Patient satisfaction in managed care

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Chapter 1

Introduction

“Nowadays people know the price of everything and the value of nothing.”

Oscar Wilde (1854-1900)

The purpose of this paper is to examine the use of patient satisfaction in Managed Care Organizations (MCOs). This will be achieved by reviewing the literature on managed care, patient satisfaction and the use of patient satisfaction in Managed Care Organizations. The author will also analyze how Health Alliance Plan (HAP) measures patient satisfaction and uses satisfaction data to improve their service. HAP is a Michigan based health maintenance organization (HMO). Lastly, the paper will give recommendation for improvements based upon the literature review and analysis of HAP.

One can define managed care as a process used to deliver cost-effective care without limiting quality or access (Al-Assaf, 1993). Managed care describes an array of health care delivery and payment systems, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans (gatekeeper POSs). Managed care is rapidly dominating the health care financing and delivery industry in the United States. Managed care has become a big business. Some 36.7 million HMO enrollees are in multi-state firms, including nonprofits such as Kaiser Permanente and HAP (InterStudy, 1995). Roy Amara and associates 2000, predict HMOs will increase from 27 percent to 47 percent of all Americans by 2007.

One definition of patient satisfaction is how patients value and regard their care (Bluementhal, 1996). Patient satisfaction is a process as much as an attitude, and so it
must be planned, monitored continually, and measured frequently. Patient satisfaction has emerged as an important component of the quality of medical care. In the last decade, patients have emerged as the central focus of health care delivery (Council on Medical Service 1986). Managed care organizations use patient satisfaction data to improve their services.

Patient satisfaction surveys are questionnaires that are used to determine how satisfied members are with their managed care plan or primary care physician (Knight, 1998). There are many problems associated with patient satisfaction surveys. One problem is validity. There are many possible biases that can affect patient evaluations. Such biases are due to non-response, mode of administration, timing of survey, and response format. A second problem is that sometimes organizations believe they are measuring patient satisfaction when instead they are measuring the family members’ or friends’ perceptions of the actual patient’s health care encounter (Strausser and Schweikhart, 1992). In summary, no comprehensive instrument or survey method has been tested enough for quality measures thus far, however, a few do appear worthy of further testing (Rubin, 1990).

**Research Questions**

This study will attempt to answer the following questions:

a. What role does patient satisfaction play in health care?

b. What is managed care?

c. What role does patient satisfaction play in managed care?

d. How is patient satisfaction measured and implemented in managed care?
Significance of the Study

This study will examine why patient satisfaction measurement matters in managed care. A well designed, implemented, and utilized patient satisfaction measurement system can help health care managers improve the quality of their clinical and administrative activities. Specifically, patient satisfaction measurements can be used to protect or increase patient revenues, conduct sound market research, and improve the quality of care.

Definition of Terms

Health Maintenance Organization (HMO): An entity that provides and manages the coverage of health services provided to plan members in return for a fixed, prepaid premium; the four types of HMO models are the group, independent practice association (IPA), network, and staff models (Knight, 1998).

Point-of-service (POS): A managed care plan that provides flexibility for an enrollee to receive a service from a participating or non-participating provider, with corresponding benefit or “penalty” of co-pay depending upon the level of benefit selected, with the goal of encouraging the use of participating providers (Knight, 1998).

Preferred Provider Organization (PPO): A Preferred Provider Organization is a group of healthcare providers (professional and institutional) that agrees to provide services to a specific pool of patients at an agreed upon, fee-for-service discounted rate (Robinson, 1998). Patients retain free choice of providers but are given economic incentives for utilizing physicians within the organization.
**Gatekeeper:** A physician who directs and coordinates the care of a member in a managed care plan. The gatekeeper is responsible for authorizing referrals to specialists and hospitalizations (Knight, 1998).

**Traditional fee-for-service:** Services that are supplied by self-employed doctors who charge on a fee-for-service basis and by predominantly private owned hospitals (Bischof, 1996).

**Member:** An individual who is enrolled in or covered by a managed care plan (Knight, 1998).

**Provider:** A physician or other health care practitioner who delivers health care services to individuals in health care plans (Knight, 1998).

**Patient Satisfaction Surveys:** Questionnaires that attempt to determine how satisfied members are with their managed care plan or primary care physician (Knight, 1998).

**Quality Assurance:** The activities MCOs use to assure regulators, purchasers, consumers, providers, and the public that the care delivered by affiliated providers under the guidelines of the plan meets basic standards of quality (Knight, 1998).

**Patient Satisfaction:** One definition of patient satisfaction is how patients value and regard their care (D. Bluementhal, 1996).
Chapter 2

Review of Literature

Managed Care: An Introduction

Managed care refers to a broad and constantly changing array of health plans, which attempt to control the cost and quality of care by coordinating medical and other health-related services (Knight, 1998). The vast majority of Americans with private health insurance are currently enrolled in managed care plans (Knight, 1998). Proposals currently being considered by the United States Congress would, if enacted, guarantee that many millions of Americans who are covered by Medicare and Medicaid will soon join managed health care plans (Knight, 1998). The following are some of the key terms associated with managed care (Knight, 1998).

Capitation (CAP):
The fixed amount of money paid on a monthly basis to an HMO medical group or to an individual health provider for the full medical care of an individual.

Case Manager:
A health professional (e.g. nurse, doctor, social worker) affiliated with a health plan that is responsible for coordinating the medical care of an individual enrolled in a managed care plan.

Co-Insurance:
The amount of money paid out of pocket by plan members for medical services. Co-insurance payments usually constitute a fixed percentage of the total cost of a medical service covered by the plan. If a health plan pays 80% of a physician’s bill, the remaining 20%, which the member pays, is referred to as co-insurance.
**Co-Payment:**

A flat fee paid by plan members for specific medical services. For example, a $5 or $10 "co-pay" is often required for prescriptions and office visits.

**Deductible:**

The sum of money that an individual must pay out of pocket for medical expenses before a health plan reimburses a percentage of additional covered medical expenses.

**Fee-for-service:**

Health insurance plans, which reimburse physicians and hospitals for each individual service, they provide. These plans allow consumers to chose any physician or hospital.

**Staff Model HMOS:**

Employee salaried physicians and other health professionals who provide care solely for members of one HMO.

**Independent Physician Associations (IPA):**

IPAs contract with groups of independent physicians who work in their own offices. These independent practitioners receive a per-member payment or capitation from the HMO to provide a full range of health services for HMO members. These providers often care for members of many HMOs.

**Point-of-service (POS):**

A growing number of HMOs now offer a Point of Service (POS) option. These "escape hatch" plans allow HMO members to seek care from non-HMO physicians, but the premiums for POS plans are much more costly than those for traditional HMOs which restrict choice of physician. Moreover, when an HMO member receives care from a non-participating physician or hospital, the HMO pays far less than its usual 100% coverage.
of necessary medical services.

**Health Plan:**
An HMO, preferred provider organization or traditional health insurance plan that covers a set range of health services.

**Medicaid:**
The federal-state health insurance program for low income Americans. Medicaid also foots the bill for nursing-home care for the indigent elderly.

**Medicare:**
The federal health insurance program for older Americans and the disabled.

**Preventive care:**
An approach to health care which emphasizes preventive measures such as routine physical exams, diagnostic tests (e.g. PAP tests), immunization, etc.

**Primary Care Physicians:**
These physicians provide a full range of basic health services to their patients. General practitioners, pediatricians, family practice physicians and internists are recognized by health plans as primary care physicians, and a growing number of plans are including obstetrician/gynecologists in this category. HMOs require that each enrollee be assigned to a primary care physician who functions as a GATEKEEPER.

**Risk Contract:**
An arrangement through which a health provider agrees to provide a full range of medical services to a set population of patients for a pre-paid sum of money. The physician is responsible for managing the care of these patients, and risks losing money if total expenses exceed the pre-determined amount of funds.
Utilization Review:

The various methods used by health plans to measure the amount and appropriateness of health services used by its members. These checks can occur before, during and after services have been sought or received from health professionals.

