



**ROOM FOR IMPROVEMENT:
PATIENTS REPORT ON THE QUALITY
OF THEIR HEALTH CARE**

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CONTENTS

Introduction	1
Patients' Assessment of Quality of Care.....	2
Medical Errors	3
Communication and Continuity	4
Preventive Care and Management of Chronic Conditions	8
A 2020 Vision for American Health Care.....	10
Acknowledgments	14
Survey Methodology	14

LIST OF CHARTS

Chart 1	Americans in Fair or Poor Health Were Less Likely to Be Satisfied with Quality of Care.....	2
Chart 2	Americans in Fair or Poor Health Were Less Confident About Their Ability to Get Care in the Future	2
Chart 3	More than One-Fifth of Adults Reported They or a Family Member Experienced a Medical Error or Prescription Drug Error.....	3
Chart 4	Nearly One-Fifth of Adults Cited Problems Communicating with Their Physician.....	4
Chart 5	College-Educated as Well as High School Graduates Cited Problems Communicating with Their Physician.....	4
Chart 6	Fewer than Two-Thirds of Adults Found It Very Easy to Understand Materials from the Doctor's Office.....	5
Chart 7	Nearly One-Fourth of Americans Had a Time When They Did Not Follow Their Physician's Advice.....	5
Chart 8	Two-Thirds of Americans Did Not Have a Long-Term Relationship with Their Physician.....	6
Chart 9	Younger Americans Were Less Likely to Have a Long-Term Relationship with Their Physician	7
Chart 10	Health Status Did Not Affect the Length of the Patient-Physician Relationship	7
Chart 11	Many Men and Women Failed to Receive Preventive Services at Recommended Intervals.....	8
Chart 12	Many Diabetics Failed to Receive Recommended Screenings in the Past Year	9

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Introduction

The American health care system is unparalleled in its technological sophistication. Yet a new Commonwealth Fund 2001 Health Care Quality Survey reveals that medical care falls far short of the ideal. It is not enough to have the best technology. Health care should be safe, effective, patient-centered, timely, efficient, and equitable.¹ High-quality care involves meeting patients' personal needs and treating them equitably regardless of their race, ethnicity, gender, income, or health status.

Furthermore, high-quality care depends on a shared understanding between physicians and patients of the nature of the medical problem and an agreed-upon approach to addressing it. Communication between physicians and patients is often poor, however. Many patients say that physicians do not listen and that they do not have an opportunity to raise questions and to share in making decisions about their care. A disturbing one of four patients confessed that they did not always follow physicians' advice. Twenty-four percent reported a time in the past two years when they did not follow a doctor's advice or treatment plan, get a recommended test or see a referred doctor, in large part because they did not agree with the doctor, or the advice or plan ran counter to their beliefs or was impractical given their economic or other life circumstances.

The simple routine care interventions that are needed to prevent disease, catch disease at an early stage, or keep chronic conditions from deteriorating all too often fail to take place. Opportunities for preventive care are missed, and management of chronic conditions such as diabetes fails to meet quality standards for almost one-half of patients. Patient satisfaction with the quality of their health care is variable and many Americans are not confident about their ability to get good health care in the future. These findings reinforce the call issued by the Institute of Medicine for directing national attention to improving the quality of American health care.²

The Commonwealth Fund 2001 Health Care Quality Survey, a national survey of Americans' experiences with the health care system, highlights the importance of addressing the care issues of concern to patients—improving communication between patients and physicians, ensuring that care is responsive to patients' preferences, increasing

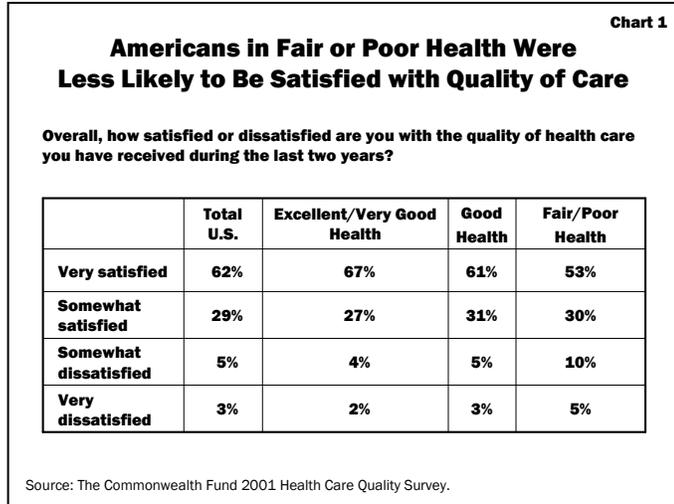
¹ Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academy Press, 2001).

² IOM, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, November 1999); IOM, *Crossing the Quality Chasm*.

choice, promoting trust and continuity in patient–physician relationships, and instituting systems to ensure regular preventive care and better management of chronic conditions.

