



EXPLORING CONSUMER PERSPECTIVES ON GOOD PHYSICIAN CARE: A SUMMARY OF FOCUS GROUP RESULTS

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EXECUTIVE SUMMARY

The study reported here is part of a multifaceted Commonwealth Fund–supported study, “Developing Patient-Centered Measures of Physician Quality,” that explored consumer preferences for information about physicians as well as potential sources for information. The study was conducted by the National Committee for Quality Assurance (NCQA), a nonprofit oversight organization that evaluates and produces reports on the quality of health plans. After an extensive literature and “work in progress” search of research related to consumer preferences and use of information, the NCQA project team determined that there was a need for further work in the area using qualitative research methods. In consultation with members of the project advisory group (see Appendix E), the team developed a protocol for six focus groups consisting of a cross section of consumers of varying socioeconomic status and enrolled variously in commercial, Medicare, and Medicaid health insurance plans. The focus group exercises were conducted by the NCQA team between June 13 and 21, 2001.

A major goal of the focus groups was to determine if consumers could both understand and value not only their own perceptions of quality at the physician office level, but also the aspects of quality seen as important by physicians and experts. The team hypothesized that if consumers were given a carefully constructed frame of reference, they would be able to understand and value information related to domains of quality beyond patient-centered perceptions of care. Thus, after eliciting initial preferences for information about physician practice, the team presented participants with a framework for helping them understand multiple dimensions of physician performance, including the three main concepts seen by physicians and quality experts as critical: “Patient-Centered Care” (patient-centeredness), “Health Care That Works” (effectiveness), and “Safe Health Care” (safety).

The primary finding of the research confirmed the initial hypothesis—namely that consumers can understand and will value information about effectiveness and patient safety (as well as patient-centeredness) if they are presented with information in a consumer-friendly framework. These findings provide some basis for further research to determine if consumers will actually use information about multiple domains of information on quality of physician care in selecting or otherwise recognizing high quality physician practice. Coupled with a growing recognition by physicians and quality experts of the critical importance of patient perceptions of care (patient-centeredness), the finding also provides some hope that the medical community can move toward the broad and comprehensive measures and use of information on quality suggested in the Institute of Medicine (IOM) report *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001).

Major findings from the focus group exercises included:

1. **Consumers initially focused on the patient–doctor relationship.** Consumer understanding of and desire for information on physician performance was limited to patient-centered concepts prior to the introduction of the framework. The focus group participants emphasized the dynamics of the patient–doctor relationship, with the majority of initial responses calling for empathetic qualities, e.g., “time,” “personal attention,” “caring,” “good communication skills,” “showing concern,” and “good bedside manner.”
2. **Once given a framework, consumers valued the concepts of safety and effectiveness equally with patient-centeredness.** After the framework was introduced, consumers were able to understand the concepts of effective and safe physician care as well as patient-centered concepts and appeared to value them about equally. This understanding was tested by presenting the concepts to the participants and engaging them in a discussion about what they thought the concepts meant, e.g., for “patient-centered care” participants responded with “patient-focused...you have a voice in your care”; for “effective care” participants responded with “consistent”; and for “safe health care” participants responded with “doing the right things, the right way.”
3. **To a lesser extent, consumers also understood many of 12 specific measurement areas associated with the three main concepts (see Appendix D).** For example, participants were presented with the measurement area, “doctor has up-to-date information on patient drug allergies,” and 50 of the 55 individuals were able to categorize the measurement area under the concept that most closely corresponded with the measurement area “Safe Health Care.”
4. **As has been noted in prior research, socioeconomic status and education affected comprehension of some high-level concepts.** The moderator and research staff in attendance observed that the participants in the Medicaid and “blue collar” groups struggled more than others with understanding some of the concepts and measurement areas and were less able to describe how these areas relate to good physician care.
5. **The Medicare population, more than other consumer groups, tended to equate good physician care with aspects of the patient–doctor relationship and to a lesser extent with the level of a doctor’s experience.** These participants seemed to give more emphasis to aspects of the interpersonal relationship between a patient and doctor, such as aspects of communication, listening, and bedside manner, with comments such as “I want to be more than just an appointment” and “A relationship is important...I want him to know my name.”
6. **Consumers want to work together with their physicians and be included in the decision-making process but do not want to assume sole or primary responsibility for their care.** When the participants were asked to choose the definition

that most closely encompassed the concept of patient-centered care; only 9 of the 55 participants selected “Doctor provides patient with the education and support to manage their own health,” whereas 24 of the 55 participants selected “Doctor and patient work together to make decisions that take into account the patient’s needs.”

7. **The Medicare population appears to be more accepting and forgiving of physician errors.** Despite their apparent understanding of the concept of medical errors and patient safety, these participants expressed a belief that health care can never be truly safe, and the human component of physician care creates an inherent potential for medical mistakes. This notion was particularly evident in the Medicare group, indicating that the Medicare consumers may be more reluctant to undermine or question a doctor’s authority.
8. **Consumers perceive a distinction between accountability for “physician” care and for “health” care.** Participants clearly struggled with the use of the term “health care” in the three main concepts and suggested that measurement areas and concepts should clearly specify the physician as the actor in any measurement describing a component of the service a physician provides.
9. **Consumers are very sensitive to word choices; when using text to describe measures or concepts, each word may have a profound impact on consumer comprehension.** In the measurement area “doctor provides the right treatment for short-term illness,” right can mean “correct,” as in the doctor provided the correct treatment for the illness, or it can mean “effective,” as in the doctor provided a treatment that led to an improvement in the patient’s condition.

Overall, focus group findings support the idea that consumer ability to understand and value health care quality information, specifically that of the IOM concepts of patient-centeredness, safety, and effectiveness, is enhanced when a consumer-friendly framework is employed. Careful attention to the words used to define measurement is necessary to achieve the correct understanding for the lay user; future cognitive evaluation of the measurements and the appropriate level of detail needed is key to this process.

Clearly, much work remains to be done on how to design and use frameworks that provide the critical level of consumer understanding, as well as exploration of whether the “value” expressed by consumers in our qualitative focus group study translates into actual use of the information in practice. An additional major barrier is the lack of reliable and valid information on quality at the physician office practice level. While these issues must be addressed, the conclusion that consumers can understand and value information on the safety and effectiveness of physician practice, if confirmed, has important implications for clinicians and consumers, as well as those interested in monitoring, improving, and reporting on physician office practice quality.

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INTRODUCTION

The Need for a Meaningful Evaluation System

As the science of performance measurement matures and public interest in information on health care quality grows, efforts to report quality information have expanded. To date, the most sophisticated forms of performance measurement and public reporting efforts have been limited to managed care organizations and, in a more limited manner, to hospitals and nursing homes. However, surveys indicate that consumers are most interested in information about quality of physician care. Efforts are underway by researchers to create performance evaluation measures and programs at the physician group and individual physician levels. In order to create evaluation systems that are meaningful to consumers, as well as purchasers or clinicians, researchers have been exploring what information related to the quality of physician care consumers feel they need or want.