Historical Evolution of Managed Care

The American health insurance system developed out of a need for hospitals and physicians to make their product affordable to ordinary people. Health insurance first became a reality for Americans in the 1930s with the creation of specialized health insurance companies – the blue cross and blue shield plans (Amara, 2000). The system was given a boost when health insurance became an employment benefit during World War II, and when Medicare (for the elderly) and Medicaid (for the poor) were created in 1965 (Bodenhorn, 2000). It was this indemnity – based system of mixed public and private insurance sources that constituted the mainstream of American health care until the early 1980s. Only in some regions, notably in the West, were substantial number of people enrolled in the prepaid health plans that were later called HMOs (Health and Health Care 2010, 2000).

The Seventies

The industry got a push in 1973 by the enactment of the 1973 Federal HMO Act (Pallarito, 1997). Paul Ellwood, MD, a pediatrician who is often considered to be the father of managed care, had many discussions with leaders of the U.S. Department of Health, Education and Welfare and had been involved in designing the Health Planning Act of 1966 (Ginzberg, 1996). He coined the term Health Maintenance Organization, to be used instead of prepaid plans, and developed its basic concepts. Under the 1973 HMO
Act, grants and loans were made available for start-up phases and restrictive state laws were under certain circumstances overridden (Fairfield, 1997). There was a provision requiring employers of more than 25 employees who offered indemnity coverage to also offer federally qualified HMOs with closed panels, staff model, or open panels (Gottlieb, 1999). The Act did not serve to boost HMO development, at least initially. Through the 1970s there was steady growth and soon thereafter the growth accelerated. By the mid-1980s there were still only 300 HMOs, mostly quite small, and in 1985 just under 19 million people were covered by an HMO. It is estimated that as much as $190 million was provided through federal grants and loans for the development of HMOs (Prager, 1999).

As managed care in the form of HMOs began to grow, so did other types of health care delivery vehicles. Preferred Provider Organizations (PPOs) became popular. Unlike a typical HMO, in a PPO, members can go outside of the service plan, but they would have to pay a larger deductible or coinsurance. This variation referred to as an POS or Point of Service preference. PPO growth in the 1970s and 1980s also accelerated.

During this same period of time, when HMOs and PPOs were experiencing a great deal of growth, there was an increasing dissatisfaction with traditional health insurers on the part of the business community. In the mid-to late-1970s, employers became unhappy with the relationship with the insurance industry, feeling that they were paying large fees just to process hospital and physician claims for their covered employees. Some businesses began to self-insure and soon others were discontinuing their reliance on commercial insurance. Many for-profit carriers, apparently to protect
their profitable niche in the expending health insurance market, failed to follow the managed care trend (Wilensky, 1998).

The Eighties

By the early 1980s the HMO industry, even though still small, gained a great deal of influence and began to take on a leadership role. Essentially there were three types of health care insurance arrangements at that time – although the second and the third really blend together. First, in the early 1980s, the vast majority of working Americans and their dependents were covered by conventional indemnity health insurance plans, purchased by employers as a benefit (Duffy, 1995). Employees were free to choose any provider, and health care providers had little constraint on practice. The insurance provider acted principally as a vehicle for passing the compensation between the employer and the provider. Bills were submitted on a fee-for-service basis and paid. Second was the prepaid HMO, which covered only 5% of American workers in 1980. The majority of these workers received care from a group model HMO and the remainder were in open panel HMOs. The third type of health insurance arrangement, developed by the end of the 1980s, was the new financing and delivery arrangement, which has now become known as classical managed care. There was a focus on utilization, cost reduction, risk sharing, and risk pools. This innovation exploded so that by the end of the 1980s, 50% of employees were receiving services through managed care organizations (Duffy and Farley, 1995). These new organizations were able to drop costs and bring savings to employers. Managed care plans sought to purchase the services they needed from hospitals and physicians for the lowest possible price, but with an interest in maintaining
an acceptable level of quality of care and patient satisfaction. These plans included HMOs, PPOs, a POS arrangement, and hybrid arrangements.

The Nineties

As a result of efforts to decrease costs, physician income showed a decline for the first time in 1994 (Balas, 1996). As the managed care market becomes fully developed, organizations will no longer be able to compete on the basis of cost alone, but will need to compete on the basis of quality (Sickos, 1997).

Managed care has come under tremendous attack in the 1990s. Many people felt that quality was being sacrificed and that the consumer did not receive the same high quality care under managed care plans as in fee-for-service. A four-year study in Boston, Chicago, and Los Angeles areas of chronically ill patients, mostly the elderly and poor who we managed by HMOs, determined that they did not fare as well as their counterparts who were treated by fee-for-service physicians. Of the 822 patients in the study who were 65 years old or more, 54% of the 346 enrolled in an HMO had a deterioration in health as compared to 28% of the 476 in a fee-for-service environment (Telemedicine, 1996).

Gillian and associates, described these stages of managed care, dividing them into the following five categories:

- First Generation: characterized by retrospective utilization review, contracts with preferred providers, second opinion programs, and little consumer information of education.
- Second Generation: characterized by proactive utilization review, increased use of capitation and gatekeepers, and prospective payment of hospitals.
Third Generation: typified by sophisticated utilization management, management of high cost cases, provider profiling, clinical practice guidelines, complex financial incentives, and full capitation or risk.

Fourth Generation: an increasing interest in health outcomes, health plan report cards, health system integration, and improved information systems and system monitoring.

Fifth Generation (the end point toward which managed care is working): would have anticipatory case management, integration of clinical services, outcomes based reimbursement, and informed consumers.

Accreditation

The National Committee for Quality Assurance (NCQA) was established in 1991 for the purpose of assessing the quality of managed plans. The committee is a private, not-for-profit organization that is governed by a board of directors consisting of employers, consumers and labor representatives from organized medicine. Health providers, employers, and union representatives developed the NCQA standards to provide purchasers and consumers of managed care with more information about their health care choices. The ideal objective of the NCQA is to help managed care organizations to focus on quality of care rather than on the cost issues surrounding health care. Consumers have shown their support for the NCQA accreditation with the fact that “more than 75% of all Americans covered by HMOs are in HMOs that have been reviewed by the NCQA.” (NCQA, 1995).

To receive accreditation from the NCQA, fifty different standards are used to guide the health plan (NCQA, 1995). These standards are divided into six broad
categories. The six categories are: quality improvement, utilization management, physician credentialing, members’ rights and responsibilities, preventive health services, and medical records. After compliance with these six categories are, evaluated, the NCQA applies one to four possible accreditation levels. The four levels are: full accreditation, one-year accreditation, provisional accreditation, provisional accreditation, or denial of accreditation. The accreditation level of each of the managed care programs granted by the NCQA can be accessed on the Internet (NCQA, 1995).

NCQA accreditation places the most emphasis on the quality improvement category, making it 40% of the total score (NCQA, 1995). This category is used to assess the quality of care provided, coordination of all the parts of the delivery system, access to care by the members, and improvements that the plan will be able to demonstrate. The physician credentials categories represent 20% of the score for accreditation (NCQA, 1995). This category covers the training and experience of its physicians, history of malpractice suits, and periodic evaluations of the physician’s performance in the plan.

The entire accreditation process is used to assure that the health organization plan is fundamentally capable of providing acceptable health care to its members. To make the accreditation process more valid, the NCQA has also developed the HEDIS program to determine how well the organization actually provides care to its members. HEDIS is a computer program that compares health plans by using 71 performance standards (NCQA, 1995). These standards are amended periodically to keep them current with technological advances. These standards have been used to provide organizations with “report cards” to show achievement by the managed care organization. Through this
program, the NCQA has been able to provide consumers with standardized data of comparing and evaluating the various health plans that are available to them.

The development of the NCQA has also offered physicians many opportunities to cope better with the changes managed care has had on the health care environment. The NCQA provides critical information about the various plans with which a physician will have contact (NCQA, 1995). This information allows the physician to make an educated choice as to the plan chosen. In addition, physicians will know which plans need improvement and work with these plans to provide better health care.

The NCQA creates a competition among various health plans (NCQA, 1995). There is an incentive for the plans to make the improvements suggested to them so that they will receive the national recognition that will be appealing to plan members. Ultimately, the “NCQA’s mission is directly aligned with the practicing physician’s mission, which is to ensure that patients get the best care and service possible” (NCQA, 1995) It is quite evident that inadequate or inaccurate documentation would make NCQA accreditation very difficult.

