw. 2004 Jun;78(6):38-40, 42.

Cost drivers. Liability. Responding to patients quickly and with candor can avert costly lawsuits.

Larkin H.

PMID: 15232934 [PubMed - indexed for MEDLINE]

Hosp Health Netw. 2004 May;78(5):41-8, 2.

Patient-friendly billing.

Scalise D.

A project to redesign hospital and physician bills is picking up steam as providers realize the benefits for financial and operational performance, and for patient satisfaction.

PMID: 15192880 [PubMed - indexed for MEDLINE]

Hosp Health Netw. 2004 May;78(5):34-8, 40, 49-51.

The patient room.

Scalise D, Thrall TH, Haugh R, Runy LA.

Of all the advances that hospitals are making in the delivery of care, nowhere is the impact felt more drastically than in the patient room. Even as room decor grows cozier and more home-like, dazzling new technology is bringing the future directly to the bedside, giving clinicians the power to monitor patients more carefully and giving patients more control over their own experience. Creating flexible, comforting rooms that can accommodate ever-changing technology, that encourage loved ones to spend more time with patients, and that allow staff to work more efficiently is a challenge for hospital planners, one that they are confronting with ingenuity and finesse.

PMID: 15192879 [PubMed - indexed for MEDLINE]

Int J Behav Med. 2004;11(1):1-7.

Predicting anxiety in magnetic resonance imaging scans.

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This study evaluated a brief screening instrument for predicting psychological distress in patients undertaking magnetic resonance imaging (MRI) scans. The scale is adapted from Wolpe and Lang's (1964) Fear Survey Schedule (FSS; see Lukins, Davan, & Drummond, 1997). Noise and/or confinement were identified as the most unpleasant feature of the MRI by 48.3% of 118 outpatients. The MRI-FSS (Lukins et al., 1997; 9 items) significantly predicted the number of panic attack symptoms and state anxiety experienced during MRI scan better than a range of other measures. There was a significant increase in MRI-FSS scores from prescan to postscan among those who experienced high levels of anxiety during the scan. The MRI-FSS appears to be a useful indicator of likely adverse psychological reactions in the MRI scan that is sensitive to the sequelae of the MRI procedure.

PMID: 15194514 [PubMed - indexed for MEDLINE]

Internet Healthc Strateg. 2004 May;6(5):1-5.

Online scheduling applications may improve customer satisfaction, but setup is not always easy.

[No authors listed]

PMID: 15181764 [PubMed - indexed for MEDLINE]

Issue Brief Natl Health Policy Forum. 2004 May 14; (798):1-19.

Consumer cost sharing in private health insurance: on the threshold of change. Goff V.

Employers are asking employees to pay more for health care through higher premium contributions, share of contribution, and out-of-pocket maximums, along with variations in deductibles, co-pays, and coinsurance based on choice of providers, networks, drugs, and other services. This issue brief examines consumer cost-sharing trends in private insurance, discusses the outlook for cost sharing in employment-based benefits, and considers public policies to support health care markets for consumers.

PMID: 15151137 [PubMed - indexed for MEDLINE]

Issues Emerg Health Technol. 2004 May; (56):1-4.

Independence(TM) iBOT(TM) 3000 Mobility System: a stair-climbing wheelchair.

[No authors listed]

Independence (TM) iBOT(TM) 3000 is a wheelchair that may be used to climb stairs, elevate the user to standing adult eye level and cross uneven terrain. Limited evidence indicates that the device may offer more mobility and freedom to users than conventional wheelchairs. The iBOT may be difficult to manoeuvre indoors due to the seat height, but it operates well outdoors. The use of this technology is limited by the high cost of ownership and uncertain incremental benefit for users. While the device is not yet licensed for use in Canada, it is approved by the Food and Drug Administration for use in the US.

PMID: 15164734 [PubMed - indexed for MEDLINE]

J Healthc Qual. 2004 May-Jun;26(3):4-9.

Using patient satisfaction data to improve home healthcare.

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Patient satisfaction surveys are used extensively by home health agencies for a wide variety of purposes, but their utilization is often limited by a variety of practical and methodological problems. This article explores current and potential uses of satisfaction data and outlines steps that home health agencies may take to focus their use of these data to improve quality of care.

PMID: 15162627 [PubMed - indexed for MEDLINE]

J Pain Palliat Care Pharmacother. 2004;18(1):87-109.

Comment in:

J Pain Palliat Care Pharmacother. 2004;18(1):1-2.

