



## **CUSTOMER FOCUSED HEALTH CARE DELIVERY AND SATISFACTION**

**August 2004**

AANA J. 2004 Jun;72(3):211-7.

An evaluation of anesthesia patient satisfaction instruments.

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The purpose of this study was to systematically review the instruments used to obtain anesthesia-specific patient satisfaction data and to determine the degree to which each instrument controlled for measurement error bias, such as poor survey design. By using an assessment and evaluation tool developed for the present study that held proven internal reliability and construct validity, we analyzed and scored each instrument according to the presence or absence of measurement error in survey design. We found that a paucity of anesthesia-specific patient satisfaction studies exists and that patient satisfaction studies dealing with anesthesia care were erratically defined, nonstandardized, and imprecise regarding intent and method. Moreover, the simple rating forms used in most of the reviewed studies were inadequate to achieve the goal of measuring the quality of anesthesia care. One instrument, the Iowa Satisfaction With Anesthesia Scale (ISAS), developed by Dexter et al (1997), was the first found to inculcate scientifically accepted psychometric item construction algorithms, an indicator of measurement reliability. Although the ISAS holds substantial potential for future application in this realm, we recommend that it be refined further and that the search for a superlative instrument to obtain anesthesia-specific patient satisfaction continue.

PMID: 15208969 [PubMed - indexed for MEDLINE]

Am J Manag Care. 2004 Jun;10(6):393-400.

Willingness to recommend a health plan: who is dissatisfied and what don't they like?

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**OBJECTIVES:** To explore the characteristics of individuals who are dissatisfied with their health plan, assess what aspects of the medical care experience are associated with plan dissatisfaction, and examine how this association varies according to plan type. **STUDY DESIGN:** Retrospective observational study using

the 1996 Medical Expenditure Panel Survey. METHODS: Unwillingness to recommend a health plan to others was used as a measure of overall plan dissatisfaction. Descriptive statistics were calculated to characterize the dissatisfied population. Logistic regressions and predicted probabilities controlling for personal characteristics were calculated to determine the association between plan or provider attribute and unwillingness to recommend a plan. RESULTS: We found no personal characteristics that significantly differentiated individuals who reported their family was unwilling to recommend a health plan from those who were willing. The largest predictors of unwillingness to recommend a plan were dissatisfaction with choice of providers and preventive services coverage; in contrast, provider and personal characteristics were not significant predictors of dissatisfaction. We estimated the probability of being unwilling to recommend a health plan was 38% for individuals dissatisfied with the choice of providers and 34% for those dissatisfied with preventive services coverage. Although provider attributes were not found to be predictors of plan dissatisfaction for the entire sample, they were predictors of dissatisfaction for HMO and multiple plan members. CONCLUSIONS: Enrollee dissatisfaction with the choice of providers and preventive services coverage are major predictors of health plan dissatisfaction. Managers concerned about plan satisfaction may want to examine enrollee assessments of these measures.  
PMID: 15209483 [PubMed - indexed for MEDLINE]

Am J Public Health. 2004 Jun;94(6):1049-53.

What patients expect from complementary therapy: a qualitative study.  
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OBJECTIVES: Complementary and alternative therapies have become popular with patients in Western countries. Studies have suggested motivations for patients' choosing a wide range of complementary therapies. Data on the expectations of patients who use complementary therapy are limited. We assessed the expectations of patients who use complementary therapy. METHODS: Patients attending a British National Health Service (NHS) outpatient department that provided acupuncture, osteopathy, and homoeopathy were asked to complete a qualitative survey. RESULTS: Patients expected symptom relief, information, a holistic approach, improved quality of life, self-help advice, and wide availability of such therapies on the NHS. CONCLUSIONS: Physicians' understanding of patients' expectations of complementary therapies will help patients make appropriate and realistic treatment choices.

PMID: 15249314 [PubMed - indexed for MEDLINE]

Amyotroph Lateral Scler Other Motor Neuron Disord. 2004 Mar;5(1):40-5.

Major stressors facing patients with amyotrophic lateral sclerosis (ALS): a survey to identify their concerns and to compare with those of their caregivers.