Obstacles to Assessing Consumer Preferences

While a number of studies have been conducted on the kind of information consumers want, understanding consumer preferences has been hampered by a number of factors. The relatively complex nature of medical practice and its evaluation, the limited knowledge of consumers about the multiple domains of quality, and the lack of information on physician performance that is actually available have all led to instability in what consumers indicate is important in selecting physicians. Several investigators have also found that consumer preferences for information about physicians are influenced by what information they are given and how it is presented. Consumer reliance on limited information and the tendency to be easily swayed have contributed to what appears to be a major gap between what practitioners and quality experts see as critical to physician practice quality and how patients understand quality and use actual or experimental information to choose physicians. While physicians and quality experts see valid and reliable measures of safety, effectiveness, and efficiency as critical, studies of patient preferences suggest that patients rely almost exclusively on their own perceptions of care or on the experience and recommendations of friends and relatives, which are limited to a few basic characteristics of physician practice. This disconnect causes physicians to distrust the ability of consumers to use information on practice to choose wisely and casts considerable doubt on the future of consumers as an effective “lever” to drive quality improvement.

METHODOLOGY: DESIGNING A FOCUS GROUP STUDY

The study reported here is part of a multifaceted Commonwealth Fund–supported study, “Developing Patient-Centered Measures of Physician Quality,” that explored consumer preferences for information about physicians as well as potential sources for information. The study was conducted by the National Committee for Quality Assurance (NCQA), a nonprofit oversight organization that evaluates and produces reports on the quality of health plans. After an extensive literature and “work in progress” search of research related to consumer preferences and use of information, the NCQA project team determined that there was a need for further work in the area using qualitative research methods. In consultation with members of the project advisory group (see Appendix E), the team developed a protocol for six focus groups consisting of a cross section of consumers of varying socioeconomic status and enrolled variously in commercial, Medicare, and Medicaid health insurance plans. The focus group exercises were conducted by the NCQA team between June 13 and 21, 2001.

A major goal of the focus groups was to determine if consumers could both understand and value not only their own perceptions of quality at the physician office level, but also the aspects of quality seen as important by physicians and experts. The team hypothesized that if consumers were given a carefully constructed frame of reference, they would be able to understand and value information related to domains of quality beyond patient-centered perceptions of care. An initial step in the focus groups was to elicit participant’s ideas about areas of physician performance that would be useful in choosing a physician. Then the project team shared with the groups three of the main concepts of quality noted in two recent reports from the Institute of Medicine (IOM), *Envisioning the National Health Care Quality Report* and *Crossing the Quality Chasm: A New Health System for the 21st Century*: “Patient-Centered Care” (patient-centeredness), “Health Care That Works” (effectiveness), and “Safe Health Care” (safety).

The research was designed to:

- Determine whether presenting a framework for measuring physician performance would expand consumer understanding of physician quality;
- Determine if participants would understand and value the three concepts of good physician care: effectiveness, patient-centeredness, and safety;
- Explore different ways of describing the areas of physician performance so that it was most meaningful and understandable to consumers; and
- Examine whether participants understand the measurement areas for each concept and believe each measurement area represents good physician care.

NCQA contracted with The Family Research Group (FRG) to assist in the development of focus group protocols, to moderate the focus groups, and to draft an initial analysis of the groups. See Appendices A through D for detailed descriptions of focus group methodologies and protocols. In addition, staff worked closely with Judith Hibbard in the development of the focus group exercises and on the findings. Substantial input on the general conduct of the study and in understanding the results was also provided by an expert panel. See Appendix E for a list of the expert panel members.

MAJOR FINDINGS FROM FOCUS GROUP EXERCISES

Each of the nine major findings from the focus groups is discussed in more detail below. When possible, we have included actual comments recorded during the focus groups. These comments appear in italics.

1. Consumers initially focused on the patient–doctor relationship.

The initial focus group exercise asked participants to describe what constitutes good physician care. All of the focus groups dealt primarily with the dynamics of the patient–doctor relationship. The majority of initial responses called for empathetic qualities, such as “time,” “personal attention,” “caring,” “good communication skills,” “showing concern,” and “good bedside manner.” For example, participants said:

“I want a doctor who is going to take his time... explain things to me and not rush me out of the office.”

“I want to be more than just an appointment.”

“It would be nice if they’re concerned about your comfort... their staff should care, too.”

“A relationship is important... I want him to know my name.”

These findings are consistent with current research showing that consumers are concerned about the patient–doctor relationship and its impact on their care. Consumers list most often the aspects of the interpersonal relationship between a patient and doctor such as communication, listening, and bedside manner, as the items they would like to know about physician care,. This is not surprising, since issues of the patient–doctor relationship and patient-centeredness are things patients are familiar with, without having a meaningful framework for understanding and using other types of quality information, such as information on effectiveness.

After the initial focus group exercise, safety and effectiveness frameworks were presented to the groups. Overwhelmingly the groups indicated that if information about these elements was available to them, they would review the data and use the information.

Implications: These findings suggest that consumers value the patient-centered aspects of physician care. Some consumers may be more likely to prefer physicians who concentrate on building and maintaining meaningful relationships with their patients and involve the patient in the care process. However, framing quality information to help consumers understand the safety and effectiveness aspects of quality care provides another source of information that consumers will use when making choices.

2. Once given a framework, consumers valued the concepts of safety and effectiveness equally with patient-centeredness.

One purpose of the focus groups was to determine whether consumers understand the concepts of effective, patient-centered, and safe health care. The moderator tested this hypothesis by presenting the concepts on poster boards and engaging the participants in a discussion about what they thought the concepts meant. This discussion was followed by the presentation of three definitions for each concept and a group discussion on how well the definitions described the concept. The focus groups revealed that, in general, the participants understood the concepts, although there were problems with language that the participants felt was confusing or vague.

For example, when asked “What is Patient-Centered Care?” most participants understood the concept:

“Patient-focused... you have a voice in your care.”

“Accessible.”

“You have a relationship... he knows your name.”

“Doesn’t rush... takes time to explain to you what’s going on.”

Some participants, however, were confused by the concept:

“It’s a center for patients.”

“It’s a place where patients go... like a clinic.”

Throughout the discussions, the participants struggled to create a better way of phrasing the concept behind Patient-Centered Care. After several sessions, members from one group suggested that the term “patient–doctor relationship” is a better term to reflect the concept of Patient-Centered Care. Later groups agreed with this term, indicating that “patient–doctor relationship” more clearly indicates a mutually respectful relationship with two-way communication and shared decision-making between the patient and the doctor.

In contrast to Patient-Centered Care, the majority of participants understood the concepts of Health Care That Works and Safe Health Care. The participants described Health Care That Works as:

“Effective.”

“Consistent.”

“Preventive and corrective care.”

The participants described Safe Health Care as:

“The doctor does not give you medicine you’re allergic to.”

“Doing the right thing, the right way.”