Advance care planning: preferences for care at the end of life.

Kass-Bartelmes BL, Hughes R.

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Predictors of patient wishes and influence of family and clinicians are discussed. Research findings on patient decision-making relating to preferences in end-of-life care are described. Advance directives and durable powers of attorney are defined and differentiated. Most patients have not participated in advance care planning and the need for more effective planning is documented. Appropriate times for discussions of such planning are described. Scenarios discussed include terminal cancer, chronic obstructive pulmonary disease, AIDS, stroke, and dementia. Patient satisfaction is discussed, as is a structured process for discussions about patient preferences. Results of patient responses to hypothetical scenarios are described. Invasiveness of interventions, prognosis and other factors that favor or discourage patient preferences for treatment are discussed. Findings resulting from research funded by the Agency for Healthcare Research and Quality (AHRQ) are discussed. This research can help providers offer end-of-life care based on preferences held by the majority of patients under similar circumstances.

Publication Types:

Review

Review, Tutorial

PMID: 15148012 [PubMed - indexed for MEDLINE]

J Pain Symptom Manage. 2004 Jun;27(6):492-501.

Measuring the quality of structure and process in end-of-life care from the bereaved family perspective.

Morita T, Hirai K, Sakaguchi Y, Maeyama E, Tsuneto S, Shima Y; Quality Assurance Committee, Japanese Association of Hospice and Palliative Care Units.

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Measurement of the structure/process of care is the first step in improving end-of-life care. The primary aim of this study was to psychometrically validate an instrument for directly measuring the bereaved family's perception of the necessity for improvement in structural/procedural aspects of palliative care. Different sets of questionnaires were sent to 800 and 425 families who lost family members at one of 70 certified palliative care units in Japan in the development and validation phases, respectively, and 281 families of the latter group in the follow-up phase. The participants were requested to fill out a newly-developed Care Evaluation Scale (CES), along with outcome measures (the perceived experience and satisfaction levels) and potential covariates (the degree of expectation, the Center for Epidemiologic Studies Depression Scale, and the Social Desirability Scale). We obtained 485, 310, and 202 responses in the development, validation, and follow-up phases (response rates: 64%, 75%, and 72%, respectively). The 28-item CES had an overall Cronbach's coefficient alpha of 0.98; the intra-class correlation coefficient in the test-retest examination was 0.57. A confirmatory factor analysis revealed 10 subscales: physical care (by physicians, by nurses), psycho-existential care, help with decision-making (for patients, for family), environment, family burden, cost, availability, and coordination/consistency. The CES subscales were only moderately correlated with the perceived-experience and satisfaction levels of corresponding areas ($r=0.36-0.52$ and $0.39-0.60$, respectively). The CES score was not significantly associated with the degree of expectation, the changes of depression, or the Social Desirability Scale. The CES is a useful tool to measure the bereaved family's perception of the necessity for improvement in structural/procedural

aspects of palliative care. The advantages of the CES are: 1) it specifically evaluates the structure and process of care, 2) it directly identifies needed improvements, 3) it is not affected by the degree of expectation, depression, or social desirability, and 4) it has satisfactory psychometric properties.

Publication Types:

Evaluation Studies

Validation Studies

PMID: 15165647 [PubMed - indexed for MEDLINE]

J Pain Symptom Manage. 2004 Jun;27(6):481-91.

Impact of a half-day multidisciplinary symptom control and palliative care outpatient clinic in a comprehensive cancer center on recommendations, symptom intensity, and patient satisfaction: a retrospective descriptive study.

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To characterize a new, one-stop multidisciplinary palliative care (MD) clinic which offers standardized multidisciplinary assessment, specific care recommendations, patient and family education, and on-site counseling, we retrospectively compared the assessments of 138 consecutive patients with advanced cancer referred to the MD clinic and 77 patients referred to a traditional pain and symptom management (PSM) clinic. The two groups were similar in tumor type, demographics, and symptom distress. The MD clinic team (physicians; nurses; pharmacists; physical, speech, and occupational therapists; social workers; chaplains; nutritionists; psychiatric nurse practitioner) delivered 1,066 non-physician recommendations (median 4 per patient, range 0-37). The PSM clinic team made no non-physician recommendations, but referred 14 patients to other medical specialists. In 80 (58%) MD-clinic patients with follow-up 9 days (median) after assessment, significant improvement was observed in pain, nausea, depression, anxiety, sleep, dyspnea, and well-being, but not in fatigue, anorexia, or drowsiness. In 83 patients interviewed after the MD clinic, satisfaction was rated as excellent (5 out of 5) in 86-97% of seven areas. Assessment at an MD clinic results in a high number of patient care recommendations, improved symptoms, and high levels of patient satisfaction.