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OBJECTIVE: To identify and compare the primary existential, physical, and psychosocial stressors affecting patients with ALS and their caregivers. Health care providers, together with patients and their caregivers, are challenged to identify both physical and psychosocial concerns that have the greatest impact

on quality of life over the course of a serious illness. It is also helpful to understand the priorities of these concerns from the patients' and caregivers' perspectives so that we can render optimal care and help patients and their families with the myriad problems that accompany a progressive and fatal disease. METHODS: We analyzed responses from the first 66 patients with ALS and 61 ALS caregivers who attended the Baylor College of Medicine, Department of Neurology, Vicki Appel MDA ALS Clinic and who completed our internally generated 19-item survey. Subjects were asked to choose their three most important concerns. For analysis purposes we categorized the data into three domains: existential, physical, and psychosocial. Demographic data were collected. The Appel ALS Rating Scale (AALS) was used to measure disease symptom severity. RESULTS: Sixty-six patients (45 men, 21 women) with a mean age of 57.9 (range 30-82) years and 61 caregivers completed the checklist. At the time the patients completed the survey, their mean AALS total score was 77.0 (range 34-132), indicating mild to moderate disability. The most important stressors identified by patients and caregivers were existential concerns (86.4% of patients and 79.7% of caregivers) and physical stressors (80.3% of patients and 76.3% of caregivers). Less than 50% of both groups endorsed psychosocial stressors (38%). However, when we analyzed the domain specific items, there was a significant difference between patients and caregivers on worries about the patient's dependency (37.9% of patients and 6.8% of caregivers). DISCUSSION: Health care professionals should apply a holistic approach to treatment and care of patients with ALS. Families should be included in the process, and it should not be assumed that patients and caregivers will agree on all issues. Future research should focus on therapeutic interventions to help ALS patients and their families cope with the multiple stressors accompanying a catastrophic illness. PMID: 15204023 [PubMed - indexed for MEDLINE]

Ann Fam Med. 2004 May-Jun;2(3):224-30.

Patient pain in primary care: factors that influence physician diagnosis.

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BACKGROUND: The accurate recognition of patient pain is a crucial, but sometimes difficult, task in medical care. This study explored factors related to the physician's diagnosis of pain in primary care patients. METHODS: New adult patients were prospectively randomized to care by primary care providers at a university medical center clinic. Study participants were interviewed prior to the initial visit, and their level of self-reported pain was measured with the Visual Analog Pain Scale and the Medical Outcomes Study Short Form-36. The medical encounter was videotaped in its entirety and later analyzed using the Davis Observation Code to characterize physician practice style. Patient satisfaction was measured immediately after the visit. A review of the medical record was used to assess physician recognition of patient pain. RESULTS: For all patients (N = 509), as the amount of pain increased, the percentage of patients having pain diagnosed by the physician also increased. Female patients reported a greater amount of pain than male patients. When women were in severe pain, they were more likely than men to have their pain accurately recognized by their physician. The correct diagnosis of pain was not significantly related to patient satisfaction. Physician practice styles emphasizing technically oriented activities and health behavior discussions were strongly predictive of the physician diagnosing patient pain. CONCLUSIONS: The diagnosis of pain is influenced by the severity of patient pain, patient gender, and physician practice style. If the routine use of pain assessment tools is found to be

effective in improving physician recognition and treatment of patients' pain, then application of these tools in patient care settings should be encouraged.

Publication Types:

Clinical Trial

Randomized Controlled Trial

PMID: 15209199 [PubMed - indexed for MEDLINE]

Behav Healthc Tomorrow. 2004 Jun;13(3):16-9.

What are patients telling us?

Jones ER, Brown J.

PMID: 15216716 [PubMed - indexed for MEDLINE]

BMJ. 2004 Jul 10;329(7457):86. Epub 2004 Jun 21.

Comment in:

BMJ. 2004 Jul 10;329(7457):87.

Patients' evaluation of informed consent to postponed information: cohort study. Boter H, van Delden JJ, de Haan RJ, Rinkel GJ; Home Evaluation of Stroke Induced Aid Study Group.

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Publication Types:

Clinical Trial

Randomized Controlled Trial

PMID: 15210571 [PubMed - indexed for MEDLINE]

Crit Care Med. 2004 Jul;32(7):1484-8.

Comment in:

Crit Care Med. 2004 Jul;32(7):1609-11.

Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction.

McDonagh JR, Elliott TB, Engelberg RA, Treece PD, Shannon SE, Rubenfeld GD, Patrick DL, Curtis JR.

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OBJECTIVE: Family members of critically ill patients report dissatisfaction with family-clinician communication about withdrawing life support, yet limited data exist to guide clinicians in this communication. The hypothesis of this analysis was that increased proportion of family speech during ICU family conferences would be associated with increased family satisfaction. DESIGN: Cross-sectional study. SETTING: We identified family conferences in intensive care units of four Seattle hospitals during which discussions about withdrawing life support were likely to occur. PARTICIPANTS: Participants were 214 family members from 51 different families. There were 36 different physicians leading the conferences, as some physicians led more than one conference. INTERVENTIONS: Fifty-one conferences were audiotaped. MEASUREMENTS: We measured the duration of time that families and clinicians spoke during the conference. All participants were given a survey assessing satisfaction with communication. RESULTS: The mean conference

time was 32.0 mins with an sd of 14.8 mins and a range from 7 to 74 mins. On average, family members spoke 29% and clinicians spoke 71% of the time. Increased proportion of family speech was significantly associated with increased family satisfaction with physician communication. Increased proportion of family speech was also associated with decreased family ratings of conflict with the physician. There was no association between the duration of the conference and family satisfaction. CONCLUSIONS: This study suggests that allowing family members more opportunity to speak during conferences may improve family satisfaction. Future studies should assess the effect of interventions to increase listening by critical care clinicians on the quality of communication and the family experience.  
PMID: 15241092 [PubMed - indexed for MEDLINE]

Harv Bus Rev. 2004 Jul-Aug;82(7-8):116-23, 188.