**Patient Satisfaction in Health Care**

One definition of patient satisfaction is how patients value and regard their care (Bluementhal, 1996). Another definition of patient satisfaction is conceptually defined as patients’ value judgments and subsequent reactions to the stimuli they perceive in the health environment just before, during, and after the course of their inpatient stay or clinical visit (Strasser, 1991). I define patient satisfaction as the measurement of patients’ perception of care rendered.
Patient satisfaction has emerged as an important component of the quality of medical care. In the last decade, patients have emerged as the central focus of health care delivery (Council on Medical Service, 1986). This new emphasis on quality of care and outcome measurement has led to an increased appreciation of the significance of patients’ perception of care. Today, patient satisfaction is a focal concern of quality assurance and an expected outcome of care (Donabedian, 1981).

Determinants Of Patient Satisfaction

The socio-demographic categories that have been found to have the most consistent relationships with service satisfaction are patient age and gender. Typically, increased service satisfaction was found to be significantly and positively associated with being older (Pascoe 1983; Locker and Dunt 1978) and being female (Pascoe 1983).

The way in which care is organized and financed appears to be related to patient satisfaction, especially in outpatient settings (Cleary and McNeil 1988). Greenly and Schoenherr (1981) results suggest that patient satisfaction is indirectly but significantly affected by the environmental and organizational characteristics of the agency or office setting in which the service takes place. They found that patients were more satisfied when they received care in organizations that had more autonomy, and more communication than with other organizations. The patients felt their needs were being met and the staff listened to.

Studies examining the cost of care have found that the higher the cost the lower the level of patient satisfaction and that persons in prepaid plans tend to be more satisfied with financial aspects of care (Clearly and McNiel 1988). Different groups of patients may react differently to organizational and financial arrangements. For example, patients
with higher incomes and more education tend to be less satisfied with large prepaid plans, whereas patients with lower socioeconomic status have sometimes expressed a preference for clinic care from large prepaid plans (Pascoe, 1983).

Structure of care also includes provider characteristics. Despite the variability in methodology, design, instrumentation, and implementation, certain contributing factors to health care satisfaction emerge with some regularity. These factors are nursing care, medical care, food quality, noise level, and physical surroundings (Clearly, 1983). Most of the studies show that satisfaction with nursing care is consistently a positive correlate of overall satisfaction with the hospital stay (Doering, 1983).

With few expectations, research studies indicate that patient satisfaction is positively related to accessibility, availability, and convenience of care (Clearly and McNeil 1988; Weiss and Ramsey, 1989). Continuity of care for hospitalized patients is addressed by looking at length of stay and prior hospitalization within the same hospital. Specifically, they note that patients who are hospitalized for less than two weeks rate their care better than patients who are in the hospital for more than two weeks. These researchers also report that a positive relationship exists between previous admission at the same hospital and the patient’s total satisfaction score.

Patient Satisfaction In Managed Care

A widely used measure of MCO quality is the members’ satisfaction with the plan. According to the American Association of Health Plans (AAHP), 99.5 percent of health maintenance organizations (HMO) and 80.6 percent of preferred provider organizations (PPOs) conduct member satisfaction surveys (knight, 1998). Patient satisfaction surveys that ask members questions about their interactions with affiliated
providers can frequently help MCOs identify perceived or actual deficiencies in care. Occasionally, member responses will suggest potential quality of care issues with specific providers. For example, a member might comment on the uncleanliness of a participating hospital or the lack of follow-up care by a physician.

HMO members are less satisfied than PPO members (Consumer Reports, 1996). In addition, consumers in (PPOs) also are more satisfied than HMO members, mainly because of the choice of physicians that their network provides (Consumer Reports, 1996). PPOs do not use primary-care physicians as gatekeepers, which make access to specialists a less serious problem for enrollees than for those in HMOs.

There are advantages and disadvantages to using patient satisfaction data to evaluate quality of care. The following is a listing of the major pros and cons of using satisfaction data:

**Cons:**

1. Patients lack the expert knowledge to accurately assess the technical competence of medical personnel. Further, their physical or emotional status can easily impede accurate judgment.

2. Patients are influenced by “non-medical factors” such as the interpersonal skills of the provider. For instance, a good bedside manner can easily mask questionable technical quality.

3. Patients are often reluctant to disclose what they really think because of their senses of dependency or prior failures in patient physician communication. Patients may also fear retribution from the provider if they voice discontent.
4. Patients cannot accurately recall aspects of the delivery process. Moreover, patient surveys or even face-to-face interviews are imperfect means for measuring highly subjective phenomena.

**Pros:**

1. According to Clearly and McNeil (1988), patients can play an important role in defining quality care by determining what values should be associated with different outcomes. While they may not have the necessary knowledge to accurately assess the technical quality of care they receive, patients certainly appreciate its importance.

2. Studies have found that the quality of physicians’ interpersonal skills influences patient outcomes more than the quantity of teaching and instruction given to the patient. Also, it has been suggested that the effects of physician communication skills on the patient’s adherence to medical regimes are mediated by patient satisfaction and recall (Barlett, Grayson, and Barker, 1984).

3. Sometimes actual healing may occur because of patient perceptions of the medical interaction. This placebo effect may contribute up to one-third of the actual healing process (Press, Ganey, and Malone 1990).

4. “Non-medical factors,” such as attitudes toward patients, interpersonal aspects of care, and physician-patient communication, can cause reduced use of pain medication, shorter lengths of stay, and improved compliance (Press, Ganey, and Malone, 1990).
To conclude, it will cost the health care organization if it loses a dissatisfied patient to another institution. The exact amount is unclear. What is clear is that if enough of these patients go elsewhere, it can hurt your business. Viewed from a slightly different perspective, one might argue that, at the very least, dissatisfied patients are not likely to help the health care organization in any way.

The system of managed care in this country is no longer a one-way, top down relationship, commencing with the provider and ending with the patient. It is a reciprocal relationship, which the health care organization must nurture in order to maintain and improve quality and to remain competitive. This is certainly consistent with current thinking on patient satisfaction.

How Patient Satisfaction Is Measured In Managed Care

**HEDIS Measures**

Developed by a board-based committee of the NCQA. HEDIS is a set of standardized measures used to compare the performance of MCOs in various clinical, administrative, and financial areas (NCQA, HEDIS 3.0, 1997). Initially released in 1995, HEDIS measures have been updated to reflect evolving improvements in quality measurements. HEDIS is the most widely used tool for evaluating MCO performance. Purchasers and consumers use HEDIS measures to rank and compare the performance of MCOs. They are also used by MCOs to develop benchmarks from which to measure continued improvements in performance. The data set includes structure, process, and outcomes measures; however, most measures focus on the structure and process of care – the extent to which the plan partners with public health organizations or immunizes older adults, for example.
The most recent measurements set, HEDIS 3.0, attempts to improve the methods and scope of MCO assessment (NCQA, HEDIS 3.0, 1997). For example, new measures are included that assess the ability of plans to improve the functional well-being of their members and care for their chronically ill members. In recognition of need for continuous improvement of patient satisfaction, the HEDIS 3.0 data set incorporates emerging measures so plans can prepare for their eventual implementation. The following HEDIS 3.0 measures are used to assess patient satisfaction (NCQA, HEDIS 3.0, 1997):

- Access/availability of care. Can members assess care in a responsive, timely, and accessible manner? Examples of measures include the availability of PCPs and the availability of obstetrical/ prenatal care providers.

- Satisfaction with the experience of care. Is the plan satisfying the health needs of its members? Examples of measures include member satisfaction with choice of physician and referrals to specialists.

- Informed health care choices. How well does the plan involve members in the active management of their own health care? Examples of measures include language translation services.

**Patient Satisfaction Measurement**

Patient surveys have become a way of life in managed care, an indispensable management tool. The patient survey is a collective assessment of patient expectations; it is also a way to monitor their satisfaction, behavioral intentions, and practice problems and trends (Nelson, 1990). In this age of consumerism, especially in the health care industry, making sure that patients are satisfied with their visits is critical. Managed care
organizations know that patients have feet; when things do not satisfy them, they choose another health plan.