Implications: Consumers comprehend the IOM concepts of effectiveness, patient-centeredness, and safety when the concepts are phrased using consumer-friendly terms. All three terms resonate with consumers, although the specific wording of the concepts may affect comprehension, as was seen in the case with Patient-Centered Care. The three concepts from the IOM report could provide the foundation for an effective framework for health care quality information for consumers.

3. To a lesser extent, consumers also understood many of 12 specific measurement areas associated with the three main concepts (see Appendix D).

While the three main concepts of effectiveness, patient-centeredness, and safety may provide the foundation for a framework for quality information, developers of quality information must pay attention to the construction and portrayal of the individual measurement areas that comprise each concept. As described in the protocol in Appendix A and the list in Appendix D, the moderator presented 12 measurement areas to the focus group participants. The participants then were instructed to categorize the measurement areas under one of the two concepts, Health Care That Works or Safe Health Care.

Participants understood most measurement areas and were generally able to identify whether a measurement area was categorized under Health Care That Works or Safe Health Care. However, there was some confusion over items that could be interpreted in more than one way. For example, staff considered the measurement area “doctor identifies illness early” to be categorized under Health Care That Works, since this measurement area applies to preventive care (e.g., mammography). In contrast, a few participants felt that a doctor who did not identify illness early by failing to screen for cancer was risking a patient’s safety and therefore categorized this concept under Safe Health Care.

The results from the categorization exercise, by measurement area, are given below. The numbers appearing under the Health Care That Works and Safe Health Care columns indicate the number of participants that categorized each measurement area under that concept. Stars indicate the concept that staff felt most closely corresponded with the measurement area.

Measurement Area	Health Care That Works	Safe Health Care
“Doctor provides the right treatment for short-term illness.” <i>Example: Doctor provides antibiotics for strep throat infection.</i>	40*	15

The majority of participants clearly understood this measurement area. Some participants who selected Safe Health Care reported that they did so because of the example. As one participant explained, if a physician provides the wrong prescription for strep throat, this would harm the patient and threaten patient safety. This finding was instructive, as staff had intended to use the word “right” to indicate “effective.” Other participant comments about this measurement area included:

“If it works... and the patient gets well, the right care has been given.”

“Good results. It’s effective.”

“It’s one visit... you’re done.”

Measurement Area	Health Care That Works	Safe Health Care
“Doctor writes accurate prescriptions.” <i>Example: Doctor writes prescriptions that can be accurately read.</i>	2	53*

Based on the participants’ feedback, this measurement area and example were very clear. In one participant’s words:

“If you’re given the wrong prescription... it’s clearly a mistake. That’s unsafe.”

Measurement Area	Health Care That Works	Safe Health Care
“Doctor has up-to-date patient records.” <i>Example: Doctor has up-to-date information on patient drug allergies.</i>	5	50*

This measurement area and example were also very clear to the participants. For example, the participants stated:

“A doctor needs to know about allergies, otherwise it would be unsafe.”

“If he doesn’t keep accurate records and know your history... mistakes will happen.”

Measurement Area	Health Care That Works	Safe Health Care
“Doctor follows up with patient after a serious illness.” <i>Example: Doctor ensures stroke patients get the right amount of rehabilitation.</i>	43*	12

The majority of participants clearly understood the measurement area. Again, some participants who selected Safe Health Care felt that the example’s use of “right” swayed them to Safe Health Care. In their words:

“Follow-up is health that is effective.”

“It ensures the ‘right’ amount... no mistakes.”

“I’m a cancer patient in remission. If a doctor doesn’t follow up with me, that’s unsafe.”

Measurement Area	Health Care That Works	Safe Health Care
“Doctor provides the right treatments for ongoing illness.” <i>Example: Doctor gives the right medication for diabetes.</i>	32*	23

This measurement area and example confused participants. Here again, the word “right” communicates the “possibility of a mistake” and sways participants to Safe Health Care while NCQA staff felt this measurement area should be categorized under Health Care That Works. For example, the participants said:

“Safe Health Care... if you get the wrong medication, it’s not safe.”

“Does the word ‘right’ mean, right-correct or right-successful?”

Measurement Area	Health Care That Works	Safe Health Care
“Doctor’s license is in good standing.” <i>Example: Doctor has no disciplinary actions against license.</i>	5	50*

This measurement area and example were very clear. In one participant's words:

"If his license is taken away... he's done something that's not safe."

Measurement Area	Health Care That Works	Safe Health Care
<p>"Doctor follows the recommended procedures when performing surgery in the office." <i>Example:</i> Doctor's tools are properly cleaned and sterilized.</p>	2	53*

This measurement area and example were very clear. The participants were able to categorize this measurement area under Safe Health Care:

"It would be unsafe to have dirty equipment."

"Even if he cleans his tools it doesn't mean that he will perform effective surgery."

Measurement Area	Health Care That Works	Safe Health Care
<p>"Doctor ensures proper maintenance and storage of equipment and medication." <i>Example:</i> Doctor ensures that medications are properly labeled.</p>	10	45*

This measurement area and example were not confusing. While NCQA staff felt this measurement area should be categorized under Safe Health Care, a few participants attributed dispensing the proper medicine as falling under Health Care that Works. However, the majority of participants categorized this measurement area under Safe Health Care. In their words, this measurement area can be defined as:

"Putting safety first."

"If it's not labeled correctly, it's likely to be unsafe."

Measurement Area	Health Care That Works	Safe Health Care
<p>"Doctor identifies illness early." <i>Example:</i> Doctor tests for cancer.</p>	44*	11

This measurement area and example were not confusing. While a few participants mentioned that failing to test for disease would be unsafe, most participants categorized it under Health Care That Works:

“The doctor is proactive... following through. That’s effective.”

Measurement Area	Health Care That Works	Safe Health Care
<p>“Doctor has systems that ensure patients gets test results without mix-up or delay.”</p> <p><i>Example:</i> Doctor notifies patient of blood test results as soon as the results are available.</p>	27	28*

Both the measurement area and example initially confused participants, although after a group discussion many later confirmed that they understood the concept. Some participants felt that the phrase “without mix-up” indicates a lack of mistakes, leading the participant to categorize the measurement area under Safe Health Care. Other participants felt that the idea of “without... delay” communicates that the doctor is “providing good care” and therefore categorized the measurement area under Health Care that Works. The participants’ words reflect this conflict:

“Mix-up or delay is a safety issue.”

“If your tests come back and the doctor’s office calls you right away, you’re not sitting there waiting. He cares about how you feel.”

Measurement Area	Health Care That Works	Safe Health Care
<p>“Doctor has adequate experience performing a specific procedure.”</p> <p><i>Example:</i> Number of times the doctor has performed heart surgery.</p>	23	31*

Participants who selected Safe Health Care were more likely to rationalize that if the doctor is inexperienced that’s unsafe. Participants who selected Health Care that Works noted that experience is “effective” medicine:

“If the doctor has never done [surgery]... it’s unsafe.”