Publication Types:

Clinical Trial

Controlled Clinical Trial

Validation Studies

PMID: 15165646 [PubMed - indexed for MEDLINE]

J Psychosoc Nurs Ment Health Serv. 2004 May;42(5):12-20.

The family's role in person-centered care: practice considerations.

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Effective implementation of person-centered care requires a shared understanding and commitment to make it a reality by administrative personnel, direct care providers, and residents and their family members. Long-term care facilities must seek ways to engage residents' families in person-centered care through its training, policies, care planning, and documentation. Doing so may require revisions to policies and work practices, and ongoing leadership efforts to maintain this care framework within the realities of staff turnover and

regulatory requirements. Developing protocols and procedures that facilitate family members' communication with staff and build consensus and shared values will result in a system that represents and honors the unique perspectives, values, and needs of each resident receiving care. It is important for facility leadership to set the tone for acknowledging the importance of family involvement in person-centered care by modeling acceptance of concerns and criticisms as valid and by acknowledging that direct care providers, residents, and their family members have a voice in care decisions. Such an approach has the greatest chance of success in promoting person-centered care and the shared values necessary to ensure its successful implementation.

Publication Types:

Review

Review, Tutorial

PMID: 15182046 [PubMed - indexed for MEDLINE]

J Public Health Dent. 2004 Spring;64(2):88-95.

Use of clinical services compared with patients' perceptions of and satisfaction with oral health status.

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OBJECTIVES: To examine the relationship between rates of clinical service use and self-reported perception of and satisfaction with oral health status.

METHODS: Dental services provision rates were calculated using health maintenance organization electronic data for members 55 years of age and older with at least four years of eligibility between 1990 and 2000. A mail survey yielded 986 responses (response rate = 65.7%). Poisson regression was used to examine the relationship between service utilization rates and self-reported perception of and satisfaction with oral health status, controlling for age, education, sex, and marital status. RESULTS: Perceptions of oral health status and levels of satisfaction with oral health status generally were closely associated. Greater dissatisfaction with oral health status and perception of poorer oral health status were associated with higher usage of nonpreventive dental services. Less satisfaction with oral health status was associated with higher restorative services usage and lower preventive services usage and slightly associated with periodontal service usage. Perception of a less favorable oral health status was strongly associated with higher restorative and periodontal services usage, but had only a weak association with preventive services usage. CONCLUSIONS: Dental plan members' service use is associated with their perception of their oral health status and their level of satisfaction with it. Future work should seek to clarify whether opinions on oral health status and satisfaction are a result of clinical experiences over time or whether the behavior and the values associated with seeking and obtaining care instead shape opinions on status and satisfaction.

PMID: 15180077 [PubMed - indexed for MEDLINE]

Med Care. 2004 Jun;42(6):579-90.

Patient satisfaction with primary care: does type of practitioner matter?

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OBJECTIVE: The objective of this study was to evaluate the association of

patient satisfaction with type of practitioner attending visits in the primary care practice of a managed care organization (MCO). STUDY DESIGN: We conducted a retrospective observational study of 41,209 patient satisfaction surveys randomly sampled from visits provided by the pediatrics and adult medicine departments from 1997 to 2000. Logistic regression, with practitioner and practice fixed effects, of patient satisfaction versus dissatisfaction was estimated for each of 3 scales: practitioner interaction, care access, and overall experience. Models were estimated separately by department. Independent variables were type of practitioner attending the visit and other patient and visit characteristics. RESULTS: Adjusted for patient and visit characteristics, patients were significantly more likely to be satisfied with practitioner interaction on visits attended by physician assistant/nurse practitioners (PA/NPs) than visits attended by MDs in both the adult medicine and pediatrics practices. Patient satisfaction with care access or overall experience did not significantly differ by practitioner type. In adult medicine, patients were more satisfied on diabetes visits provided by MDs than by PA/NPs. Otherwise, patient satisfaction for the combined effects of practitioner type and specific presenting condition did not differ. CONCLUSIONS: Averaged over many primary care visits provided by many physicians and midlevel practitioners, patients in this MCO were as satisfied with care provided by PA/NPs as with care provided by MDs.

PMID: 15167326 [PubMed - indexed for MEDLINE]

Med Care Res Rev. 2004 Jun;61(2):171-86.