Getting the most out of all your customers.  
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Companies spend billions of dollars on direct marketing, targeting individual customers with ever more accuracy. Yet despite the power of the myriad data-collecting and analytical tools at their disposal, they're still having trouble optimizing their direct-marketing investments. Many marketers try to minimize costs by pursuing only those customers who are cheap to find and cheap to keep. Others try to get the most customers they possibly can and keep all of them for as long as they can. But a customer need not be loyal to be highly profitable, and many loyal customers turn out to be highly unprofitable. Companies can get more out of direct marketing if they see it as a single system for generating profits than if they try to maximize performance measures at each stage of the process. This article describes a tool for doing just that. Called ARPRO (Allocating Resources for Profits), the tool is essentially a complex regression analysis that can estimate the impact of a company's direct-marketing investments on the profitability of its customer pool. With data that companies already gather, the tool can show managers how much to spend on acquisition versus retention and even what percentage of their funds they should allocate to the different direct-marketing channels. Using the model, companies can easily see that even small deviations from the optimal levels of customer profitability are expensive. Applying it to one catalog retailer showed, for instance, that a 10% reduction in marketing costs would lead to a 1.8 million dollar drop in long-term customer profits. Conversely, spending 69% less on marketing would actually increase average customer profitability at one B2B service provider by 42%. What's more, the tool can show that finding the optimal balance between investments in acquisition and retention can be more important than finding the optimum amount to invest overall.  
PMID: 15241958 [PubMed - indexed for MEDLINE]

Harv Bus Rev. 2004 Jun;82(6):119-27, 138.

Capitalizing on capabilities.  
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By making the most of organizational capabilities--employees' collective skills and fields of expertise--you can dramatically improve your company's market value. Although there is no magic list of proficiencies that every organization

needs in order to succeed, the authors identify 11 intangible assets that well-managed companies tend to have: talent, speed, shared mind-set and coherent brand identity, accountability, collaboration, learning, leadership, customer connectivity, strategic unity, innovation, and efficiency. Such companies typically excel in only three of these capabilities while maintaining industry parity in the other areas. Organizations that fall below the norm in any of the 11 are likely candidates for dysfunction and competitive disadvantage. So you can determine how your company fares in these categories (or others, if the generic list doesn't suit your needs), the authors explain how to conduct a "capabilities audit," describing in particular the experiences and findings of two companies that recently performed such audits. In addition to highlighting which intangible assets are most important given the organization's history and strategy, this exercise will gauge how well your company delivers on its capabilities and will guide you in developing an action plan for improvement. A capabilities audit can work for an entire organization, a business unit, or a region-- indeed, for any part of a company that has a strategy to generate financial or customer-related results. It enables executives to assess overall company strengths and weaknesses, senior leaders to define strategy, midlevel managers to execute strategy, and frontline leaders to achieve tactical results. In short, it helps turn intangible assets into concrete strengths.

PMID: 15202293 [PubMed - indexed for MEDLINE]

Harv Bus Rev. 2004 Jun;82(6):100-7, 138.

Will you survive the services revolution?

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Of late, offshoring and outsourcing have become political hot buttons. These words have been conflated to mean that high-paying, white-collar jobs have been handed to well-trained but less expensive workers in India and other locales.

The brouhaha over the loss of service jobs, which currently account for over 80% of private-sector employment in the United States, is not merely an American phenomenon. The fact is that service-sector jobs in all developed countries are at risk. Regardless of what the politicians now say, worry focused on offshoring and outsourcing misses the point, the author argues. We are in the middle of a fundamental change, which is that services are being industrialized. Three factors in particular are combining with outsourcing and offshoring to drive that transformation: The first is increasing global competition, where just as with manufactured goods in the recent past, foreign companies are offering more services in the United States, taking market share from U.S. companies. The second is automation: New hardware and software systems that take care of back-room and front-office tasks such as counter operations, security, billing, and order taking are allowing firms to dispense with clerical, accounting, and other staff positions. The third is self-service. Why use a travel agent when you can book your own flight, hotel, and rental car online? As these forces combine to sweep across the service sector, executives of all stripes must start thinking about arming and defending themselves, just as their manufacturing cousins did a generation ago. This will demand proactive and far-reaching changes, including focusing specifically on customer preference, quality, and technological interfaces; rewiring strategy to find new value from existing and unfamiliar sources; de-integrating and radically reassembling operational processes; and restructuring the organization to accommodate new kinds of work and skills.