“The doctor with more experience is more effective.”

Measurement Area	Health Care That Works	Safe Health Care
<p>“Doctor provides preventive care at the right time.”</p> <p><i>Example:</i> Doctor offers flu shots to patients prior to the flu season.</p>	46*	8

This measurement area and example were very clear:

“He knows effective medication for prevention.”

“This is preventive medicine. It works.”

Implications: The results from this exercise confirm that the concepts of effectiveness and safety are not completely discrete ideas, but involve a degree of overlap. Indeed, many participants indicated that a doctor that did not provide effective care was threatening a patient’s safety. The indelible link between these concepts may make the categorization of individual measures under those concepts more challenging. It seems that when the measure suggests any possible “harm” some consumers think this means “safety.” Perhaps safety needs to be framed more in terms of mistakes to help differentiate it from effectiveness. Clearly, more research will need to be done before individual measures are “mapped” to the concepts of effectiveness and safety for use in various reporting mechanisms.

4. As has been noted in prior research, socioeconomic status and education affected comprehension of some high-level concepts.

To some extent, the focus groups were controlled for certain key demographics, such as socioeconomic status and education level. Results from two groups, the Medicaid group and the “blue collar” group, were analyzed to determine whether socioeconomic status affected the consumers’ ability to comprehend and their willingness to value the three main concepts and the more detailed measurement areas.

The moderator and staff in attendance felt that the participants in the Medicaid and “blue collar” groups struggled with understanding the concepts and measurement areas and were less able to describe how these areas relate to good physician care. However, there were no clear patterns in either the written exercises or dialogue that allow for drawing conclusions on the characteristics or severity of this problem.

Implications: Additional research must be conducted to probe whether individuals of lesser socioeconomic status have information needs and preferences that differ from other demographic groups. Developers of measures and reporting frameworks must ensure that products are accessible and understandable by individuals of all socioeconomic backgrounds.

5. The Medicare population, more than other consumer groups, tended to equate good physician care with aspects of the patient–doctor relationship and to a lesser extent with the level of a doctor’s experience.

As described in Finding #1, consumers often value most aspects of the interpersonal relationship between a patient and doctor such as communication, listening, and bedside manner. This is not surprising, since issues of the patient–doctor relationship and patient-centeredness are what patients are familiar with. These ideas are consistent with current research. Through these focus groups, we have learned that the addition of a meaningful framework enhances consumers’ ability to understand and value health care quality information, such as information on effectiveness of care.

“I want a doctor who is going to take his time... explain things to me and not rush me out of the office.”

“I want to be more than just an appointment.”

“It would be nice if they’re concerned about your comfort... their staff should care, too.”

“A relationship is important... I want him to know my name.”

To a lesser extent, participants offered traits such as “knowledgeable,” “trustworthy reputation,” and “experience” as indicators of a good physician. Interestingly, few participants directly referred to qualities related to clinical effectiveness or positive outcomes, such as “prescribing the appropriate medicine” and “making me better” when asked open-ended questions without having a framework or context for the information.

During this exercise, the participants were asked whether they value having access to information on physician quality. The participants overwhelmingly responded that information on physician quality is extremely important and desirable:

“Your life depends on [the doctor] you see... [information on quality] is extremely important.”

Implications: Consumers are very interested in knowing and using other quality measures of physician care. Although additional research is needed, the Medicare population concepts of clinical effectiveness appear to differ from other populations. Nevertheless, these findings demonstrate that consumers are highly interested in having access to information that provides insight into the quality of care that a physician provides.

6. Consumers want to work together with their physicians and be included in the decision-making process but do not want to assume sole or primary responsibility for their care. Recent shifts in the U.S. health care system have put a greater focus on the role of the individual consumer in managing both their health and their health care benefits. Insurance product types that emphasize the role of the individual consumer, such as defined contribution models, have received increased attention as employers and the health care system struggle to control escalating costs. Similarly, disease management programs, many of which focus on the role of the patient to self-manage their condition, have become widely employed as an effort to address many of the chronic diseases that require extensive resources to manage and treat. With this increased emphasis on the individual's responsibility for their own health and health care, it is important to investigate consumers' perspectives on their enhanced role in the health care system.

During the focus group sessions, the moderator described Patient-Centered Care as "being responsive to and respectful of patients" and "making sure patients have what they need to participate in their own care." The moderator presented several definitions of Patient-Centered Care, and participants were asked to discuss each definition and choose the one that best represented the concept. These definitions were:

- Doctor has good communication skills and works with the patient to manage his or her own health.
- Doctor and patient work together to make decisions that take into account the patient's needs.
- Doctor provides patient with the education and support to manage his or her own health.

The participants clearly preferred definitions of Patient-Centered Care that focused on a reciprocal relationship between the patient and the doctor, two-way communication, and shared decision-making. The participants disliked the definition "doctor provides patient with the education and support to manage his or her own health," perceiving this as emphasizing one-way communication that leaves the patient to make decisions on his or her own. Several participants specifically disliked this definition because they felt that the "doctor is the expert" and that patients are ill equipped to make these decisions on their own.

Below is a summary of the participants' selections of the definition that is most meaningful and most closely describes the concept of Patient-Centered Care.

Number of participants who selected definition	Definition
22	“Doctor has good communication skills and works with the patient to manage his or her own health.”
24	“Doctor and patient work together to make decisions that take into account the patient’s needs.”
9	“Doctor provides patient with the education and support to manage his or her own health.”

The two favored definitions communicate an emphasis on a reciprocal, two-way relationship. “Doctor has good communication skills and works with the patient to manage his or her own health,” echoed participants’ desires for good communication and attention. For example, the participants said:

“‘Communication skills’ are important.”

“‘Works with’” tells me he will completely understand my situation.”

For those participants who selected an alternate definition, the language “to manage his or her own health” seems to remove some of the responsibility from the doctor.

Again, “Doctor and patient work together to make decisions that take into account the patient’s needs,” echoed participants’ desires with the words, “work together to make decisions.” In the participants’ own words:

“‘Work together’ means that I have a say in my care.”

“They will deal with me as a whole person... my needs.... not just my illness.”

In contrast, the definition “Doctor provides patient with the education and support to manage his or her own health” was interpreted as a one-way communication with the primary responsibility on the patient. In one participant’s words:

“I want someone who works with me... I don’t want to manage my own health.”

Implications: Some consumers may be reluctant to accept a new role in the changing health care system that places a greater emphasis on their responsibility for being active or even proactive partners in managing their own health. These consumers seem to have firmly rooted ideas that the physician “is the expert” and that the reason why they have health insurance is for someone else to take care of certain things and make certain decisions. Despite these strong views, consumers do desire a voice in the decisions about their health care. Employers and health plans

that wish to promulgate products and systems that place a greater emphasis on the consumers' role will need to closely manage the message about how much responsibility is expected of the patient. For measure development activities and reporting frameworks, effort must be made to include dimensions of how well a physician communicates with patients and provides a voice for the patient in decision-making.