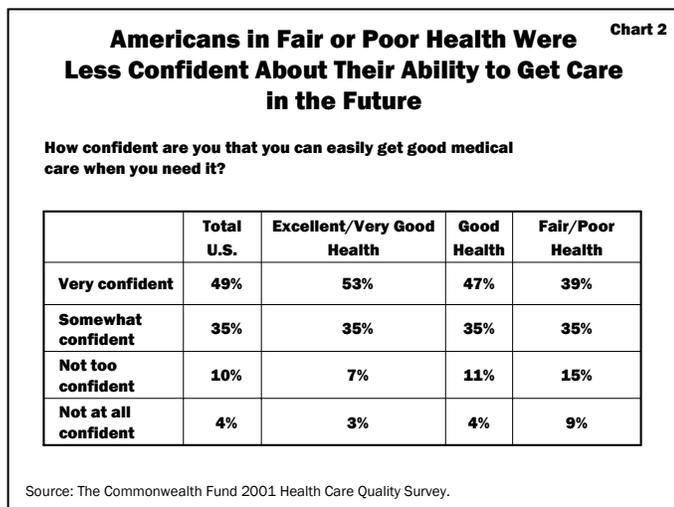
Patients’ Assessment of Quality of Care

One important test of the performance of the U.S. health care system is how well it meets the expectations of patients. At first glance, the system appears to satisfy the overwhelming majority of its customers. Only 8 percent, or one of 12 respondents, reported being dissatisfied with their care (Chart 1). But almost twice as many (15%) who were in fair or poor health, and thus more likely to use the health care system frequently, reported that they were dissatisfied.



Is it acceptable that one of every seven Americans in fair or poor health is dissatisfied? Such high levels of dissatisfaction among frequent customers in other sectors of the economy would lead to loss of business because other companies would compete to address consumer demands. In the health care system, however, individuals are not always free to choose who provides their care. The survey revealed that only half of all patients said they had a great deal of choice in where they went for medical care, while nearly one-fifth (18 percent) said they had very little or no choice. Competition alone, therefore, will not solve the problems in quality of care.

Americans’ faith in the health care system is sadly wanting. Not only do they express concerns with the care they have received to date, but they also are apprehensive about the future. People are noticeably concerned about their ability to get quality medical care when needed: not quite half of all respondents (49%) stated that they were “very confident” they would

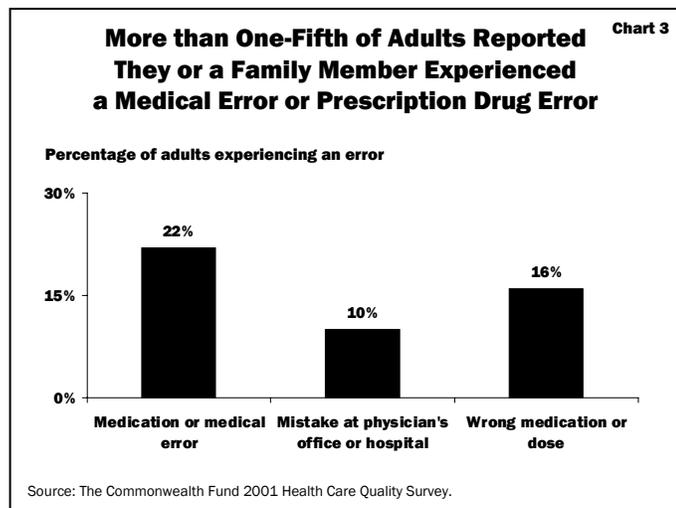


be able to get good medical care easily in the future. Furthermore, fewer than 40 percent in fair or poor health were “very confident” they would be able to get good medical care in the future (Chart 2).

The lack of choice and paucity of information on the quality of care offered by different health care providers may partially explain public apprehensions. Concerns about the future also may reflect the rising cost of health care and inadequate health insurance coverage. Population groups at the greatest risk of not receiving high-quality care—uninsured and minority Americans are even less likely to be “very confident” that they will get such care in the future.³

Medical Errors

Patients’ concerns about quality of care are sometimes rooted in experiences of medical errors. Twenty-two percent of respondents reported that they or a family member had experienced a medical error of some kind. Ten percent reported that they or a family member had gotten sicker as a result of a mistake made at a doctor’s office or in the hospital, while 16 percent had been given the wrong medication or wrong dose when filling a prescription at a pharmacy or while hospitalized (Chart 3). About one-third (33%) of those reporting a prescription error said it occurred while hospitalized.



About half (51%) of those experiencing an error at a doctor’s office or hospital reported that the problem was very serious, while 22 percent of those experiencing a medication error reported that the error turned out to be a very serious problem. Nationally, these reports translate into an estimated 22.8 million people with at least one family member (which could include family members outside the household) who experienced a mistake in a doctor’s office or hospital or were given the wrong medication or dose. Based on evaluation of these errors, an estimated 8.1 million households reported that the error turned out to be a very serious problem. The survey results suggest that the

³ K. S. Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (New York: The Commonwealth Fund, March 2002).