PMID: 15202291 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 1):1005-26.

Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers.

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**BACKGROUND:** Controlling costs and achieving health care quality improvements require the participation of activated and informed consumers and patients.

**OBJECTIVES:** We describe a process for conceptualizing and operationalizing what it means to be activated and delineate the process we used to develop a measure for assessing activation, and the psychometric properties of that measure. **METHODS:**

We used the convergence of the findings from a national expert consensus panel and patient focus groups to define the concept and identify the domains of activation.

These domains were operationalized by constructing a large item pool. Items were pilot-tested and initial psychometric analysis

performed using Rasch methodology. The third stage refined and extended the measure. The fourth stage used a national probability sample to assess the measure's psychometric performance overall and within different subpopulations.

**STUDY SAMPLE:** Convenience samples of patients with and without chronic illness, and a national probability sample (N=1,515) are included at different stages in the research. **CONCLUSIONS:** The Patient Activation Measure is a valid, highly

reliable, unidimensional, probabilistic Guttman-like scale that reflects a developmental model of activation. Activation appears to involve four stages:

(1) believing the patient role is important, (2) having the confidence and knowledge necessary to take action, (3) actually taking action to maintain and improve one's health, and (4) staying the course even under stress. The measure has good psychometric properties indicating that it can be used at the individual patient level to tailor intervention and assess changes.

**Publication Types:**

Validation Studies

PMID: 15230939 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 1):727-48.

Patient satisfaction, treatment experience, and disability outcomes in a population-based cohort of injured workers in Washington State: implications for quality improvement.

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**OBJECTIVE:** To determine what aspects of patient satisfaction are most important in explaining the variance in patients' overall treatment experience and to evaluate the relationship between treatment experience and subsequent outcomes.

**DATA SOURCES AND SETTING:** Data from a population-based survey of 804 randomly

selected injured workers in Washington State filing a workers' compensation claim between November 1999 and February 2000 were combined with insurance

claims data indicating whether survey respondents were receiving disability compensation payments for being out of work at 6 or 12 months after claim

filing. **STUDY DESIGN:** We conducted a two-step analysis. In the first step, we tested a multiple linear regression model to assess the relationship of

satisfaction measures to patients' overall treatment experience. In the second step, we used logistic regression to assess the relationship of treatment experience to subsequent outcomes. PRINCIPAL FINDINGS: Among injured workers who

had ongoing follow-up care after their initial treatment (n = 681), satisfaction with interpersonal and technical aspects of care and with care coordination was strongly and positively associated with overall treatment experience (p < 0.001). As a group, the satisfaction measures explained 38 percent of the variance in treatment experience after controlling for demographics, satisfaction with medical care prior to injury, job satisfaction, type of injury, and provider type. Injured workers who reported less-favorable treatment experience were 3.54 times as likely (95 percent confidence interval, 1.20-10.95, p = .021) to be receiving time-loss compensation for inability to work due to injury 6 or 12 months after filing a claim, compared to patients whose treatment experience was more positive.

PMID: 15230925 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1219-34.

Consumer-directed health care: will it improve health system performance?  
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Publication Types:

Review

Review, Tutorial

PMID: 15230922 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1211-8.

Commentary--Looking at the effects of consumer-centric health plans on expenditures and utilization.

Bertko J.

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PMID: 15230921 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1189-210.

Evaluation of the effect of a consumer-driven health plan on medical care expenditures and utilization.

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OBJECTIVE: To compare medical care costs and utilization in a consumer-driven health plan (CDHP) to other health insurance plans. STUDY DESIGN: We examine claims and employee demographic data from one large employer that adopted a CDHP

in 2001. A quasi-experimental pre-post design is used to assign employees to three cohorts: (1) enrolled in a health maintenance organization (HMO) from 2000 to 2002, (2) enrolled in a preferred provider organization (PPO) from 2000 to 2002, or (3) enrolled in a CDHP in 2001 and 2002, after previously enrolling in either an HMO or PPO in 2000. Using this approach we estimate a difference-in-difference regression model for expenditure and utilization

measures to identify the impact of CDHP. PRINCIPAL FINDINGS: By 2002, the CDHP cohort experienced lower total expenditures than the PPO cohort but higher expenditures than the HMO cohort. Physician visits and pharmaceutical use and costs were lower in the CDHP cohort compared to the other groups. Hospital costs and admission rates for CDHP enrollees, as well as total physician expenditures, were significantly higher than for enrollees in the HMO and PPO plans.