Patient satisfaction surveys that ask members questions about their interactions with affiliated providers can frequently help MCOs identify perceived or actual deficiencies in care (Nelson, 1990). Occasionally, member responses will suggest potential quality of care issues with specific providers. For example, a member might comment on the un-cleanliness of a participating hospital or the lack of follow-up care by a physician.

Patient satisfaction in managed care is measured using telephone and written questionnaire-type surveys that are given to patients (Market Measurements, 2000). The literature has reflected that the surveys used in managed care organizations are not standardized and most thus far have not been scientifically tested for external validity (Market Measurements, 2000). However, surveys that are designed by professional research firms are viewed as having face validity and content validity by the managed care organizations that use them (Market Measurements, 2000). The surveys are administered and then analyzed by survey and research professionals. Though standardization of these surveys in different health service settings could improve external validity, it is also possible that specialized surveys may be needed to fully understand the complexity and variety of patients’ experiences.

The two methods used for measuring patient satisfaction are quantitative and qualitative. Survey measurement is a quantitative method. The quantitative measurement of patient satisfaction is defined as the measurement of patients’ stimuli, value judgments, and reactions to their health care experience through numerical representation
Patient Satisfaction

(Strasser, 1991). With quantitative methodologies, discharged patients are typically asked a survey question on a scale on which they may indicate their responses. The scale may go from (excellent to poor, strongly disagree to strongly agree, or yes to maybe to no); numerical values are assigned to each anchor point on the scale. For instance, excellent might receive the numerical equivalent of a 5, good might be equivalent to 4, and so on.

In the qualitative measurement of patient satisfaction, the health care manager collects information by asking patients to write or to express verbally (as in interviews and focus groups) their view of stimuli and their value judgments and reactions (Nelson, 1990). The kinds of questions that elicit qualitative data from patients vary. For instance, patients may be asked to write about their impression of how well or poorly their physicians and nurses communicated with them. In other cases, patients may be asked to identify two aspects of their stay that they liked best and two they liked least.

Often, qualitative data can be more useful than quantitative data (Kalton, 1972). There are a few reasons for this. First, patients may feel less constrained when not confined to a multiple-choice format. Quantitative survey items may not be phrased or worded in ways that the patient understands and can relate to. The limitations imposed by any quantitative response scales may fail to represent the depth and intensity of an individual patient’s health care experience. Qualitative comments often allow patients to say exactly what they feel in their own words. For example, “I know the nurses were trying their hardest and were very busy, but they were consistently late with my medications and that made me very mad!” From the patients, perspective, qualitative survey questions may allow them to explain exactly how they feel and why they feel that
way. Giving patients the choice to state their specific problems rather than the use of a multiple-choice survey gives them more freedom of expression.

**Improving Patient Satisfaction In Managed Care**

Health care managers should develop a vision of patient satisfaction as something more than simply measuring patient exposure to stimuli, value judgments, and reactions. Instead, patient satisfaction can be viewed, and ultimately used, as an effective organizational development, strategic planning, and total quality management tool that touches all hierarchical levels, functions, and subsystems in the organization.

Patient satisfaction data could be used to:

- Make people accountable for their own high quality job performance and not solely to document poor performance.
- Help staff identify ways to improve their performance.
- Help staff identify what they are doing well and reward them for it.
- Help improve the quality of care rendered – not to simply clean up the messes so that minimally acceptable standards of performance can continue.

This section of the literature review has looked at ways in which patient satisfaction survey data can be used to benefit the organization, its patients, and its employees. To conclude the benefits of patient satisfaction measurement are comprehensive, and health care managers must understand this to maximize the utilization of patient satisfaction data.
Chapter 3

Methodology

History of Health Alliance Plan (HAP)

HAP’s origins go back to the 1960s – long before the term Health Maintenance Organization was coined (Health Alliance Plan, 1999). Community Health Association, the first incarnation of what is now HAP, began operating in 1960 as Michigan’s first nonprofit, prepaid group practice. Health Alliance Plan was licensed as a HMO in 1979. Membership has grown from 65,000 in 1964 to exceeding 506,000 today. HAP’s HMO is fully accredited by the National Committee for Quality Assurance (Health Alliance Plan, 2000).

Overview

Each year HAP commissions several member satisfaction surveys to see how well they are meeting their members’ needs. Results from the mid-year 1999 HAP Member survey were used to identify member issues and opportunities for improvements. The study, conducted by Market Measurement, Birmingham, MI, surveyed over 600 HAP members by telephone in July 1999 regarding their levels of satisfaction with HAP’s performance.

The questionnaire that HAP uses was prepared by Market Research Inc., an outside survey and research firm. This questionnaire has some open-ended questions but detailed response retrieval is insured by the use of live-telephone operators that are trained to probe for the most detailed answers and to provide clarification where needed.
Market Research Inc. research specialist, Carl Hendrickson, confirmed that this questionnaire was tested for reliability and validity, (Carl’s entire correspondence is in Appendix C), (Market Research Inc., 2000). A copy of the entire 2000 Quantitative Analysis instrument is attached in Appendix A.

**Methodology**

I worked with HAP to attain the information needed to complete the methodology and findings for this paper. Cleve Killingsworth Jr., President and CEO of HAP suggested I come work with his company to complete my methodology and findings chapters of my paper. I started my research with HAP by interviewing and collecting data in the summer of 1999.

I interviewed key HAP staff members for their input on patient satisfaction in managed care (e.g., Beth Stanley, Manager of Customer and Member Services, Angela Branch, Manager of Customer Communication and Retention). I reviewed their patient satisfaction survey measurements, and the types of programs that were implemented because of them. One of the many staff members with whom I spoke was Donald Hirt, Vice President of Research and Strategic Planning at HAP. Don explained the physician referral program to me and how it worked. Don gave me HAP’s 1999 Patient Satisfaction Survey and Questionnaire and literature on the physician referral program.
Chapter 4

Findings

Analysis of patient satisfaction surveys from HAP

In this section, the author will report on the strategic plans and goals that have been generated from HAP patient satisfaction survey results. After reviewing the results of the 1999 patient satisfaction survey, HAP concluded that member referrals were very low. In response to the low score, HAP started an Internet program for physician referrals.

Summary of Survey Results. (The entire 1999 survey results are in Appendix B.)

The 1999 study suggests that there has been a significant reversal in HAP member sentiment. In fact, from the 12-year low of 52% of members being “very satisfied”, recorded in the mid – 1999 study, ratings are now near historical highs (61% - “very satisfied”, which is highly consistent with the 1994-1996 survey results, before ratings declined). Similarly, the proportion of HAP members “very” or “somewhat likely” to consider switching healthcare plans moved from almost a third (32%) in the mid-year 1999 study to about one-in-four (24%), or comparable to the 12-year average rating (MORPACE International, 1999).

Why the Ratings Have Improved

Market Measurements recommends caution in attempting to develop a definitive action plan based on the dramatic improvement of member sentiment during 1999. Nevertheless, based upon the results of the 1999 survey, the rationale for improved ratings appears to be associated with:

- Support for HAP as a low cost alternative for health insurance.
- Continued improvements in member sentiment toward depth/breadth of coverage.
- Continued improvements in sentiment toward choice of doctors.
- Improved sentiment toward specialty physician access.
- Measurably higher physician ratings for HFMG, particularly when considering issues associated with “personalized care”.

**HAP’s Action Plan**

Strategies that HAP plans to implement because of survey results.

- Be highly competitive when considering cost and coverage.
- Respond to widespread member criticism of the specialty referral process.
- Better respond to consumer demand for greater choice of physicians (i.e., ability to choose and choices available).

HAP developed an Internet referral program. HAP, with the assistance from Anderson Consulting, created the referral program in response to members’ feedback. Now the referral process is completed over the Internet – on line and on time. Internet technology dramatically reduced referral processing and notification time for HAP network physicians and members. More than 85% of the referrals are automatically approved in minutes before members leave their doctor’s office. Referral for medical care from specialists, shared in real time among doctors and specialists, give HAP members immediate access to medical services and virtually eliminate the paper referral process perceived as a barrier in managed care.
The Advantages of this Internet Program are:

- Faster, more convenient access to specialists.
- Faster processing due to fewer errors. At least 25% of the referrals submitted on paper were incomplete or had errors that delayed their processing. The online application checks all information for accuracy.
- Fewer rejected claims. The online referral application is electronically linked to HAP’s claims information system. This eliminates the chance that HAP members in physician offices will be billed because the referral hadn’t been entered into the claims system.
- Meet NCQA guidelines. The National Committee for Quality Assurance, which accredits health plans, now requires that referrals be processed within two days.