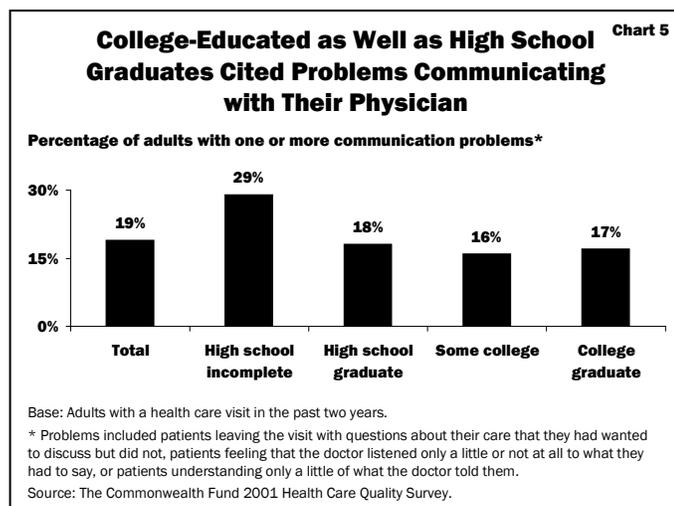
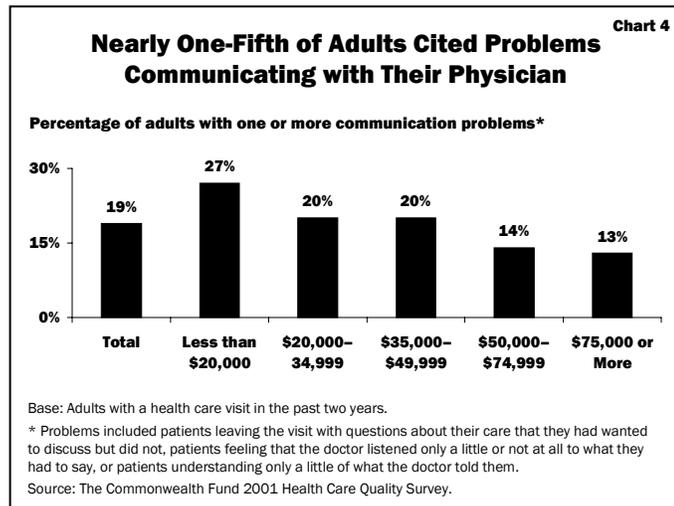
Institute of Medicine report on medical errors, *To Err Is Human: Building a Safer Health System*,⁴ which reported 44,000 to 98,000 deaths annually, may be only the tip of the iceberg concerning the adverse health consequences for patients resulting from medical errors.

Communication and Continuity

A trusting relationship with a physician and open two-way communication are required for high-quality care. Based on these criteria, the survey found the quality of many patient-physician interactions to be deficient. Nearly one-fifth of all respondents (19%) said that they had experienced one or more communication problems the last time they visited a doctor (Chart 4). These problems

included patients leaving the visit with questions about their care that they had wanted to discuss but did not (12%), patients reporting that the doctor listened some or only a little to what they had to say (9%), or patients understanding some or only a little of what the doctor told them (7%). One-third of Hispanics and one-fourth of African Americans or Asian Americans reported one or more of these communication problems.

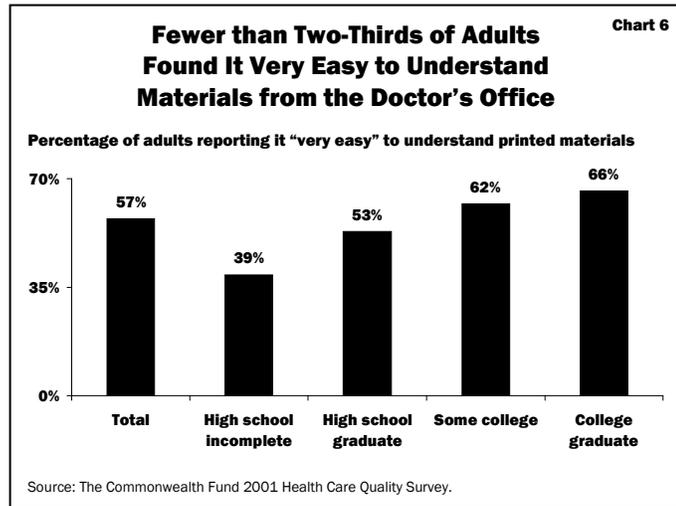
Income had a strong relationship with these results: individuals with incomes less than \$20,000 had much more difficulty communicating with their doctors than those with incomes over \$75,000 (27% vs. 13%, respectively) (Chart 4). With respect to education, 29 percent of those who did not complete high school reported communication problems compared with 17 percent of college graduates (Chart 5). But the fact that one of six college graduates had a



⁴ IOM, *To Err Is Human*.