CONCLUSIONS: An early evaluation of CDHP expenditures and utilization reveals that the new health plan is a viable alternative to existing health plan designs. Enrollees in the CDHP have lower total expenditures than PPO enrollees, but higher utilization of resource-intensive hospital admissions after an initially favorable selection.

PMID: 15230920 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1167-88.

Risk segmentation related to the offering of a consumer-directed health plan: a case study of Humana Inc.

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OBJECTIVE: To determine whether the offering of a consumer-directed health plan (CDHP) is likely to cause risk segmentation in an employer group. STUDY SETTING AND DATA SOURCE: The study population comprises the approximately 10,000 people

(employees and dependents) enrolled as members of the employee health benefit program of Humana Inc. at its headquarters in Louisville, Kentucky, during the benefit years starting July 1, 2000, and July 1, 2001. This analysis is based on primary collection of claims, enrollment, and employment data for those employees and dependents. STUDY DESIGN: This is a case study of the experience of a single employer in offering two consumer-directed health plan options ("Coverage First 1 and Coverage First 2) to its employees. We assessed the risk profile of those choosing the Coverage First plans and those remaining in more traditional health maintenance organization (HMO) and preferred provider organization (PPO) coverage. Risk was measured using prior claims (in dollars per member per month), prior utilization (admissions/1,000; average length of stay; prescriptions/1,000; physician office visit services/1,000), a pharmacy-based risk assessment tool (developed by Ingenix), and demographics. DATA COLLECTION/EXTRACTION METHODS: Complete claims and administrative data were

provided by Humana Inc. for the two-year study period. Unique identifiers enabled us to track subscribers' individual enrollment and utilization over this period. PRINCIPAL FINDINGS: Based on demographic data alone, there did not appear to be a difference in the risk profiles of those choosing versus not choosing Coverage First. However, based on prior claims and prior use data, it appeared that those who chose Coverage First were healthier than those electing to remain in more traditional coverage. For each of five services, prior-year usage by people who subsequently enrolled in Coverage First 1 (CF1) was below 60 percent of the average for the whole group. Hospital and maternity admissions per thousand were less than 30 percent of the overall average; length of stay per hospital admission, physician office services per thousand, and prescriptions per thousand were all between 50 and 60 percent of the overall average. Coverage First 2 (CF2) subscribers' prior use of services was somewhat higher than CF1 subscribers', but it was still below average in every category. As with prior use, prior claims data indicated that Coverage First subscribers were healthier than average, with prior total claims less than 50 percent of

average. CONCLUSIONS: In this case, the offering of high-deductible or consumer-directed health plan options alongside more traditional options caused risk segmentation within an employer group. The extent to which these findings are applicable to other cases will depend on many factors, including the employer premium contribution policies and employees' perception of the value of the various plan options. Further research is needed to determine whether risk segmentation will worsen in future years for this employer and if so, whether it will cause premiums for more traditional health plans to increase.  
PMID: 15230919 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1141-58.

Early experience with employee choice of consumer-directed health plans and satisfaction with enrollment.

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OBJECTIVE: To assess the initial impact of offering consumer-defined health plan (CDHP) options on employees. DATA SOURCES/STUDY SETTING: A mail survey of 4,680

employees in the corporate offices of Humana Inc. in June 2001. STUDY DESIGN: The study was a cross-sectional mail survey of employees aged 18 and older who were eligible for health care benefits. The survey was conducted following open enrollment. The primary outcome is the choice of consumer-directed health plan or not; the secondary outcome is satisfaction with the enrollment process.

Important covariates include sociodemographic characteristics (age, gender, race, educational level, exempt or nonexempt status, type of coverage), health status, health care utilization, and plan design preferences. DATA COLLECTION METHODS: A six-page questionnaire was mailed to the home of each employee, followed by a reminder postcard and two subsequent mailings to nonrespondents. PRINCIPAL FINDINGS: The response rate was 66.2 percent. Seven percent selected one of the two new plan options. Because there were no meaningful differences between employees choosing either of the two new options, these groups were combined in multivariate analysis. A logistic regression modeled the likelihood of choosing the novel plan options. Those selecting the new plans were less likely to be black (odds ratio [OR] 0.46), less likely to have only Humana coverage (OR 0.30), and more likely to have single coverage (OR 1.77). They were less likely to have a chronic health problem (OR 0.56) and more likely to have had no recent medical visits (OR 3.21). They were more likely to believe that lowest premiums were the most important plan attribute (OR 2.89) and to think there were big differences in the premiums of available plans (OR 5.19).

Employees in fair or poor health were more likely to have a difficult time during the online enrollment process. They were more likely to find the communications very helpful (OR 0.42) and the benefits information very understandable (OR 0.38). They were less likely to feel that they had enough time to make their enrollment decision (OR 0.47). CONCLUSIONS: Employees who were attracted to the new CDHP plan options valued the attributes that distinguished these plans from other choices. The shift to consumer-defined plans and to the electronic provision of information, however, requires a significant increase in the communication support for all employees, but particularly for those in fair or poor health whose information needs are the most complex and individualized.