Physicians’ office staff goes to HAP’s homepage, [www.hapcorp.org](http://www.hapcorp.org), and click on the referral application icon. Physician access is secured using identification codes and passwords. The referral information is encrypted and sent through HAP’s firewall and into HAP’s computer system. To get wired, doctors’ offices need a personal computer, modem, Web browser and Microsoft PowerPoint ’97 software.

To conclude, the program was developed out of need to reduce patient wait time. The wait time for a written referral to see a specialist took too long, according to HAP members. Doctors mailed their referral requests to HAP for review. HAP then sent the authorizations to the doctors. It took up to 10 days to process these paper referrals through the mail. Using the Internet HAP has increased the referral time for their members. They have also increased patient satisfaction by shortening referral time.
Chapter 5

Conclusion

The system of health care in this country is no longer a one-way, top-bottom relationship, commencing with the provider and ending with the consumer. It is a reciprocal relationship, which the health care organization must nurture in order to maintain and improve quality and to remain competitive. This is certainly consistent with current thinking on total quality management (Strasser, 1991).

Satisfaction surveys are often the structural mechanism through which patients can alert providers to their concerns, needs, and perceptions of treatment. Patient satisfaction feedback is also important to the quality assessment process since it helps health care providers identify potential areas for improvement. Some of those areas are patient education and follow-up, specific quality of care issues, and hospital procedures. Satisfaction surveys are also useful for purposes of program planning and evaluation (Donabedian, 1988).

Valid and reliable self-administered surveys allow Managed Care Organizations to evaluate patient’s satisfaction with the services they receive. Research has shown that MCOs typically use surveys as their instrument of choice to measure patient satisfaction. The instruments used for data collection do not assume that consumers have enough medical expertise to know when they are getting good medical care. MCOs should use patient satisfaction measurements as a tool to strengthen organizational development; strategic planning; and patient satisfaction.

HAP has used the results of their 1999 patient satisfaction survey to start an Internet physician referral program. HAP observed from the results of the 1999 patient satisfaction
satisfaction survey that the wait for patients needing a referral was too long. It took nearly 10 days to process through the mail. After the Internet referral program started, 85% of the referrals were automatically approved in minutes before members left the doctor’s office. HAP members now have immediate access to medical services. The Internet referral program has virtually eliminated the paper referral process perceived as a barrier in managed care and to HAP.

Ways To Improve Survey Methodology

There are a few ways patient satisfaction surveys could be improved. Sometimes we think we are measuring patient satisfaction when instead we are measuring the family members’ or friends’ perceptions of the patient’s health care encounter (Strausser and Schweikhart, 1992). Family members of friends who complete the survey, originally intended for the patient to complete, are generally dissatisfied. The problem intensifies since about 10 to 12 percent of respondents are family members and friends who are expressing their personal impressions of the patient’s stay (Strausser and Schweikhart, 1992). This problem could be avoidable by asking a question at the of the survey stating please circle “Whose impressions are expressed in this survey: (1) patient, or (2) family member or friend?” This will allow researchers and organizations avoid confusion while at the same time increasing the precision and validity of their measurements.

Other methodological improvements can also be made. First, while difficult to accomplish, more studies need to analyze non-respondents in order to better establish external validity (Hinshaw and Atwood, 1982). Second, given the nature of the patient population, there is a strong probability that mailed and perhaps, telephone surveys may generate results that under-report the perceptions of very old or chronically ill patients, or
both. Third, more work is needed in developing surveys that measure children’s perceptions of satisfaction. Pediatric inpatient and outpatient visits represent a substantial proportion of all health care encounters (Cleary and McNeil, 1988). In addition, most (if not all) of the data on pediatric patient satisfaction is based on the parent’s perceptions of their own experience of their perception of their child’s experience rather than on the child’s perceptions of care. Instruments designed to measure children’s perceptions need to be developed and tested (Skipper and Ellison, 1996).

Research has not yet found a simple, direct correlation between patient satisfaction and improved outcome. Patients can play an important role in defining quality care by determining what values should be associated with different outcomes. While they may not have the necessary knowledge to accurately assess the technical quality of care they receive, patients certainly appreciated its importance (Clearly and McNeil, 1988).

To conclude, consumer satisfaction surveys have been conducted in the health care field for about a quarter of a century (Birenbaum, 1997). The benefits of patient satisfaction measurement are comprehensive, and health care managers must understand this to maximize the utilization of these data. The literature review has shown that the patient is too easily lost in the shuffle. A commitment to patient satisfaction measurement is one step in the direction of elevating patients to the high priority they deserve.
References


Skipper, J.K. (Fall 1996). Personal Contact as a Technique for Increasing Questionnaire

Service. Ann Arbor, MI: Health Administration Press.


Weiss, G.L., Ramsey, C.A. (June 1989). Regular Source of Primary Medical Care and
Appendix A

HAP Patient Satisfaction Survey

Market Measurement
November 15, 2000
Extension # ________________
Sample Pg. # ____________
Time Start ________________
Time End ________________
Resp. __________ 1-4
Tele. __________ 5-14

SUPERVISION USE ONLY:
Independent Physicians
of Macomb ........ 01
St. Joe Pontiac (MOPN) 02
Wyandotte............... 03
Eastern Shores........ 04
Providence............... 05
Crittenton............... 06
Sinai...................... 07
Allegiance (HVPA). .... 08
Balance of Network. 16

FINAL QUESTIONNAIRE
HMO MEMBERS

(ASK FOR RESPONDENT LISTED ON SAMPLE. CAN SPEAK TO OTHER HEAD OF HOUSEHOLD IF THEY QUALIFY)

Hello, I'm ______________ calling from Market Measurement, a national market research firm. We've been asked by HAP to contact members and identify ways to better meet your health care needs. Your individual responses will remain completely confidential and you will not be asked to purchase anything. My questions should take no more than about eleven minutes.

A. First, just to confirm, are you a member of HAP?

Yes

ASK TO SPEAK TO A HAP MEMBER---- | ✗ No
IF "NONE" TERMINATE | ✗ Don't know
| ✗ Refused/NA

B. Do you or any family members work for HAP or Henry Ford Health System?

Yes (TERMINATE)
No (CONTINUE)
Don't know (CONTINUE)
Refused/NA (CONTINUE)
C. Thinking about the selection of a doctor or the type of medical insurance used by members of your household, would you say that you are a... (READ)

Decision-maker (CONTINUE)

- OR-

ASK TO SPEAK TO DECISION----- | Are you not involved
MAKER THEN REPEAT | in these decisions
INTRODUCTION | Don't know
| Refused/NA

D. Please answer my questions thinking only about the household members covered by your HAP contract. (READ IF NECESSARY: *Or the HAP contract under which you are covered). First, about how long have you been a member of HAP?