7. The Medicare population appears to be more accepting and forgiving of physician errors.

The participants in NCQA's focus groups recognized that safety is an important issue in health care and were able to note several examples of medical errors (e.g., prescribing the wrong drug or operating on the wrong limb). Despite this awareness, participants in all of the groups expressed a belief that health care can never be truly safe and that the human component of physician care creates an inherent potential for medical mistakes. This notion was particularly evident in the Medicare group, indicating that the Medicare consumers may be more reluctant to undermine or question a doctor's authority.

For the focus group exercises, the moderator described the concept of Safe Health Care as "Preventing harm that can occur through medical mistakes" and "Ensuring that there is no harm to patients because of mistakes or poor practices." The moderator presented several definitions of Safe Health Care and participants were asked to discuss each definition and choose the one that best represented the concept of Safe Health Care. These definitions were:

- Doctor follows processes that prevent errors that could harm patients.
- Doctor follows practices that minimize mistakes and accidental harm to patients.
- Doctor uses processes to guard against mistakes so patients are not harmed by the treatment.

The following table summarizes participants' selections based on the one definition that they felt is most meaningful and most closely describes the concept of Safe Health Care.

Number of participants who selected definition:	Definition
26	"Doctor follows processes that prevent errors that could harm patients."
8	"Doctor follows practices that minimize mistakes and accidental harm to patients."
21	"Doctor uses processes to guard against mistakes so patients are not harmed by the treatment."

With this exercise, some participants were concerned by the use of certain words. For example, the majority of participants favored the definition “Doctor follows processes that prevent errors that could harm patients.” However, their rationale for this choice was based on the fact that they disliked some of the words used in the other definitions:

“I don’t like, ‘guard against’ or ‘minimize...’ ‘Prevent errors’ sounds more positive.”

The second most favored was the definition “Doctor uses processes to guard against mistakes so patients are not harmed by the treatment.” Participants favoring this definition stated:

“You can only ‘guard against,’ you can not prevent errors.”

“It encompasses the other two definitions.”

“Accidents do occur... this definition takes that into account and I like, ‘are not harmed by the treatment’.”

Some participants rejected the definition “Doctor follows practices that minimize mistakes and accidental harm to patients” because of its negative tone, indicating that some words used to describe measurement concepts may be so strong that the words divert attention from the information communicated through the measure. For example, one participant disliked the definition because:

“It’s such a negative statement... it scares me.”

In addition to strongly worded negative terms, participants did not like some terms that neither the moderator nor NCQA staff had predicted. In several focus group sessions, participants preferred the word “processes” to the word “practices” when used in the context of office processes or practices. This was true even by participants who selected a definition that used the word “practices” but who indicated a dislike for the term when the group discussed the term out of the context of the definition.

Implications: It appears that many consumers have adopted fatalistic beliefs regarding the ability for the health care system to prevent medical errors and mistakes. This idea must be further tested to confirm whether this is a widespread view among consumers. If this belief is prevalent, then national education efforts should be employed to inform the public about variation in safety and substantial problems with medical errors. Until consumers understand that medical errors can be prevented, they may devalue or misunderstand quality of care information that addresses the ability of doctors or the health care system as a whole to protect patient safety.

8. Consumers perceive a distinction between accountability for “physician” care and for “health” care.

The U.S. health care system is becoming increasingly fragmented. The major players of the system no longer include only the physician, hospital, and insurer but can include a large number of other entities that have taken on discrete functions that were previously performed by larger organizations. Developers of measures and reporting frameworks should not make assumptions about the way consumers perceive the health care system and issues of quality. One assumption that was made by NCQA staff was that consumers would perceive “health care” to encompass the care a physician provides in a one-on-one interaction with a patient. During the focus groups, participants clearly struggled with the use of the term “health care” in the three main concepts (Health Care That Works, Patient-Centered Health Care, Safe Health Care). The participants suggested that measurement areas and concepts should clearly specify the physician as the actor in any measurement describing a component of the service a physician provides. These participants suggested that better terms for the three main concepts be Physician Care That Works, Patient-Centered Physician Care (later more accurately described as the Patient-Doctor Relationship), and Safe Physician Care.

Implications: As the health care system changes, research must be conducted to probe how consumers relate to this less cohesive structure. Specifically, researchers should explore consumer perceptions of the various components of the health care system and how consumers perceive that the components work together. Through the NCQA focus groups, we found that consumers perceive a distinction between physician care and care or services that are provided on a systemwide basis. Without a broader understanding of these ideas, organizations are likely to make assumptions about consumers’ knowledge and perception of the health care system that can cause consumers to devalue performance measurement information. Clearly, consumers do have the ability and prefer to distinguish care provided by a physician (“physician care”) from care or services that are provided by a system (“health care”).

9. Consumers are very sensitive to word choices; when using text to describe measures or concepts, each word may have a profound impact on consumer comprehension.

The various report cards and other frameworks (e.g., healthchoices.org) currently used for reporting quality information to consumers employ textual descriptions that accompany the results from the quantitative measures. As has been seen through testing of specific report card formats, the words chosen for those textual descriptions have as much impact on a user’s impression of the information as the actual quantitative measures themselves. Results from NCQA’s focus groups indicate that consumers may view some words so negatively that the use of the words may mask or confuse the message behind the quantitative measures.

As was discussed earlier, some participants struggled with the wording of the concept of Patient-Centered Care. The participants found the wording of the individual measurement areas even more troublesome. One focus group exercise required the participants to consider a measurement area (e.g., “doctor provides the right treatment for short-term illness”) and identify the concept that corresponds with the measurement area (e.g., Health Care That Works). When presented with measurement areas and examples, some participants felt that some of the words used in the measurement areas had multiple meanings. For example, the term “right” can have multiple meanings and the interpretation of “right” can affect whether a measurement area corresponds with Health Care That Works or Safe Health Care. In the measurement area “doctor provides the right treatment for short-term illness,” right can mean “correct,” as in the doctor provided the correct treatment for the illness, or it can mean “effective,” as in the doctor provided a treatment that led to an improvement in the patient’s condition.

Similarly, participants disliked some words because of their tone. Participants from several groups were uncomfortable with the word “scientific” because the tone of the word implies experimentation or a sterile environment that does not lend itself to physician care. Participants disliked other words because they were too vague. They were very skeptical of words such as “helpful” and “guard,” citing these words as indicating weaker action or less successful care than words like “proven to work” and “preventing mistakes.”

Implications: The results from this exercise show that how a measure is described makes a difference and that consumers may react to words without paying attention to the underlying idea behind a message. Therefore, developers of reporting frameworks must not only test reporting formats and the visual aspect of the framework but must also evaluate how users are interpreting the textual descriptions that accompany the report.

CONCLUSIONS AND IMPLICATIONS

The primary finding of this focus group study is that consumers’ ability to understand and value health care quality information is enhanced when a consumer-friendly framework is employed. Moreover, when an appropriate framework is provided, consumers report that they value information on physician office quality related to patient safety and effectiveness of care, as well as areas such as office location and elements of the physician-patient relationship.