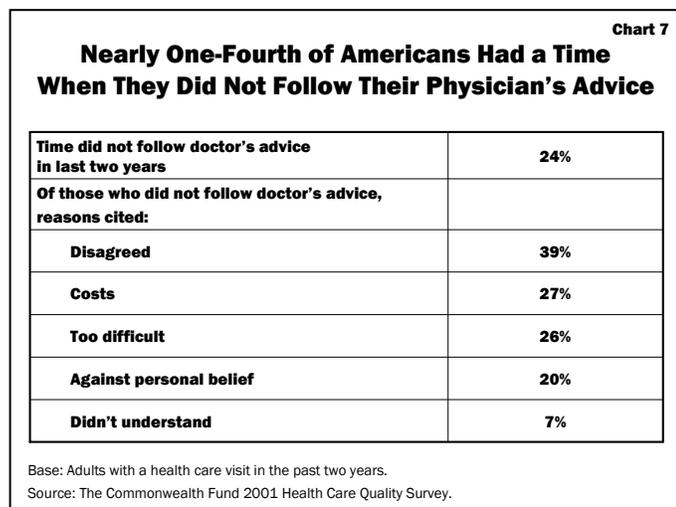
problem communicating with his or her physician demonstrates that communication difficulties are common and not restricted only to the poor and less educated. Too often patients fail to benefit from physicians' professional and scientific expertise because the human side of medicine falls short.

Further, the failure of personal communication with physicians is not fully compensated by the availability of written information provided by the physician's office. Only 57 percent of all respondents reported that it was very easy to understand printed materials from the physician's office (Chart 6). Nine percent noted that it was difficult or very difficult. Difficulty in understanding printed materials is a particular problem for those with less education. Only 39 percent of those without a high school degree reported that it was very easy to understand materials from the doctor's office.



Written communication about prescription drugs is another area of concern, given the ever-increasing arsenal of drugs available to physicians and patients and the adverse consequences of medication mix-ups. One of five respondents said that they did not find it very easy to understand instructions on the prescription bottle. Five percent said it was in fact difficult to do so.

Even when patients understand what physicians recommend, not all patients follow through and act on that advice. One of four (24%) survey respondents who had a health care visit in the past two years said there had been a time when they did not follow their doctor's advice (Chart 7). The reason commonly believed to account for patient

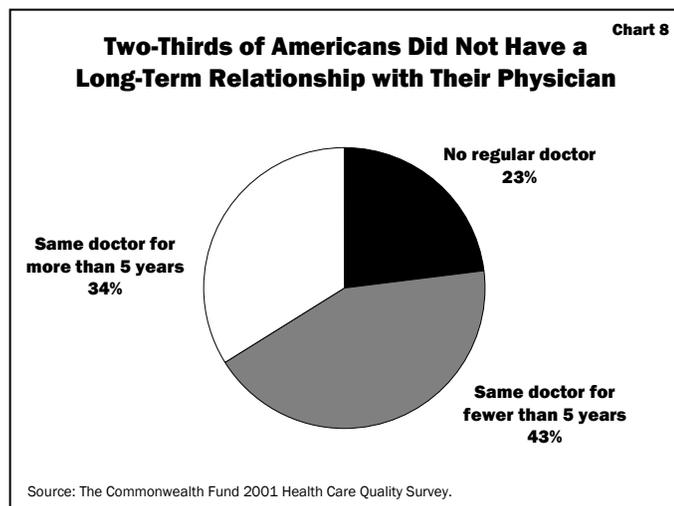


“noncompliance”—failure to understand the doctor’s advice—was cited by only 7 percent of those not following advice. The primary reason reported by nearly two of five (39%) of those not following a physician’s advice was that they disagreed with the recommendation. Over one-fourth (27%) did not follow the advice because of the costs involved, while 26 percent did not comply because they found the instructions to be too difficult. One-fifth of respondents did not follow their doctor’s advice because it was against their personal beliefs. (Some patients cited multiple reasons.) These results demonstrate a gap in communication between doctor and patient that prevents patients from receiving high-quality care.

Part of the problem is that patients do not have a physician they trust. Only 69 percent of survey respondents who had made a health care visit in the past two years said they had a great deal of confidence in their doctor. Furthermore, one-fourth of respondents did not feel as involved in medical decision-making as they wanted to be and 30 percent said they did not have as much time with the doctor as they desired.

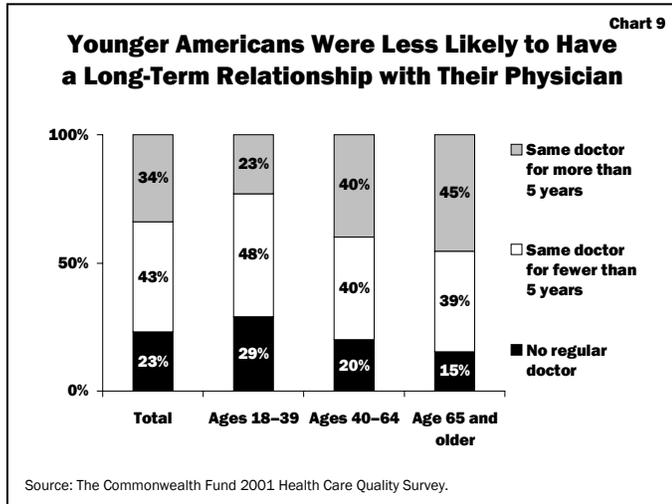
A further problem is that some patients have not developed any ongoing relationship with a physician. Twenty-three percent of survey respondents reported that they did not have a regular doctor. Instead, they rely on emergency rooms when a serious illness or injury strikes—a setting in which unfamiliarity with the patient’s medical history may have deadly consequences.