Under 1 year (CONTINUE)
1-2 years (Go to Q. 3)
Over 2, but less than 3 years (Go to Q. 3)
3 years (Go to Q. 3)
Over 3, but less than 4 years (Go to Q. 3)
4 years (Go to Q. 3)
5-6 years (Go to Q. 3)
7-10 years (Go to Q. 3)
Over 10 years (Go to Q. 3)
Don't know (Go to Q. 3)
Refused (Go to Q. 3)

E. Have you ever been a member of HAP in the past?

Yes
No
Don't know
Refused
1. Before joining HAP, which health care plan or insurer did you use?
   (ONE MENTION ONLY)

**HMO**

- Aetna/U.S. Healthcare .......................................................... 01
- Blue Care Network (SE MI-HMO) ........................................... 02
- CareChoices (formerly McAuley) .......................................... 03
- Comprehensive Health Services of Detroit/CHSD ....................... 04
- Great Lakes ................................................................. 05
- HealthPlus of Michigan .................................................... 06
- M-Care ............................................................................. 07
- OmniCare (formerly Michigan HMO Plan) ............................. 08
- SelectCare MedExtend (HMO) Total Health Care .................... 09
- Total Health Care ............................................................ 10
- ULTIMED ........................................................................ 11
- Wellness Plan .................................................................... 12

**PPO**

- Aetna (Partners-PPO) ............................................................ 13
- American Community Mutual ............................................... 14
- American Medical Security .................................................. 15
- Blue Cross Blue Shield (Preferred-PPO) .............................. 16
- CIGNA .............................................................................. 17
- CNA ............................................................................... 18
- Preferred Choices (Mercy) .................................................. 19
- Preferred Provider Organization of Michigan (PPOM) ............ 20
- SelectCare-United Health System & John Hancock (PPO) .... 21
- SelectCare VersaMed (PPO) ............................................... 22
- UNICARE ......................................................................... 23

**INDEMNITY**

- Blue Cross/Blue Shield (Traditional) ...................................... 24
- Employer's Health .............................................................. 25
- Fortis .............................................................................. 26
- Golden Rule ..................................................................... 27
- Guardian .......................................................................... 28
- John Alden ....................................................................... 29
- Metropolitan Life ............................................................. 30
- Prudential ......................................................................... 31
- Travelers .......................................................................... 32
OTHER

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna (Regular)</td>
<td>33</td>
</tr>
<tr>
<td>Aetna (Point-of-Service)</td>
<td>34</td>
</tr>
<tr>
<td>Aetna (Other-Specified)</td>
<td>35</td>
</tr>
<tr>
<td>Blue Preferred Plus (Point-of-Service)</td>
<td>36</td>
</tr>
<tr>
<td>Blue Cross (Other-Specified)</td>
<td>37</td>
</tr>
<tr>
<td>Care Choices (Point-of-Service)</td>
<td>38</td>
</tr>
<tr>
<td>HealthPlus (Point-of-Service)</td>
<td>39</td>
</tr>
<tr>
<td>M-Care (Point-of-service)</td>
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<tr>
<td>OmniCare Plus (Point-of-Service)</td>
<td>41</td>
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<tr>
<td>Partners</td>
<td>42</td>
</tr>
<tr>
<td>SelectCare (Point-of-Service)</td>
<td>43</td>
</tr>
<tr>
<td>SelectCare (Other-Specified)</td>
<td>44</td>
</tr>
<tr>
<td>None/Had no previous healthcare plan</td>
<td>45</td>
</tr>
</tbody>
</table>

Other (SPECIFY)................................................. 46
Don’t know.................................................... 47
Refused......................................................... 48

2. NOT USED
3. Why did you join HAP instead of some other health care plan? (PROBE: What other reasons led you to choose HAP? - PROBE FOR MULTIPLE MENTIONS)

(IF "OFFERED BY EMPLOYER," RECORD AND PROBE FOR ADDITIONAL MENTIONS.)

(SKIP PATTERNS FOR FIRST MENTIONS ONLY)

<table>
<thead>
<tr>
<th>1st Mention</th>
<th>Other Mention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better coverage than previous medical insurance/more comprehensive</td>
<td>1</td>
</tr>
<tr>
<td>Close proximity to home</td>
<td>2</td>
</tr>
<tr>
<td>Close proximity to work place</td>
<td>3</td>
</tr>
<tr>
<td>Convenient hours</td>
<td>4</td>
</tr>
<tr>
<td>Don't like Blue Cross</td>
<td>5</td>
</tr>
<tr>
<td>Easy to use billing system</td>
<td>6</td>
</tr>
<tr>
<td>Emphasizes preventive medicine</td>
<td>7</td>
</tr>
<tr>
<td>Good choice of doctors</td>
<td>8</td>
</tr>
<tr>
<td>HAP took over IHP/Maxicare</td>
<td>9</td>
</tr>
<tr>
<td>Low cost/saves money</td>
<td>1</td>
</tr>
<tr>
<td>No charge for doctor office visits</td>
<td>2</td>
</tr>
<tr>
<td>Offers wider variety of services</td>
<td>3</td>
</tr>
<tr>
<td>Offered by employer</td>
<td>4</td>
</tr>
<tr>
<td>Only choice available</td>
<td>5</td>
</tr>
<tr>
<td>Quality of care</td>
<td>6</td>
</tr>
<tr>
<td>Recommendation of friends</td>
<td>7</td>
</tr>
<tr>
<td>Other (SPECIFY)</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>8</td>
</tr>
<tr>
<td>Refused/NA</td>
<td>9</td>
</tr>
</tbody>
</table>
4a. NOT USED

4b. NOT USED

5. Let me just confirm, were you offered the choice of Blue Cross or any other health care plan?
   Yes (Re-read Q.3)
   No
   Don't know
   Refused/NA

6. NOT USED

7. How satisfied are you with HAP? Are you...
   Very,
   Somewhat,
   Only slightly, OR
   Not at all satisfied
   Don't know
   Refused/NA

8. What do you like about HAP's health care coverage and medical services? (DO NOT READ - PROBE FOR MULTIPLE MENTIONS)
   Convenient locations
   Easy to get appointments
   Friendly staff members
   Good coverage/many services
   Good doctors
   Less paperwork/no claim forms
   Low cost/no cost-premiums
   Low cost/no cost-prescriptions
   Low cost/no cost (unspecified)
   Many services available
   Quality of care
   Simple/easy to understand
   Other (SPECIFY)

   Nothing
   Don't know
Refused/NA
9. How, if at all, could HAP better serve your needs? (DO NOT READ LIST)
(PROBE FOR MULTIPLE MENTIONS)

Add dental coverage (Go to Q. 11b)
Better coverage/more comprehensive (Go to Q. 11b)
Better doctors (Go to Q. 11b)
Better/easier referrals (Go to Q. 11b)
Better eye care/vision coverage (Go to Q. 11b)
Better quality care (Go to Q. 11b)
Choose doctor of my own choice (Go to Q. 11b)
Cover entire family (Go to Q. 11b)

Easier appointment scheduling (Go to Q. 11a.)
Easier claims filing (Go to Q. 11b)
Easier referrals/specialist referrals (Go to Q. 11b)
Less doctor turnover (Go to Q. 11b)

More doctors (CONTINUE)

More personalized service (Go to Q. 11b)
Pay for prescriptions (Go to Q. 11b)
Reduce cost/out-of-pocket expenses (Go to Q. 11b)

Other (SPECIFY) (Go to Q. 11b)

Nothing (Go to Q. 11b)
Don't know (Go to Q. 11b)
Refused/NA (Go to Q. 11b)

10. Do you want more doctors because... (READ RESPONSES)

You have difficulty getting (Go to Q. 11a)
appointments

-OR-

You want more doctors to
choose from (CONTINUE)
Both (VOL.) (CONTINUE - ASK Q. 11 and Q. 11a)

Neither (VOL.) (Go to Q. 11b)
Other (SPECIFY) (Go to Q. 11b)

Don't know (Go to Q. 11b)
Refused/NA (Go to Q. 11b)
11. Why do you say you want more doctors to choose from? (PROBE FOR MULTIPLE MENTIONS)

(GO TO Q. 11b)

11a. Have you had appointment scheduling problems with...(READ CHOICES)

Primary care doctors, such as general practitioners, pediatricians and OB-GYNs

-OR-

Specialty physicians

Both (VOL.)

Other (SPECIFY) (VOL.)

Don't know
Refused

11b. What things are most important to you when thinking about being able to get medical care when you need it?