Does consumer satisfaction information matter? Evidence on member retention in FEHBP plans.

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Taking advantage of a natural experiment, this study explores the crucial link between consumer satisfaction, distribution of consumer satisfaction information, and member retention at open enrollment. Multiple data sources, panel data regression analysis, and instrumental variable techniques inform how retention is affected by consumer satisfaction, before and after free distribution of report card information, controlling for market structure, consumer characteristics, premiums, benefits, and other plan attributes in about 250 Federal Employee Health Benefit Program (FEHBP) plans nationwide. Study results suggest that consumer satisfaction boosts member retention. Free distribution of consumer satisfaction information to federal employees during open enrollment is associated with lower member retention, which may suggest that consumers might have used this newly distributed information and then decided to withdraw from their previous plans.

PMID: 15155050 [PubMed - indexed for MEDLINE]

Med Econ. 2004 Apr 23;81(8):34-40.

Caring for Latino patients.

Weiss B.

PMID: 15146702 [PubMed - indexed for MEDLINE]

Mod Healthc. 2004 May 3;34(18):21.

Lost in translation. Professional interpreters needed to help hospitals treat immigrant patients.

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CyraCom International, Tucson, Ariz., USA.

PMID: 15164547 [PubMed - indexed for MEDLINE]

Nurs Older People. 2004 May;16(3):22-7; quiz 28.

Person-centred assessment with older people.

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This article describes the principles behind the assessment of older people's needs and the challenges inherent in developing a person-centred framework for assessment. It suggests that person-centred assessment calls for skilled, empowered and well-supported nurses who are able to work in creative, innovative ways and who recognise that the needs of the older person are at the centre of all therapeutic working.

Publication Types:

Review

Review, Tutorial

PMID: 15150996 [PubMed - indexed for MEDLINE]

Nurs Stand. 2004 May 19-25;18(36):33-9.

Music and the reduction of post-operative pain.

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BACKGROUND: The prevention and treatment of post-operative pain, and the promotion of comfort are the challenges facing practitioners working in the recovery room setting. Surgical pain produces autonomic, psychological, immunological and behavioural responses that can delay or inhibit normal healing. Nurses spend more time with patients experiencing pain than any other healthcare professional. Therefore, they are in an ideal position to consider other pain-relieving strategies to complement the analgesics currently used. **CONCLUSION:** The studies reviewed cannot prove that music is effective in reducing post-operative pain, because the research methodology in the majority is poor. Patients' experience of listening to music post-operatively was positive, aiding distraction and increasing comfort. This shows the difference between inconsistent results for the objective measures of pain and what the patient is reporting.

Publication Types:

Review

Review, Tutorial

PMID: 15176110 [PubMed - indexed for MEDLINE]

Nurs Times. 2004 May 4-10;100(18):22-4.

Enhancing nurse communication.

Oxtoby K.

PMID: 15151001 [PubMed - indexed for MEDLINE]

Prof Nurse. 2004 May;19(9):499-501.

User involvement in care: avoiding tokenism and achieving partnership.

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St Wilfrid's Hospice, Chichester.

Public involvement in health care has increased in recent years, and patients now expect to have greater input into the care and services they receive. This paper describes an initiative in one trust in which patients with cancer were able to take a lead in improving services. The evolution of the group into a cancer patients' forum offers an example of good practice.

PMID: 15152407 [PubMed - indexed for MEDLINE]

Prof Nurse. 2004 May;19(9):472.

Patient choice in renal care.

Cropper L.

Publication Types:

Review

Review, Tutorial

PMID: 15152401 [PubMed - indexed for MEDLINE]

Rehabil Nurs. 2004 May-Jun;29(3):77, 89.

How do we ethically manage patients who refuse therapy?

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Publication Types:

Case Reports

PMID: 15152414 [PubMed - indexed for MEDLINE]

Sex Transm Infect. 2004 Jun;80(3):192-7.

Patient satisfaction with care for genital herpes: insights from a global survey.

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OBJECTIVE: To describe patient experiences and views regarding genital herpes management. METHODS: Between February 2002 and January 2003, subjects with genital herpes were recruited via the International Herpes Alliance website and through banners on additional sites. Surveys were available in English, French, Spanish, Italian, and German and assessed views on access to care, diagnosis, related emotional experiences, educational resources, counselling, pharmacotherapy, and satisfaction with care. RESULTS: 2075 patient responses from 78 countries were analysed. 49% reported their diagnosis was by culture (or other direct detection) and 9% by antibody test, while 34% reported they had been diagnosed by examination alone. 65% used a prescription antiviral therapy, 18% a topical antiviral therapy, and 17% an alternative therapy. Of 901 subjects who reported on frequency of antiviral use, only 30% reported a frequency consistent with a suppressive regimen while 59% of respondents said they would be likely to take daily therapy if it reduced the frequency of outbreaks.