The survey found that only one-third of respondents had had the same physician for more than five years (Chart 8). The large number of adults with a short-term or no relationship with a physician may be a consequence of changes in the American health care delivery system. The advent of managed care has caused patients to change physicians as their employers changed plans or as plans entered or withdrew from the Medicare and Medicaid programs.⁵

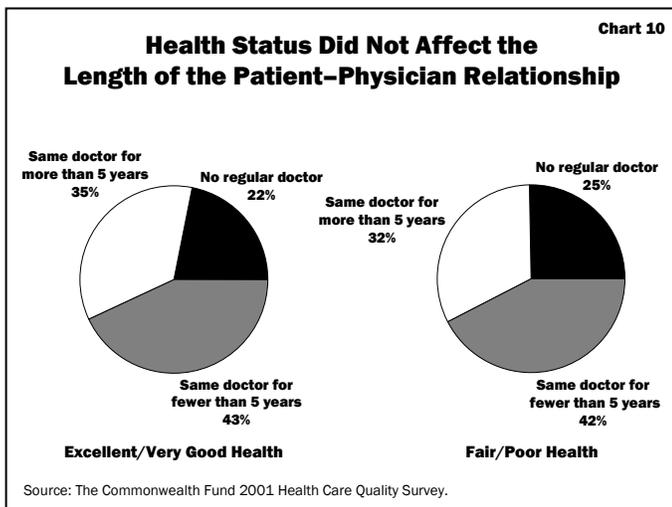


⁵ C. Hoffman et al., “Gaps in Health Coverage Among Working-Age Americans and the Consequences,” *Journal of Health Care for the Poor and Underserved* 12 (August 2001): 272–89.

This is particularly the case for younger adults ages 18 to 39. Fewer than one in four (23%) in this age group had had the same physician for more than five years (Chart 9). But even among adults age 65 and over covered by the Medicare program, fewer than half (45%) had been with the same physician for more than five years. This may reflect factors associated with aging, e.g., retirement of an older physician, geographic moves as older people retire, or need for physicians with different specializations as medical problems surface.



Health status, by contrast, seems to have little relationship to the duration of patient–physician relationships. One-third (32%) of survey respondents reporting fair or poor health had been with the same physician for more than five years, compared with 35 percent of those in excellent or very good health (Chart 10).



The need to change doctors raises several problems for all patients, including difficulty in getting information about the quality of potential new doctors,⁶ the logistical hassle of transferring medical records, and building trust and understanding with the new doctor. Absence of continuity also may have health and economic consequences. One study, for example, found that Medicare patients who had been with the same physician for 10 years or longer had fewer hospitalizations and lower Medicare outlays.⁷

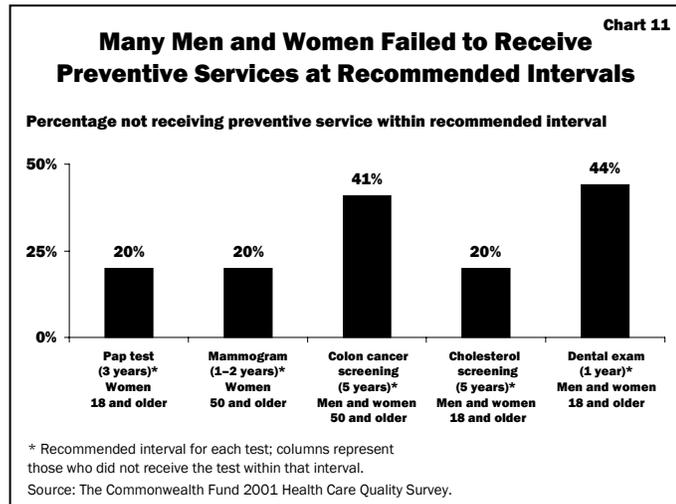
⁶ E. M. Stone et al., *Assessing Physician Information on the Internet* (New York: The Commonwealth Fund, January 2002).

⁷ J. Blustein and L. J. Weiss, “Faithful Patients: The Effect of Long-Term Physician–Patient Relationships on the Costs and Use of Healthcare by Older Americans,” *American Journal of Public Health* 86 (December 1996): 1742–47.

Preventive Care and Management of Chronic Conditions

Given the advances in medical research and the technological breakthroughs seen in recent years, perhaps it is not surprising that the health care system is constantly racing to integrate the latest information and techniques. It is harder to explain why the simple things that are well-known to be effective in preventing disease and managing chronic conditions are not systematically done.

Six Sigma is the quality standard in many American industries—meaning that there should be fewer than three defective parts in one million products produced.⁸ Except for anesthesiology, which has made a dedicated effort to meet the Six Sigma standard, the gap in the health care industry between the ideal standard and the actual standard is significant. If “perfect” quality means guaranteeing that all Americans will receive preventive services in accordance with the *Guide to Clinical Preventive Services*,⁹ the health care sector falls far short of the Six Sigma quality standard. According to the survey, 20 percent of women ages 18 and over had failed to receive a Pap smear in a three-year interval (Chart 11). Similarly, 20 percent of women ages 50 and over had failed to receive a mammogram in the past two years, two of five (41%) men and women ages 50 and over had not had a screening examination for colon cancer in the past five years, one-fifth of adults ages 18 and over had not had a cholesterol screening exam in the past five years, and 44 percent of adult men and women had not had an annual dental exam (Chart 11). In part, these results can be explained by inadequate outreach, missed opportunities for preventive care when patients have visits for other reasons, and poor follow-up.