(PROBE FOR MULTIPLE MENTIONS)

12. Are you at all familiar with ANY OTHER health care plan?

Yes (CONTINUE)
No (Go to Q. 14)

Don't know (CONTINUE)
Refused/NA (CONTINUE)
13. Here are several things that could be used to rate health care plans. For each one please tell me whether HAP is better, about the same or worse than your previous health care plan. First, would you say HAP is better, about the same or worse when thinking about (READ FIRST ISSUE RATED)? (IF "NO PREVIOUS PLAN" ASK ABOUT "OTHER HEALTH CARE PLANS YOU ARE FAMILIAR WITH")

(ROTATE)

<table>
<thead>
<tr>
<th></th>
<th>Better</th>
<th>About the Same</th>
<th>Worse</th>
<th>DK</th>
<th>REF</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Number of medical services covered</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Cost</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Ability to see specialty physicians when needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Emergency care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
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<tr>
<td>( ) Choice of hospitals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
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<tr>
<td>( ) Quality of care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
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<tr>
<td>( ) Choice of doctors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

How could your needs be better served when considering choice of doctors? (PROBE FOR MULTIPLE MENTIONS)

(Always ask last)
( ) Getting an appointment when you need it | 1      | 2              | 3     | 8  | 9   |

What problems have you had in getting appointments? (PROBE FOR MULTIPLE MENTIONS)
14. If you have a choice, how likely are you to switch to another health care plan? Are you...

Very (CONTINUE)
Somewhat (CONTINUE)
Only slightly (Go to Q. 16)
-OR-
Not at all likely (Go to Q. 16)
Don't know (Go to Q. 16)
Refused/NA (Go to Q. 16)

15. Why might you consider switching to a different health care plan? (DO NOT READ - PROBE FOR MULTIPLE MENTIONS)

Better coverage/more comprehensive
Better doctors
Better/easier referrals
Better eye care/vision coverage
Better quality care
Choose different hospitals
Choose my own doctor
Don't like HMOs
Faster appointments

Lower cost/save money
More convenient hours
More convenient location
More variety of doctors
Wider variety of services
Other (SPECIFY)

Don't know
Refused/NA
16. During the past twelve months or so, please tell me whether each of the following has improved, worsened, or stayed about the same? First, has (READ FIRST ISSUE RATED) improved, worsened, or stayed about the same?

(ROTATE)

<table>
<thead>
<tr>
<th></th>
<th>Improved</th>
<th>Same</th>
<th>Worsened</th>
<th>DK</th>
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<tr>
<td>( ) Ease of scheduling</td>
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<tr>
<td>appointments</td>
<td>1</td>
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<td>9</td>
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<td>( ) Ability to get medical</td>
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<td>care when you need it</td>
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<td>( ) Ability to get medical</td>
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<td>information and advice by</td>
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<td>telephone</td>
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<td>( ) Quality of care</td>
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<td>( ) Choice of doctors</td>
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<td>9</td>
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<tr>
<td>( ) Ability to see specialty</td>
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<tr>
<td>physicians when needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Time it takes HAP to pay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>claims submitted by your</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>9</td>
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<tr>
<td>doctors</td>
<td></td>
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</tbody>
</table>
16a. Thinking only about appointments with your regular, primary care doctor during the past 12 months or so, please tell me whether you would rate the number of days you had to wait for each of the following types of appointments as excellent, very good, good, fair or poor. First, would you rate the number of days you have had to wait for (READ FIRST APPOINTMENT TYPE RATED) as excellent, very good, good, fair or poor?

(REPEAT FOR EACH APPOINTMENT TYPE)

(If necessary read: "You can tell me if you have not had any of these types of appointments during the past twelve months" – interviewer record as "Not relevant")

<table>
<thead>
<tr>
<th>Very</th>
<th>Excellent</th>
<th>Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Not Relevant</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Refused</td>
</tr>
</tbody>
</table>

a. Preventive care, such as for an annual physical or immunizations

b. Routine care for a minor illness, such as a bad cold, minor injury or headache

c. Urgent care for what could be a serious injury or illness, such as a high fever, broken bone or ongoing vomiting or diarrhea

d. Care for a chronic or ongoing condition
17. For the rest of my questions I will use the term HAP doctor's office to mean the medical center or doctor's office at which you receive most of your HAP medical services. First, which HAP doctor's office do you use most often? (ONE MENTION ONLY)

(INTerviewer Instructions: If "PRIVATE DOCTOR'S OFFICE" Mentioned, Ask Which hospital is used by your doctor? THEN RECORD)

RESPONSE:     ASK:

NOVI          Is that the Detroit Medical Center or Providence?
TAYLOR        Is that Associated Physicians of Taylor (Taylor) or Southland (Southland - Taylor)?
SOUTHFIELD    Is that Henry Ford or Providence?
LIVONIA       Is that DMC, Providence, or Henry Ford
WEST BLOOMFIELD Is that Henry Ford or Providence?
DETROIT       Is that DMC, Henry Ford Main Campus or Detroit Northwest?
ST. JOSEPH    Is that Pontiac, Oakland, Macomb, Ann Arbor or Mt. Clemens?
MERCY HOSPITAL Is that St. Joseph Mt. Clemens, Oakland, or Pontiac?
BEAUMONT HOSPITAL Is that Royal Oak or Troy?
HORIZON       Is that Bi-County Community Hospital in Warren or Riverside Osteopathic Hospital in Trenton?

DMC HEALTHCARE CENTERS (DMC)

Detroit (8 Mile)
Livonia
Novi
Southfield
DMC Ambulatory Division
HENRY FORD MEDICAL CENTERS (HFMC)

Allen Park
Ann Arbor
Canton
Dearborn
Detroit - Main Campus
Detroit East
Detroit Northwest
East Jefferson Family Practice (St. Clair Shores
Fairlane (Dearborn)
For Seniors (LaSalle)
Grosse Pointe Pierson Clinic
Hamtramck
Lakeside (Sterling Heights)
LaSalle
Livonia
Main Campus
New Baltimore Family Practice
Novi
Orchard Lake
Plymouth
Redford
Rochester
Roseville
Royal Oak
Southfield (UNSPECIFIED)
Southfield East
Southfield West
Southland (Taylor)
State Fair
Sterling Heights
Taylor
Troy
Warren
Waterford
West Bloomfield
Westland
Woodhaven

Henry Ford/St. Joseph Mercy Health Networks
PROVIDENCE MEDICAL CENTERS (PMC)
Delighton Family Practice Center (Southfield)
Farmington Hills
Livonia
Milford
North Woodward (Berkley)
Northville
Providence Park (Novi)
South Lyon
Southfield
West Bloomfield
Adult Personal Care Physicians I
Adult Personal Care Physicians II
Pediatric Personal Care Physicians I
Pediatric Personal Care Physicians II
Specialty Care Physicians

PHYSICIAN GROUPS (NETWORK)

Allegiance Physician Group
Annapolis
Associated Physicians - Taylor
Beaumont Premier Physicians Network
Bi-County Community Hospital - Warren (Horizon Health System)
Bon Secours
Bon Secour Cottage Health Services
Botsford General Hospital - Farmington Hills
Cottage/Cottage Hospital
Crittenton Hospital - Rochester
Downriver Physician Group
Eastern Shores Network - Grosse Pointe Farms
Farmington Family Physicians
Ford-Tel Physician Group
Genesys PHO (Physician Hospital Organization)
Heritage
Horizon (PROBE: "IS THAT BI-COUNTY COMMUNITY HOSPITAL IN WARREN OR RIVERSIDE OSTEOPATHIC HOSPITAL IN TRENTON?")
Huron Valley Physicians Association
Independent Physicians of Macomb
McLaren Health Care Corporation - Flint
McLaren Health Care Corporation - Lapeer
Mercy Hospital – Detroit
Mercy Oakland Physicians Network (MOPN)
Monroe Physician Group
Pontiac Osteopathic Hospital - Pontiac
Riverside Osteopathic Hospital - Trenton (Horizon Health Care System)
PHYSICIAN GROUPS (NETWORK) (Continued)

<table>
<thead>
<tr>
<th>Hospital/Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinai Hospital - Detroit</td>
</tr>
<tr>
<td>St. Clair Network</td>
</tr>
<tr>
<td>St. Joseph Mercy Hospital - Oakland (MPHO-Mercy Physician Hospital Organization)</td>
</tr>
<tr>
<td>St. Joseph - Pontiac</td>
</tr>
<tr>
<td>St. Joseph's Mercy of Macomb - Clinton Twp. &amp; Mt. Clemens</td>
</tr>
<tr>
<td>Western Wayne Physician Group</td>
</tr>
<tr>
<td>Wyandotte Network</td>
</tr>
</tbody>
</table>