Patient satisfaction with management of physical symptoms was independently

associated with duration of initial visit ≥ 15 minutes (adjusted odds ratio (OR) = 4.52), receiving a prescription (adj OR = 2.34) and receipt of a brochure/fact sheet (adj OR = 2.14). Satisfaction with attention to emotional issues also correlated with the first two of these factors. CONCLUSIONS: Genital herpes management may be improved by including the use of confirmatory laboratory testing, employing a full range of antiviral therapy options, providing educational materials, and committing more time to counselling at the initial visit.

PMID: 15170001 [PubMed - indexed for MEDLINE]

Value Health. 2004 Mar-Apr; 7(2):204-15.

Satisfaction with medication: an overview of conceptual, methodologic, and regulatory issues.

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OBJECTIVE: Patients' satisfaction with their medication or medical device has been of increasing interest over the past decade. This is reflective of the rise of the patient as consumer and the desire of pharmaceutical and device manufacturers to obtain feedback from the consumers about their products. Satisfaction with medication is more narrowly focused and should be distinguished from other aspects of satisfaction. The purpose of this article is to place the concept of patient satisfaction with medication in an appropriate theoretical context, to explore the challenges of performing this research, and to offer recommendations for the basis of satisfaction claims. METHODS: We reviewed the literature on satisfaction with medication or medical devices. We summarize and discuss the background, conceptual issues, and theoretical justification for studying satisfaction with medication. We offer examples of domains to be included and suggestions on how to develop a psychometrically sound satisfaction measure. We also address additional issues for consideration. RESULTS: Medication satisfaction is a type of patient-reported outcome, but is distinguished from other patient-reported outcomes—specifically health-related quality of life (HRQL) and self-reports of symptoms. The Theory of Reasoned Action provides one theoretical justification for the concept. The heuristic value of this theory leads to implications regarding the relation between satisfaction and adherence. In addition, the theory is consistent with the need to focus on the patient's beliefs and values concerning the impact of taking his/her medication. Although the beliefs will differ according to the specific drug-disease combination, the beliefs can often be categorized in several domains of satisfaction: symptom relief/efficacy, side effects, ease and convenience, impact on HRQL, general satisfaction, and additional domains specific to the given research question. CONCLUSION: Patient satisfaction instruments should be subjected to the same psychometrically rigorous standards and procedures as any other patient-reported outcome and should also be subject to the same regulatory standards as other patient-reported outcomes with respect to advertising and promotion.

Publication Types:

Review

Review, Tutorial

PMID: 15164810 [PubMed - indexed for MEDLINE]

Value Health. 2004 Mar-Apr; 7(2):195-203.

The impact of managed eye care on use of vision services, vision costs, and

patient satisfaction.

Colman SS, Jones RD, Serdahl CL, Smith FM, Silva SJ, Schonfeld WH.
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OBJECTIVES: This study was designed to evaluate the impact of introducing a managed vision benefit program on the use and costs of vision services in a managed care setting and also to assess satisfaction with those services after the program was introduced. **METHODS:** Utilization and costs were compared for two groups of patients. The comparison group (n = 36,168) included all patients enrolled for 18 months before implementation of the managed eye-care plan. The study group (n = 23,816) included those enrolled for 18 months following its implementation. Medical claims, survey, and administrative data were used to evaluate study outcomes. **RESULTS:** The overall use of vision care was similar before and after the introduction of the managed eye-care programs, with 24% of each group receiving at least one vision service during the 18-month period. Nevertheless, an increase in the use of routine eye-care services and a decrease in medical eye-care services were observed following program implementation. The overall cost of providing eye-care services to patients decreased from 1.86 dollars to 1.36 dollars per member per month after the program started, largely owing to a reduction in spending associated with medical eye-care services. More than 90% of patients surveyed were satisfied with their vision care provided by the program. **CONCLUSIONS:** Findings suggest that introducing routine and medical managed eye-care programs in a managed care setting allows for a reduction in medical costs while maintaining access to care and patient satisfaction.
PMID: 15164809 [PubMed - indexed for MEDLINE]

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