Physician counseling can make a difference in helping patients address serious health behavior problems. Fifty million Americans smoke and 40 percent will try to quit this year,¹⁰ yet only about 10 percent will succeed in those efforts. Physician counseling of patients to stop smoking coupled with the use of new nicotine replacement methods, for

⁸ M. R. Chassin, “Is Health Care Ready for Six Sigma Quality?” *Milbank Quarterly* 76 (4 1998): 565–91.

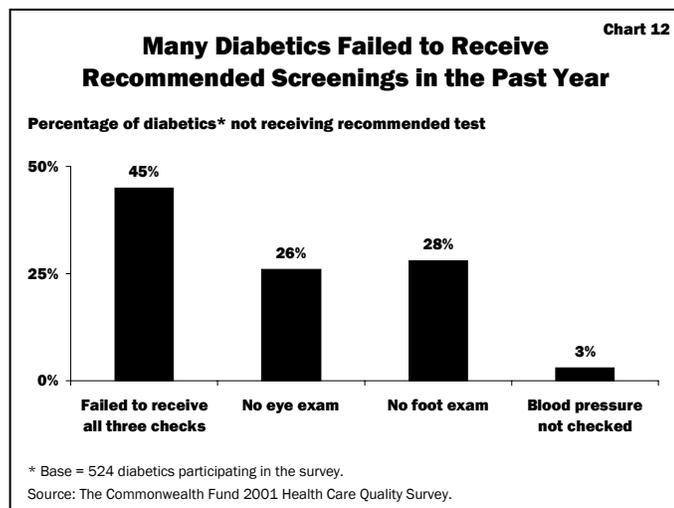
⁹ Agency for Healthcare Research and Quality, *Guide to Clinical Preventive Services, Third Edition* (Washington, D.C.: U.S. Department of Health and Human Services, 2000).

¹⁰ Sally Squires, “The Butt Stops Here,” *Washington Post*, February 19, 2002, p. F1.

example, can dramatically improve these rates to 25 to 30 percent. In the survey, one in five patients who smoked reported not receiving counseling from their physicians about smoking cessation.

Almost half (45%) of survey respondents reported a serious health problem – high blood pressure, heart attack, cancer, diabetes, anxiety or depression, obesity, or asthma – diagnosed by a physician in the past five years. In the past two decades, significant advances have been made in developing guidelines for the management of these chronic conditions. We know what to do to prevent or reduce serious episodes requiring hospitalization and how to help patients with these conditions function and carry on with their normal activities. But knowing what to do is not ensuring that it is done.

Diabetes is one example of a condition that requires consistent monitoring to be kept under control. It affects 9 percent of all adults. If not properly managed, it can lead to limb amputation, end-stage renal disease, and blindness. Yet 45 percent of diabetics surveyed reported that they had not received three recommended annual checks (eye exam, foot exam, and blood pressure) (Chart



12). Systems are rarely in place to remind patients to get screening examinations at recommended intervals, to assess hemoglobin A1c levels regularly to determine whether the condition is being properly managed, and to provide the kind of patient education and support required to lower patient risk factors.

These missed opportunities mean that many lives are lost each year and many people experience needless suffering and reduced quality of life, because of conditions that can be effectively prevented or treated with modern medicine. Unlike American industries that make worker safety number one and install systems to minimize lost lives, however, the U.S. health care system has no mechanisms in place to ensure that all adults receive preventive care at recommended intervals and are provided with the services required for proper management of chronic conditions, nor does it systematically train and encourage physicians to counsel patients regarding healthy behavior.

A 2020 Vision for American Health Care

The Commonwealth Fund 2001 Health Care Quality Survey makes it clear that there is ample room for improvement in the U.S. health care system. Key to ensuring that all patients are receiving appropriate care and following an evidence-based course of treatment is making patients active partners in their own care. This requires first and foremost a trusting relationship between physician and patient. Physicians need to understand patients' concerns, preferences, and beliefs, even economic circumstances that may affect their ability to follow care recommendations. Patients must feel comfortable and have time to raise questions, seek clarification, and reach agreement with the physician on a course of action.

To be active partners in their care, patients need and want information—information on their illness, their risk factors, and medications that are prescribed, as well as on the components of high-quality care for their particular condition. In today's world, patients are avid seekers of such information. The survey found that half of all respondents often used books or other printed materials to obtain health information, and one of four (26%) often used the Internet to obtain such information. Ideally, however, physicians would themselves be the central source of reliable health information and also a resource in pointing patients to reliable, understandable information on their particular medical problems.