PMID: 15230917 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1123-40.

Consumer experiences in a consumer-driven health plan.  
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OBJECTIVE: To assess the experience of enrollees in a consumer-driven health  
plan (CDHP). DATA SOURCES/STUDY SETTING: Survey of University of Minnesota  
employees regarding their 2002 health benefits. STUDY DESIGN: Comparison of  
regression-adjusted mean values for CDHP and other plan enrollees: customer  
service, plan paperwork, overall satisfaction, and plan switching. For CDHP  
enrollees only, use of plan features, willingness to recommend the plan to  
others, and reports of particularly negative or positive experiences. PRINCIPAL  
FINDINGS: There were significant differences in experiences of CDHP enrollees  
versus enrollees in other plans with customer service and paperwork, but similar  
levels of satisfaction (on a 10-point scale) with health plans. Eight percent of  
CDHP enrollees left their plan after one year, compared to 5 percent of  
enrollees leaving other plans. A minority of CDHP enrollees used online plan  
features, but enrollees generally were satisfied with the amount and quality of  
the information provided by the CDHP. Almost half reported a particularly  
positive experience, compared to a quarter reporting a particularly negative  
experience. Thirty percent said they would recommend the plan to others, while  
an additional 57 percent said they would recommend it depending on the  
situation. CONCLUSIONS: Much more work is needed to determine how consumer  
experience varies with the number and type of plan options available, the design  
of the CDHP, and the length of time in the CDHP. Research also is needed on the  
factors that affect consumer decisions to leave CDHPs.  
PMID: 15230916 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1113-8.

Commentary--How consumer-driven health care evolves in a dynamic market.  
Scandlen G.  
Center for Consumer-Driven Health Care, Galen Institute.  
PMID: 15230914 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1091-112.

Employee choice of consumer-driven health insurance in a multiplan, multiproduct  
setting.  
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OBJECTIVE: To determine who chooses a Consumer-Driven Health Plan (CDHP) in a  
multiplan, multiproduct setting, and, specifically, whether the CDHP attracts  
the sicker employees in a company's risk pool. STUDY DESIGN: We estimated a  
health plan choice equation for employees of the University of Minnesota, who  
had a choice in 2002 of a CDHP and three other health plans--a traditional  
health maintenance organization (HMO), a preferred provider organization (PPO),  
and a tiered network product based on care systems. Data from an employee survey  
were matched to information from the university's payroll system. PRINCIPAL  
FINDINGS: Chronic illness of the employee or family members had no effect on  
choice of the CDHP, but such employees tended to choose the PPO. The employee's

age was not related to CDHP choice. Higher-income employees chose the CDHP, as well as those who preferred health plans with a national provider panel that includes their physician in the panel. Employees tended to choose plans with lower out-of-pocket premiums, and surprisingly, employees with a chronic health condition themselves or in their family were more price-sensitive. CONCLUSIONS: This study provides the first evidence on who chooses a CDHP in a multiplan, multiproduct setting. The CDHP was not chosen disproportionately by the young and healthy, but it did attract the wealthy and those who found the availability of providers more appealing. Low out-of-pocket premiums are important features of health plans and in this setting, low premiums appeal to those who are less healthy.

PMID: 15230913 [PubMed - indexed for MEDLINE]

Health Serv Res. 2004 Aug;39(4 Pt 2):1071-90.

Tales from the new frontier: pioneers' experiences with consumer-driven health care.

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OBJECTIVE: To conduct site visits to study the early experiences of firms offering consumer-driven health care (CDHC) plans to their employees and firms that provide CDHC products. DATA SOURCES/STUDY SETTING: A convenience sample of three firms offering CDHC products to their employees, one of which is also a large insurer, and one firm offering an early CDHC product to employers. STUDY DESIGN: We conducted onsite interviews of four companies during the spring and summer of 2003. These four cases were not selected randomly. We contacted organizations that already had a consumer-driven plan in place by January 2002 so as to provide a complete year's worth of experience with CDHC. PRINCIPAL FINDINGS: The experience of the companies we visited indicated that favorable selection tends to result when a CDHC plan is introduced alongside traditional preferred provider organization (PPO) and health maintenance organization (HMO) plan offerings. Two sites demonstrated substantial cost-savings. Our case studies also indicate that the more mundane aspects of health care benefits are still crucial under CDHC. The size of the provider network accessible through the CDHC plan was critical, as was the role of premium contributions in the benefit design. Also, companies highlighted the importance of educating employees about new CDHC products: employees who understood the product were more likely to enroll. CONCLUSIONS: Our site visits suggest the peril (risk selection) and the promise (cost savings) of CDHC. At this point there is still far more that we do not know about CDHC than we do know. Little is known about the extent to which CDHC changes people's behavior, the extent to which quality of care is affected by CDHC, and whether web-based information and tools actually make patients become better consumers.