The implications of these findings, while needing further confirmation in studies with a more rigorous experimental design, are important for those involved in evaluation or reporting of elements of quality at the level of physician office practice. The focus groups provided confirmation that there are major instabilities in consumer perceptions of quality. The marked dependence of consumer perceptions on word choice is one indication of this instability. Small changes in wording produced relatively large changes in how consumers understood various

concepts. This has been attributed in prior studies to the complexity of health care and the limited understanding that most consumers have of it.

In addition, if no framework is provided, which is the case with most surveys and prior studies, consumers indicate that they see quality as related almost exclusively to issues in the physician–patient relationship. These include such items as listening, communication, and bedside manner. By contrast, the IOM (in their report, *Crossing the Quality Chasm*) and most health professionals see this as only one domain (patient-centeredness) of quality and see other domains, such as patient safety and effectiveness, as of equal or even greater importance. This has led some to conclude that consumers are not “interested in” or do not value areas of quality outside of patient-centeredness and that there is a major rift between consumers and physicians in their views of health care quality. However, our focus group findings suggest that this apparent rift may not be as large as assumed, since when provided with explanations and a framework for understanding other aspects of quality, consumers do express interest in knowing about the domains of effectiveness and safety. While some concepts are still difficult for consumers, especially those with less education, this study suggests that there can be a much closer relationship between what “experts” see as important in quality and what consumers might value in choosing or selecting practices.

Clearly, these findings from a set of focus groups, which were only one part of a larger project, are subject to major limitations. The larger study included an extensive literature review and explorations of how existing measures of quality might be adapted to inform consumers about physician office practice quality. Moreover, the 55 participants were recruited from insured managed care plan populations. Although they were enrolled in a variety of plans—commercial, Medicare, and Medicaid—important differences may exist between this group and the population of the United States at large. While we attempted to select individuals from different racial, ethnic, and income groups, as well as those having different levels of experience with the health care system, they were all from a relatively small geographic area (the mid-Atlantic region) and did not include substantial numbers of younger persons or the uninsured. In addition, the study, by design, was meant to be qualitative and interactive.

Clearly, much work remains to be done in designing and using frameworks that will reveal a critical level of consumer understanding, as well as in exploring if the “value” expressed by consumers in our qualitative focus group study translates into actual use of the information in practice. A major barrier to consumer decision-making remains the lack of availability of reliable and valid information on quality at the physician office practice level. While these issues must be addressed, the conclusion that consumers can understand and value information on the safety and effectiveness of physician office practice, if confirmed, has important implications for clinicians and consumers, as well as those interested in monitoring, improving, and reporting on physician office practice quality.

APPENDIX A: FOCUS GROUP PARTICIPANTS, SCHEDULE, AND PROTOCOL

At the outset of the project, NCQA staff and the project expert panel suggested that the focus groups be controlled for some key demographic characteristics. In addition to ensuring that each participant was enrolled in a managed care plan, we controlled for the participant’s insurance product line (commercial, Medicare, and Medicaid). The focus group selection protocol also called for one group of individuals with a higher level of education and one group of individuals with chronic conditions. NCQA chose several East Coast locations to save expenses since our expert panel did not feel that there would be major geographic variation in the responses to the concepts tested. The cities chosen reflected urban (Baltimore, MD), suburban (Fairfax, VA), and industrial (York, PA) environments. The breakdown of the groups and the demographics is below.

	Location	Insurance	Additional Demographic Characteristics
I	Fairfax, VA	Commercial (N=8)	Chronic conditions (illness lasting >6 months)
II	Fairfax, VA	Commercial (N=9)	Higher level of education (associate’s degree or higher) and “switchers/choosers”
III	Baltimore, MD	Medicare (N=9)	None
IV	Baltimore, MD	Medicaid (N=9)	None
V	York, PA	Commercial (N=10)	“White collar” (defined by self-report of occupation)
VI	York, PA	Commercial (N=10)	“Blue collar” (defined by self-report of occupation)

A total of 55 consumers participated in the two-hour focus group sessions. The Family Research Group (FRG) recruited participants who were of various ethnic and educational backgrounds and at least 18 years old. FRG established additional quotas for the type of health plan product, socioeconomic status, and the participant’s past change of primary care physician (in the past six months) or anticipated change (in the next six months). NCQA decided to recruit these “switchers/choosers” to explore whether an individual’s comprehension and valuing of quality information is influenced by the proximity of an opportunity to use such information in a decision. See Appendix B for more detailed information on the composition of the groups.

Protocol

At the beginning of each focus group session, the moderator initiated the discussion by asking open-ended questions about the participants’ views on the attributes of good physician care (NCQA staff developed measurement areas and examples of each for the sessions). The moderator also asked participants about their opinions on whether consumers should have access to quality

information about individual physicians. After this icebreaker, the moderator provided some basic information about NCQA and its mission, along with an example and explanation of a sample health plan report card.

After the opening exercise, the moderator used poster boards to present each of the three concepts identified through the IOM report—effectiveness, patient-centeredness, and safety. Consumer-friendly labels were used for each of the concepts—“Health Care That Works” (effectiveness), “Patient-Centered Care” (patient-centeredness), and “Safe Health Care” (safety). The moderator described each concept and presented three similar definitions for each concept. For each concept participants then selected the one definition that was “most meaningful and most closely described the concept.” The moderator then led the group through a brief discussion to elicit the participants’ rationales for their choices. Using a scale of 5 to 1, with “5” meaning “Extremely Important” and “1” meaning “Not at All Important,” the participants then rated how important each concept was to their choice of physician. Refer to Appendix C for the concept definitions that were tested.

Following the discussion on the concepts’ definitions, the moderator led the group through an exercise that probed their understanding of detailed measurement areas that correspond to each of the three concepts. Because of the significant amount of research that has been conducted on the Computer Assessment of Health Plans (CAHPS®) survey and issues of patient centeredness, NCQA chose to concentrate the more detailed exercises on measurement areas related to Health Care That Works (effectiveness) and Safe Health Care (safety). The protocol for this exercise was slightly different in the first two groups than in the remaining focus groups. In focus groups I and II (Fairfax), the moderator provided the participants with “Post-It” notes that were preprinted with 12 detailed measurement areas that corresponded to one of the three concepts. An example was also provided for each of the 12 measurement areas. Participants were instructed to read the measurement area, identify the concept (Health Care That Works or Safe Health Care) that most closely corresponded with the measurement area, and affix the Post-It note to the corresponding poster board that included the concept and its definition. The moderator then asked the participants to describe their interpretations of the measurement area and the rationales for their choices.

Due to logistical challenges, the exercise with the Post-It notes proved to be problematic. Therefore, the moderator changed the protocol slightly for the remaining groups. In the remaining focus groups, participants were provided with a list of the 12 measurement areas and asked to identify the concept (Health Care That Works or Safe Health Care) that most closely corresponded with the measurement area. Participants indicated their choice by circling the corresponding concept on a worksheet. Again, the moderator followed the exercise with a discussion about the participants’ interpretations of the measurement concepts and the rationales for their choices. Refer to Appendix D for the measurement concepts that were tested.