What can be done to correct the current situation? Some solutions require a commitment of greater resources to health care—providing health insurance coverage to enable affordable access to physician services, prescription medications, laboratory tests, and specialized services. It is an unfortunate fact of American life that 38 million persons are uninsured.¹¹ But this is not just a problem for health care financing; it has ramifications for the health care delivery system as well. The uninsured have health care needs that must be met when they do encounter the system, and the solutions for providing them with quality care will be different from those for the insured.

Much that is needed goes beyond simply getting in the door. Major change is required, including changing the kind of care that is provided and creating fail-safe systems that reliably and consistently deliver patient-centered, evidence-based care to all. Care must be genuinely accessible and responsive to patient preferences and concerns. Physicians inarguably face extreme time pressures, but information technology systems can help free up time for patient interaction while also helping physicians manage their caseloads. Information technology also can help make sure that the routine is routine—

¹¹ U.S. Census Bureau, "Health Insurance Coverage: 2000," *Current Population Reports*, September 2001.

from reminder systems that ensure that preventive services are delivered at clinically appropriate intervals, to systems that track whether patients with chronic conditions are getting recommended screenings, medications, and periodic laboratory test.

This survey provides a clear-eyed view of the current state of the quality of U.S. health care, as perceived and experienced by patients. It demonstrates that we cannot afford to remain complacent with the notion that “American health care is the best in the world.”¹² We must move beyond denial. For too long, physicians and hospitals have demonstrated little interest in knowing how they are judged on quality of care, preferring to be blinded by institutional or professional pride. The reality is that substandard quality is not a problem for just a few disadvantaged patients or a handful of poorly trained physicians—it is pervasive throughout the health care system and is the end result of the fact that inadequate mechanisms are in place to ensure quality.

Physicians are taught early on “First, do no harm.” Yet the evidence clearly shows that harm is widespread—medical errors that create very serious problems occur at unacceptable rates. At a minimum, U.S. medicine needs to commit to achieving Six Sigma quality levels in patient safety. This is a goal that has been achieved in anesthesiology, which made a concerted effort to put systematic mechanisms and safeguards in place.¹³ That goal should be extended to all aspects of medical care, in surgical suites, hospitals and nursing homes, physicians’ offices, and pharmacies.

Missed opportunities to improve patients’ health and functioning and to prevent disability and mortality also are abundant. The survey documented serious underuse of preventive services and inadequate monitoring of chronic conditions. Reminder systems to ensure that all patients receive periodic preventive services at recommended intervals have been found to be effective and should become the standard of care.¹⁴ Chronic disease registries,¹⁵ or special clinics set up to monitor patients requiring medications for chronic conditions such as hypertension, diabetes, high cholesterol, or congestive heart failure, can help ensure that every patient is receiving the right dosage, getting the desired results, and

¹² K. Davis, “The Quality of American Health Care: Can We Do Better?” *Commonwealth Fund 2000 Annual Report*, January 2001.

¹³ Chassin, “Six Sigma Quality.”

¹⁴ P. G. Szilagyi et al., “Effect of Patient Reminder/Recall Interventions on Immunization Rates: A Review,” *Journal of the American Medical Association* 284 (October 11, 2000): 1820–27; E. A. Balas et al., “Improving Preventive Care by Prompting Physicians,” *Archives of Internal Medicine* 160 (February 14, 2000): 301–8.

¹⁵ E. H. Wagner, B. T. Austin, and M. Von Korff, “Organizing Care for Patients with Chronic Illness,” *Milbank Quarterly* 74 (4 1996): 511–44.

suffering no adverse side effects.¹⁶ And yet these systems are not standard practice in many health care settings.

Markets cannot operate effectively to ensure quality care if patients do not have information and choice. Although the “managed care revolution” succeeded in developing health plan quality performance measures (HEDIS) that allowed for comparing health plans, many health care consumers have no opportunity for comparison shopping. A 2001 survey found that 40 percent of Americans with employer-sponsored health benefits were not given a choice of plan by their employer.¹⁷ Even when employees had a choice of plan, employers rarely provided information on plan quality, HEDIS scores, or accreditation status to employees.¹⁸

Patient–physician relationships also can be improved by providing patients with information on physician characteristics and the quality of the care they provide. Patients armed with their own personal health records and information about their medical condition and treatment options are more likely to be active partners in their care, to understand their condition, and to commit to a recommended treatment regimen. Providing information to physicians on how they are perceived by their patients also can help physicians understand in what ways they are failing to communicate and foster better understanding and relationships between physicians and patients. In a survey of U.S. physicians, 42 percent said they would find reports from patients and families about satisfaction with care helpful,¹⁹ yet, most physicians do not obtain regular and systematic feedback from their patients.

High-quality care is a common concern and requires a systemwide response, which up to now has been lacking. There is a call for reform of the U.S. health care system, called a 2020 Vision.²⁰ It has five central elements:

- Automatic and affordable health insurance coverage for all;
- Access to care and information;

¹⁶ C. L. Marshall et al., “Improving Outpatient Diabetes Management Through a Collaboration of Six Competing, Capitated Medicare Managed Care Plans,” *American Journal of Medical Quality* 15 (March/April 2000): 65–71; P. G. Gibson et al., “Self-Management Education and Regular Practitioner Review for Adults with Asthma” (Cochrane review), in *The Cochrane Library* 3, Oxford: Update Software, 2001.