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Awakening consumer stewardship of health benefits: prevalence and differentiation of new health plan models.

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CONTEXT: Despite widespread publicity of consumer-directed health plans, little is known about their prevalence and the extent to which their designs adequately reflect and support consumerism. OBJECTIVE: We examined three types of consumer-directed health plans: health reimbursement accounts (HRAs), premium-tiered, and point-of-care tiered benefit plans. We sought to measure the extent to which these plans had diffused, as well as to provide a critical look at the ways in which these plans support consumerism. Consumerism in this context refers to efforts to enable informed consumer choice and consumers' involvement in managing their health. We also wished to determine whether mainstream health plans-health maintenance organization (HMO), point of service (POS), and preferred provider organization (PPO) models-were being influenced by consumerism. DATA SOURCES/STUDY SETTING: Our study uses national survey data collected by Mercer Human Resource Consulting from 680 national and regional commercial health benefit plans on HMO, PPO, POS, and consumer-directed products. STUDY DESIGN: We defined consumer-directed products as health benefit plans that provided (1) consumer incentives to select more economical health care options, including self-care and no care, and (2) information and support to inform such selections. We asked health plans that offered consumer-directed products about 2003 enrollment, basic design features, and the availability of decision support. We also asked mainstream health plans about their activities that supported consumerism (e.g., proactive outreach to inform or influence enrollee behavior, such as self-management or preventive care, reminders sent to patients with identified medical conditions.) DATA COLLECTION/EXTRACTION METHODS: We analyzed survey responses for all four product lines in order to identify those plans that offer health reimbursement accounts (HRAs), premium-tiered, or point-of-care tiered models as well as efforts of mainstream health plans to engage informed consumer decision making. PRINCIPAL FINDINGS: The majority of enrollees in consumer-directed health plans are in tiered models (primarily point-of-care tiered networks) rather than HRAs. Tiers are predominantly determined based on both cost and quality criteria. Enrollment in HRAs has grown substantially, in part because of the entry of mainstream managed care plans into the consumer-directed market. Health reimbursement accounts, tiered networks, and traditional managed care plans vary in their capacity to support consumers in managing their health risks and selection of provider and treatment options, with HRAs providing the most and mainstream plans the least. CONCLUSIONS: While enrollment in consumer-directed health plans continues to grow steadily, it remains a tiny fraction of all employer-sponsored coverage. Decision support in these plans, a critical link to help consumers make more informed choices, is also still limited. This lack may be of concern in light of the fact that only a minority of such plans report that they monitor claims to protect against underuse. Tiered benefit models appear to be more readily accepted by the market than HRAs. If they are to succeed in optimizing consumers' utility from health benefit spending, careful attention needs to be paid to how well these models inform consumers about the consequences of their selections.

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Hosp Peer Rev. 2004 Jun;29(6):85-8.

Telling the patient satisfaction story.

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[No authors listed]  
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Is terminal sedation compatible with good nursing care at the end of life?  
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Review  
Review, Tutorial  
PMID: 15215709 [PubMed - indexed for MEDLINE]

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Responding to persistent requests for assistance in dying: a phenomenological  
inquiry.  
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Little is known about how American nurses understand and respond to requests  
made by decisionally capable patients for assistance in dying. This article is  
based on a broader qualitative study first reported elsewhere (Schwarz, 2003).  
The study used phenomenological interpretation and analysis of stories told by  
10 nurses who worked in home hospice, critical care, and HIV/AIDS care settings.  
Persistent requests for assistance in dying were relatively uncommon, but when  
heard, participants provided the following responses: refusing assistance,  
administering palliative drugs that might secondarily hasten dying, tacitly  
permitting and not interfering with patient or family plans to hasten death, and  
actively providing direct assistance in dying. Nurses' responses were  
context-driven; they did not seek guidance from professional codes of ethics or  
colleagues. Secrecy and collusion were routinely practised. Few participants  
unequivocally agreed or refused to help patients die; most struggled to find  
morally and legally acceptable ways to help patients die well. Regardless of how  
they responded, nurses who believed they had hastened death described feelings  
of guilt and moral distress. Healthcare professionals who provide care for  
symptomatic dying patients need opportunities to meet with supportive  
colleagues, to share the experience of troubling cases and of moral conflict,  
and to be supported and heard in a 'safe' environment.  
PMID: 15215707 [PubMed - indexed for MEDLINE]

Issue Brief Cent Stud Health Syst Change. 2004 Jul; (86):1-4.