The focus group sessions concluded with a “Board of Directors” exercise, in which participants assumed the role of NCQA’s leadership and were asked to identify other important information they would like included in a report on physician quality.

APPENDIX B: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

	Total (n=55)	I-Fairfax (n=8)	II-Fairfax (n=9)	III-Baltimore (n=9)	IV-Baltimore (n=9)	V-York (n=10)	VI-York (n=10)
Male	22	3	4	4	1	5	5
Female	33	5	5	5	8	5	5
18-25	3	-	-	-	1	1	1
26-35	13	3	3	-	2	3	2
36-55	21	3	4	-	5	4	5
56+	18	2	2	9	1	2	2
African-American	20	2	3	4	6	1	4
Caucasian	30	5	6	5	2	7	5
Hispanic	4	1	-	-	-	2	1
Other	1	-	-	-	1	-	-
Self /family member with chronic condition	31	4	9	6	4	4	4
Changed PCP in past 6 months	10	7	-	-	2	-	1
Likely to change PCP in next 6 months	11	1	2	2	2	2	2
Has children <18 yrs in home	19	1	3	1	7	4	3

APPENDIX C: THREE MAIN CONCEPTS TESTED

Concept Definitions

Health Care That Works (Effective Health Care)

Definitions tested:

- Doctor uses procedures that have been tested and shown to produce good results.
- Doctor provides medical care that is scientifically proven to be helpful.
- Doctor provides medical care proven to work.

Safe Health Care

Definitions tested:

- Doctor follows processes that prevent errors that could harm patients.
- Doctor follows practices that minimize mistakes and accidental harm to patients.
- Doctor uses processes to guard against mistakes so patients are not harmed by the treatment.

Patient-Centered Health Care

Definitions tested:

- Doctor has good communication skills and works with the patient to manage his or her own health.
- Doctor and patient work together to make decisions that take into account the patient's needs.
- Doctor provides patient with the education and support to manage his or her own health.

APPENDIX D: INDIVIDUAL MEASUREMENT CONCEPTS TESTED

Individual Measurement Concepts

1. “Doctor provides the right treatment for short-term illness.” Example: Doctor provides antibiotics for strep throat infection.
2. “Doctor writes accurate prescriptions.” Example: Doctor writes prescriptions that can be accurately read.
3. “Doctor has up-to-date patient records.” Example: Doctor has up-to-date information on patient drug allergies.
4. “Doctor follows-up with patient after a serious illness.” Example: Doctor ensures stroke patients get the right amount of rehabilitation.
5. “Doctor provides the right treatments for ongoing illness.” Example: Doctor gives the right medication for diabetes.
6. “Doctor’s license is in good standing.” Example: Doctor has no disciplinary actions against license.
7. “Doctor follows the recommended procedures when performing surgery in the office.” Example: Doctor’s tools are properly cleaned and sterilized.
8. “Doctor ensures proper maintenance and storage of equipment and medication.” Example: Doctor ensures that medications are properly labeled.
9. “Doctor identifies illness early.” Example: Doctor tests for cancer.
10. “Doctor has systems that ensure patients gets test results without mix-up or delay.” Example: Doctor notifies patient of blood test results as soon as the results are available.
11. “Doctor has adequate experience performing a specific procedure.” Example: Number of times the doctor has performed heart surgery.
12. “Doctor provides preventive care at the right time.” Example: Doctor offers flu shots to patients prior to the flu season.

APPENDIX E: LIST OF EXPERT PANEL MEMBERS

1. Carolyn M. Clancy, M.D., Agency for Healthcare Research and Quality
2. Kathryn Coltin, M.P.H., Harvard Pilgrim HealthCare
3. Carol Cronin, M.S.W., Independent Consultant
4. François de Brantes, M.B.A., General Electric
5. Susan Edgman-Levitan, P.A., Consultant
6. Arnold Epstein, M.D., M.A., Harvard School of Public Health
7. Barbara Fleming, M.D., Ph.D., Centers for Medicare and Medicaid Services
8. Judith Hibbard, Dr.P.H., University of Oregon
9. Sherrie Kaplan, Ph.D., M.P.H., Tufts University School of Medicine
10. Trudy Lieberman, B.S., Consumer Reports
11. Debra L. Ness, M.S.W., National Partnership for Women and Families
12. R. Heather Palmer, M.B.B.Ch., S.M., Harvard School of Public Health
13. Shoshanna Sofaer, Dr.P.H., Baruch College, School of Public Affairs

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Factors Affecting Response Rates to the Consumer Assessment of Health Plans Study Survey (June 2002). Alan M. Zaslavsky, Lawrence B. Zaborski, and Paul D. Cleary. *Medical Care*, vol. 40, no. 6. Copies are available from Paul D. Cleary, Department of Health Care Policy, Harvard Medical School, 180 Longwood Avenue, Boston, Massachusetts 02115, E-mail: cleary@hcp.med.harvard.edu.

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#539 *Improving Health Care Quality: Can Federal Efforts Lead the Way?* (April 2002). Juliette Cubanski and Janet Kline. This issue brief, prepared for the 2002 Commonwealth Fund/Harvard University Bipartisan Congressional Health Policy Conference, discusses the ways in which various federal agencies can work to improve health care quality for all Americans. Available online only at www.cmwf.org.

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Americans fail to get preventive health services at recommended intervals or receive substandard care for chronic conditions, which can translate into needless suffering, reduced quality of life, and higher long-term health care costs.

#520 *Quality of Health Care in the United States: A Chartbook* (April 2002). Sheila Leatherman and Douglas McCarthy. This first-of-its-kind portrait of the state of health care quality in the United States documents serious gaps in quality on many crucial dimensions of care: lack of preventive care, medical mistakes, substandard care for chronic conditions, and health care disparities. The chartbook is based on more than 150 published studies and reports about quality of care.

A 58-Year-Old Woman Dissatisfied with Her Care, Two Years Later (March 27, 2002). Anne-Marie Audet and Erin Hartman. *Journal of the American Medical Association*, vol. 287, no. 12. Copies are available from Anne-Marie Audet, M.D., The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692, E-mail: ama@cmwf.org.

#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.

Delivering Quality Care: Adolescents' Discussion of Health Risks with Their Providers (March 2002). Jonathan D. Klein and Karen M. Wilson. *Journal of Adolescent Health*, vol. 30, no. 3. Copies are available from Jonathan D. Klein, Strong Children's Research Center, Division of Adolescent Medicine, Department of Pediatrics, University of Rochester School of Medicine and Dentistry, 601 Elmwood Avenue, RM 4-6234, Rochester, NY, Tel: 585-275-7660, E-mail: jonathan_klein@urmc.rochester.edu.