¹⁷ T. Rice et al., “Workers and Their Health Plans: Free to Choose?” *Health Affairs* 21 (January/February 2002): 182–87.

¹⁸ J. R. Gabel, K. A. Hunt, and K. M. Hurst, *When Employers Choose Health Plans: Do NCQA Accreditation and HEDIS Data Count?* (New York: The Commonwealth Fund, August 1998).

¹⁹ R. Blendon et al., “Physicians’ Views on Quality of Care: A Five-Country Comparison,” *Health Affairs* 20 (May/June 2001): 233–43.

²⁰ K. Davis, C. Schoen, and S. C. Schoenbaum, “A 2020 Vision for American Health Care,” *Archives of Internal Medicine* 160 (December 11/25, 2000): 3357–62.

- Patient-responsive care;
- Information-driven, evidence-based health care; and
- Commitment to improvement of quality.

Health care leaders, clinicians, patients, the general public, insurers, business and labor leaders, and policy officials all can and must play a role in the reform of health care. Comparative information on quality of care needs to be generated and made publicly available. State health departments, professional societies, accrediting bodies, hospitals granting medical privileges, health plans, and insurers all can contribute to this effort. Incentives must reward the human side of medicine, spending time with patients, and encourage a team approach to care that relies on systems for reminding patients about preventive care, monitoring chronic conditions, and coordinating care across sites and providers for patients with complex medical problems. These incentives can be financial, for example, specific payments to physicians for counseling patients to stop smoking; or they can be nonfinancial, such as public recognition, e.g., an Internet site that provides recognition to physicians who deliver high-quality diabetes care.²¹ Public programs such as Medicare and Medicaid and employer health benefit plans need to be reexamined to determine ways in which payment for quality becomes the norm rather than the exception.

Physician training must be changed to reflect the new demands placed on doctors, and all health care providers must be recognized and rewarded for the critical work that they do. A collaborative approach to quality improvement is needed, sharing best practices and encouraging clinicians and health care managers to learn from their peers.

The “competitive” approach to health care advocated over the past decade has not served us well, but neither did the earlier system of fee-for-service care and clinical autonomy. What is needed in the 21st century is a new approach that has at its heart the drive to improve the quality of care for all. The Commonwealth Fund 2001 Health Care Quality Survey shows that there is considerable room for improvement of our health care system. The Institute of Medicine Report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,²² provides a blueprint for change. We know what the needs of patients are and we have clear ideas on how to best serve them. It is time to commit to making this knowledge a reality.

²¹ American Diabetes Association website, <http://www.diabetes.org/main/professional/recognition/default2.jsp>.

²² IOM, *Crossing the Quality Chasm*.

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SURVEY METHODOLOGY

The Commonwealth Fund 2001 Health Care Quality Survey was conducted by Princeton Survey Research Associates from April 30 through November 5, 2001. The survey consisted of 25-minute telephone interviews in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean with a random national sample of 6,722 adults ages 18 and older living in telephone households in the continental United States.

The study classified respondents by annual income. Twelve percent of respondents age 18 and over did not provide sufficient income data for classification. The analysis also classified the sample into four race/ethnic groups: non-Hispanic white, non-Hispanic African American, Hispanic, and non-Hispanic Asian American. The study oversampled adults living in telephone areas with disproportionately large numbers of African Americans, Hispanics, and Asian Americans. To correct for this disproportionate sampling, the final data were weighted to the parameters of the adult population age 18 and older by age, sex, race/ethnicity, education, marital status, household size, and geographic region using the U.S. Census Bureau's March 2001 *Current Population Survey*. The resulting weighted sample is representative of the 193 million adults age 18 and older who live in the continental U.S. in telephone households.

The survey had an overall margin of error of ± 1.8 percentage points at a 95 percent confidence level. Seventy-two percent of those contacted for interviews agreed to participate. Counting eligible adults that were not reached by phone despite numerous attempts, the overall survey response rate was 53 percent.

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In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org**. Other items are available from the authors and/or publishers.

#523 *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (March 2002). Karen Scott Collins, Dora L. Hughes, Michelle M. Doty, Brett L. Ives, Jennifer N. Edwards, and Katie Tenney. This report, based on the Fund's 2001 Health Care Quality Survey, reveals that on a wide range of health care quality measures—including effective patient–physician communication, overcoming cultural and linguistic barriers, and access to health care and insurance coverage—minority Americans do not fare as well as whites.

#524 *Quality of Health Care for African Americans* (March 2002). Karen Scott Collins, Katie Tenney, and Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of African Americans.

#525 *Quality of Health Care for Asian Americans* (March 2002). Dora L. Hughes. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Asian Americans.

#526 *Quality of Health Care for Hispanic Populations* (March 2002). Michelle M. Doty and Brett L. Ives. This fact sheet, based on the Fund's 2001 Health Care Quality Survey and companion piece to pub. **#523** (above), examines further the survey findings related to the health, health care, and health insurance coverage of Hispanics.