Rhetoric vs. reality: employer views on consumer-driven health care.  
Trude S, Conwell L.  
Because of rising premiums, employers are investigating new health insurance  
approaches that maintain workers' broad choice of providers while raising  
awareness of health care costs through increased patient financial

responsibility. Employers' knowledge of new health plan products, including consumer-driven health plans and tiered-provider networks, has grown considerably in recent years, according to findings from the Center for Studying Health System Change's (HSC) 2002-03 site visit to 12 nationally representative communities. But employers are concerned that consumer-driven health plans would take considerable effort to implement without much cost savings. They also are skeptical that tiered-provider networks can adequately capture both cost and quality information in a way that is understandable to patients.  
PMID: 15282892 [PubMed - indexed for MEDLINE]

J Behav Health Serv Res. 2004 Apr-Jun;31(2):217-24.

Reducing restraint use in a public psychiatric inpatient service.  
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The use of behavioral restraint in psychiatric inpatients can have physically and emotionally damaging effects. However, staff may view the use of restraint as a routine and acceptable means of maintaining safety. The goal of this project was to reduce the use of restraint in a public psychiatric inpatient service that serves an economically disadvantaged urban population. Six interventions that primarily involved changing staff behavior were made to reduce the use of restraint. These included better identification of restraint-prone patients, a stress/anger management group for patients, staff training on crisis intervention, development of a crisis response team, daily review of all restraints, and an incentive system for the staff. The rate of restraint use (number of restraints/1000 patient-days) during the 3 years before the interventions was compared with the rate during the 2 years after the interventions. There was a significant decrease in the rate of restraint use after the restraint reduction initiatives were implemented. The reduction was not accompanied by a sustained increase in incidents of assault, suicidal behavior, or self-injury.

PMID: 15255229 [PubMed - indexed for MEDLINE]

J Dermatolog Treat. 2004 Jun;15(3):182-4.

Giving patients 'perceived control' over psoriasis: advice for optimizing the physician-patient relationship.  
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Patients with psoriasis suffer from the effects of a chronic illness. One of the most bothersome aspects of the disease is a sense of loss of 'control.' 'Perceived control' is an important and well-studied psychological concept. The literature on perceived control offers guidance to help improve the physician-patient relationship and outcomes in chronic diseases such as psoriasis. Practical suggestions include the use of materials and other resources offered by patient advocacy groups (such as those from the National Psoriasis Foundation) and the development of a physician-patient relationship that gives the patient a sense of control of their disease.

Publication Types:

Review

Review, Tutorial

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J Public Health Policy. 2004;25(2):197-205; discussion 206-10.

The voice of the public in public health policy and planning: the role of public judgment.

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Community involvement with public health planning and implementation are vital to improving community health. There are a variety of community health models that are available. We describe these four models from the perspective of how they involve the broader community. These models are evaluated from a different perspective about linking the community and politics and agencies, that involves naming issues, framing options, public deliberation and public acting. We suggest ways that these models can be further refined to connect citizens to the processes that we use for community health improvement.

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Med Teach. 2004 May;26(3):223-8.

The relationship between measures of patient satisfaction and enablement and professional assessments of consultation competence.

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The authors examined the extent of the relationship between a Consultation satisfaction questionnaire and Patient enablement instrument scores and professionally assessed consultation competence scores of senior medical students. Three analyses were performed: (i) linear regression with mean overall competence score as response variable; (ii) sensitivity and specificity calculations using patient scores to classify competence; (iii) a repeated measures model with consultation-specific competence score as response variable. One hundred and nineteen students and 388 patients took part. Consultation satisfaction and enablement scores were weakly correlated with overall and consultation specific competence scores (correlation coefficient 0.16 to 0.44). 'Satisfaction with professional care' had a sensitivity of 0.68, specificity of 0.72 and positive and negative predictive values of 0.32 and 0.92 respectively. It is concluded that patient and professional assessments may complement, but do not replace, each other. Levels of patient satisfaction should not be used as proxy measures of the quality of consultation competence.

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Soc Work. 2004 Jul;49(3):415-22.

Relationships between social work involvement and hospice outcomes: results of the National Hospice Social Work Survey.

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In a struggle to balance fiscal realities with hospice philosophy, some hospices have attempted to cut costs by reducing social work involvement. This cross-sectional survey of 66 hospices found, however, increased social work involvement was significantly associated with lower hospice costs. Additional benefits included better team functioning, more issues addressed by the social worker on the team, reduced medical services, and fewer visits by other team

members, along with increased client satisfaction and lower severity of case. The authors concluded that higher salaries should be paid to a sufficient number of highly educated and experienced social workers. These social workers should be dedicated solely to the hospice social worker position, should participate in intake interviews, and should be supervised by a social worker.  
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