#503 *Accessing Physician Information on the Internet* (January 2002). Elliot M. Stone, Jerilyn W. Heinold, Lydia M. Ewing, and Stephen C. Schoenbaum. In this field report, the authors analyzed 40 websites that offer information about physicians. Finding many instances where websites had incomplete, missing, and possibly inaccurate or outdated data, the authors conclude that health care accrediting organizations, health plans, hospitals, and local and national industry organizations and associations should make efforts to improve the information on the Internet, saying that it is a potential valuable tool for consumers.

#528 *The APHSA Medicaid HEDIS Database Project* (December 2001). Lee Partridge, American Public Human Services Association. This study (available on the Fund's website only) assesses how well managed care plans serve Medicaid beneficiaries, and finds that while these plans often provide good care to young children, their quality scores on most other measures lag behind plans serving the commercially insured.

For-Profit and Not-for-Profit Health Plans Participating in Medicaid (May/June 2001). Bruce E. Landon and Arnold M. Epstein. *Health Affairs*, vol. 20, no. 3. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

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#456 *A Statistical Analysis of the Impact of Nonprofit Hospital Conversions on Hospitals and Communities, 1985-1996* (May 2001). Jack Hadley, Bradford H. Gray, and Sara R. Collins. In this study, the authors analyze the effects of private, nonprofit hospital conversions that occurred between 1985 and 1993 by comparing converting hospitals to a control group of statistically similar private nonprofit hospitals that were estimated

to have a high probability of conversion, but did not convert over the observation period. The report is available online only at www.cmwf.org.

#455 *The For-Profit Conversion of Nonprofit Hospitals in the U.S. Health Care System: Eight Case Studies* (May 2001). Sara R. Collins, Bradford H. Gray, and Jack Hadley. This report examines the 87 for-profit conversions of nonprofit hospitals in the years 1985–1994, more than one-third of which took place in three states, and nearly half of which were in the Southeast. The report is available online only at www.cmwf.org.

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Current Issues in Mental Health Policy (Spring 2001). Colleen Barry. *Harvard Health Policy Review*, vol. 2, no. 1. Adapted from an issue brief prepared for the John F. Kennedy School of Government/Commonwealth Fund Bipartisan Congressional Health Policy Conference in January 2001. Available online at <http://hcs.harvard.edu/~epihc/currentissue/spring2001/barry.html>.

Health Plan Characteristics and Consumers' Assessments of Quality (March/April 2001). Bruce E. Landon et al. *Health Affairs*, vol. 20, no. 2. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#448 *Child Development and Medicaid: Attitudes of Mothers with Young Children Enrolled in Medicaid* (March 2001). Susan Kannel and Michael J. Perry, Lake Snell Perry & Associates. This report on mothers with young children enrolled in Medicaid finds that while generally pleased with the overall care their sons and daughters receive, many mothers feel that the program—as well as pediatricians—could do a better job of providing guidance on early development.

Patient Safety and Medical Errors: A Road Map for State Action (March 2001). Jill Rosenthal and Trish Riley. Copies are available from the National Academy for State Health Policy, 50 Monument Square, Suite 502, Portland, ME 04101, Tel: 207-874-6524, Fax: 207-874-6527. Available online at www.nashp.org/GNL37.pdf.

#446 *The Quality of American Health Care: Can We Do Better?* (January 2001). Karen Davis. In this essay—a reprint of the president's message from the Fund's *2000 Annual Report*—the author looks at health care quality: how to define it, how to measure it, and how to improve it.

Envisioning the National Health Care Quality Report (2001). Committee on the National Quality Report on Health Care Delivery, Institute of Medicine. Copies are available from the National Academy Press, 2101 Constitution Avenue, NW, Box 285, Washington, DC 20055, Tel: 800-624-6242, E-mail: www.nap.edu.

#428 *Getting Behind the Numbers: Understanding Patients' Assessments of Managed Care* (November 2000). Margaret Gerteis, Teresa Harrison, Cara V. James, Michael Manocchia, and Susan Edgman-Levitan, The Picker Institute. Using data from the Medicare Managed Care Consumer Assessment of Health Plans Survey, this report examines nine managed care plans and identifies plan-level practices that contribute to a positive experience for plan members.

#427 *Effective Clinical Practices in Managed Care: Findings from Ten Case Studies* (November 2000). Suzanne Felt-Lisk and Lawrence C. Kleinman. Using HEDIS effectiveness-of-care indicators, this summary analysis of ten high-performing managed care plans shows that the plans' ability to improve their performance is influenced by both their overarching approach to managed care and by the specifics of their quality improvement efforts.

#409 *Perspectives on PPO Performance Measurement from Consumers, PPO Leaders, and Employers* (September 2000). Liza Greenberg, American Accreditation Healthcare Commission/URAC. This report presents findings from meetings with key players in the preferred provider organization (PPO) quality arena, in an attempt to determine if PPOs are capable of reporting standardized health care quality data using nationally recognized measures.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence (April 12, 2000). Martin N. Marshall, Paul G. Shekelle, Sheila Leatherman, and Robert H. Brook. *Journal of the American Medical Association*, vol. 283, no. 14. Copies are available from Genuine Article/Institute for Scientific Information, 3501 Market Street, Philadelphia, PA 19104, Phone: 1-800-336-4474 option 5, Fax: 215-386-4343, E-mail: ids@ininet.com.

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To Err Is Human: Building a Safer Health System (2000). Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (eds.). This book, produced by the Institute of Medicine's Committee on Quality of Health Care in America, concludes that medical errors are far more common, and deadly, than previously thought. Copies are available from the National Academy Press, 2101 Constitution Avenue, NW, Lockbox 285, Washington, DC 20055, Tel: 888-624-8373, Fax: 202-334-2451, E-mail: zjones@nas.edu.

Regulating Managed Care: Theory, Practice, and Future Options (2000). Stuart H. Altman, Uwe E. Reinhardt, and David R. Shactman. Copies are available from Jossey-Bass, 350 Sansome Street, San Francisco, CA 94104, Phone: 415-433-1740, Fax: 415-433-0499, E-mail: webperson@jbp.com, www.josseybass.com.

#359 *Quality Management Practices in Medicaid Managed Care* (November 10, 1999). Bruce Landon and Arnold Epstein. *Journal of the American Medical Association*, vol. 282, no. 18. In their study of Medicaid plan quality, the authors discover that plans serving predominantly Medicaid beneficiaries were more likely than those with mainly commercial enrollments to provide services to patients that address their special needs, including those related to transportation, literacy, and nutrition.

#342 *Income Levels of Bad-Debt and Free-Care Patients in Massachusetts Hospitals* (July/August 1999). Joel S. Weissman, Paul Dryfoos, and Katharine London. *Health Affairs*, vol. 18, no. 4. In this study, the authors find that most hospital patients whose expenses are written off to bad debt had incomes below the federal poverty level and thus were presumably eligible for either public programs or hospital-based free care. This disputes the common notion that these patients are able to pay their bills.