Other (SPECIFY)________________________________________________________________

- Annapolis
- Beaumont Hospital (Royal Oak)
- Beaumont Hospital (Troy)
- Beaumont (Unspecified)
- Bi-County Hospital
- Bon Secour (BON SA-COOR)
- Botsford General Hospital
- Children's Hospital of Michigan
- Crittenton Hospital
- Detroit Receiving Hospital
- Garden City Hospital
- Grace Hospital
- Harper Hospital
- Henry Ford Hospital (Downtown Detroit)
- Henry Ford Hospital (West Bloomfield)
- Henry Ford Wyandotte Hospital
- Huron Valley Hospital
- Huron Valley Sinai Hospital
- Hutzel Hospital
- Hurley Medical Center (Flint)
- Mercy Hospital (PROBE FOR SPECIFICS)
- Oakland General Hospital
- Oakwood Hospital
- Pontiac General Hospital/North Oakland Medical Center
- Pontiac Osteopathic Hospital
- Providence Hospital
- Riverside Osteopathic Hospital
- Sinai Hospital of Detroit
- St. John's Hospital (Detroit)
- St. Joseph Mercy Hospital (Pontiac)
- St. Joseph's Mercy Macomb (Mt. Clemens or East/West)
- St. Joseph Ann Arbor (Catherine McAuley)
- University of Michigan (U of M) Hospital (Ann Arbor)

Don't know
Refused
18. During the past six months, about how many times have you and any members of your household been to the HAP doctor's office you use? (IF "DON'T KNOW" PROBE FOR BEST GUESS - RECORD TOTAL VISITS OF ALL HOUSEHOLD MEMBERS)

(RECORD NUMBER OF TIMES)
None/no visits in past six months
Don't know
Refused/NA

19. Thinking about the HAP doctor you use most often, please tell me whether you are very, somewhat, or not at all satisfied with this doctor in terms of...

(IF NECESSARY READ: The doctor you last visited.)
(INTERVIEWER NOTE: "DOCTOR" CAN BE PHYSICIAN ASSISTANT, OB-GYN, NURSE PRACTITIONER, MIDWIFE, ETC.)
(ROTATE, REPEAT SCALE IF NECESSARY)

<table>
<thead>
<tr>
<th></th>
<th>Very Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Not At All Satisfied</th>
<th>Not Relevant (VOL.)</th>
<th>DK</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Clearly explaining your health condition and the treatment recommended</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Being familiar with your medical history</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Being interested in your healthcare concerns and questions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Spending enough time with you so you don't feel rushed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Having staff who are available to you by telephone, including returning your phone calls</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Being available at the time of your appointment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Being able to get medical information and advice from nurses, and other caregivers at this doctor's office</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>( ) Thoroughness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
D4. What problems, if any, have you had in getting a regular HAP doctor?
(PROBE FOR MULTIPLE MENTIONS) (NOTE: ACCEPTABLE RESPONSES INCLUDE
"DON'T WANT REGULAR HAP DOCTOR" AND "HAVE NOT TRIED TO GET A REGULAR
HAP DOCTOR")

Don't want regular HAP doctor
Have not tried to get a regular HAP doctor
Other (Specify)
Don't know
Refused

D5. In total, how many different healthcare plans, including HAP, are available to you?
(IF "DON'T KNOW," PROBE FOR BEST GUESS.)

(Record)
Don't know
Refused

D6. How many children, if any, under the age of 18 are covered by your HAP contract?

One
Two
Three
Four
Five
Six or more
None
Don't know
Refused/NA

D7. How much of the cost of your HAP insurance coverage is paid by an employer? Would you
say ...

All
Most
Some
-or-
None
Don't know
Refused

D8. NOT USED
D9. **NOT USED**

D10. Do you have access to the Internet for personal use?

Yes  
No (Go to Q. 12)  
Don't know (Go to Q. 12)  
Refused (Go to Q. 12)

D11. Would you want to use the Internet for getting information from HAP?

Yes
No (Go to Q. 12)  
Don't know (Go to Q. 12)  
Refused (Go to Q. 12)

D11a. What specific types of information, services, or capabilities would you like HAP to offer through its web site?  
**PROBE FOR MULTIPLE MENTIONS**

D11b. **NOT USED**

D12. Will your approximate total household income before taxes during 2000 be above or below $35,000?

Above $35,000 (Go to Q. D14)

$35,000 (Go to Q. D15)

Below $35,000 (CONTINUE)  
Don't know (Go to Q. D15)  
Refused/NA (Go to Q. D15)
D13. Will your income be above or below $25,000?  
   Above $25,000 (Go to Q. D15)  
   $25,000 (Go to Q. D15)  
   Below $25,000 (Go to Q. D15)  
   Don't know (Go to Q. D15)  
   Refused/NA (Go to Q. D15)  

D14. Will your income be above or below $45,000?  
   Above $45,000  
   $45,000  
   Below $45,000  
   Don't know  
   Refused/NA  

D15. Do you generally consider yourself to be... (READ LIST)  
   White  
   Black or African American  
   Hispanic  
   Asian  
   Indian  
   Or, something else (SPECIFY)  
   Don't know  
   Refused/NA  

D16. (INTERVIEWER INDICATE) Gender  
   Male  
   Female  

THANK YOU FOR TAKING THE TIME TO HELP HAP TO BETTER SERVE YOUR NEEDS  
FIRST NAME ________________________________  
ADDRESS ________________________________  
CITY ______________________ STATE _______ ZIP _______  
TELEPHONE ____________  

PROJLQ-3531-final-11-15-00.doc
Patient Satisfaction

Would you recommend your current health plan to your family or friends if they needed care?

- Definitely yes
- Probably yes
- Probably not
- Definitely not

- 60%
- 40%
- 20%
- 0%

- 7%

- 63%

- 25%

- 8%
Patient Satisfaction

% of members

Age

% of members

Gender

Race and Ethnic Background

Demographics - General

1999 CHAPS Zun Survey
MEMORANDUM

To: Veronda Finley

From: Carl Hendrickson

Date: March 21, 2001

Topic: Validity Testing for 2000 HAP Subscriber Satisfaction Study

Ms. Finley,

With regard to validity testing for this important research, we submit the following:

1. Validity Testing in Survey Research

There are several types of validity that may be assessed in designing survey research. The appropriate types of validity to measure are dependent upon the purpose of the research and how the information will be presented or used. In scientific research conducted in academic environments, the purpose may be to produce new knowledge, test theories, etc. Under these circumstances it is essential that a measurement tool be thorough in its scope of the content, that it relates to established measures in predictable ways, and/or it can be used to make accurate discriminations. In this private sector, applied business research, the acquired information is used to track satisfaction with various aspects of healthcare service experience for the purpose of planning activities. For this use, it is important that the survey information represents the views of the population sampled, and that these results are consistent over time. In addition, the survey...
must demonstrate face and content validity in that the questions are easily understood and comprehensively represent the important issues. It should also demonstrate concurrent validity by providing information that is consistent with other sources of information. Finally, the information should demonstrate predictive validity by showing a pattern over time and be able to detect the effects of interventions or policy changes implemented by HAP.

2. **Validity Testing Incorporated into the 2000 HAP Subscriber Satisfaction Study**

For this research study, which has a direct and significant impact upon HAP’s planning activities, Market Measurement demonstrates the appropriate reliability and validity:

- This survey research uses a sample size that represents opinions of the population surveyed within a 5 percent margin of error. This is the industry standard.
- This tracking research yields comparable results over time, suggesting the survey produces stable, reliable results.
- In this study, we use rating scales that we view as “highly proven,” both in terms of our extensive use of these rating scales, as well as when considering generally accepted research practices in our industry. The combination of these factors yields rating scales with a high level of construct validity in regard to the measurement of satisfaction.
- We use, quite extensively, interviewer monitoring and interviewer debriefing sessions to establish the face validity of the overall
questionnaire design, topic coverage, terminology used, question flow, etc. Questionnaire enhancements may occur during this pretesting phase.

♦ Market Measurement has extensive experience with both qualitative and quantitative research in the healthcare industry. We have designed and implemented research with a clientele that exceeds 350 public and private sector organizations. This expertise in healthcare issues was used in the development of the 2000 HAP Subscriber Satisfaction Survey, thus ensuring its content validity.

♦ HAP client feedback supports the content and concurrent validity of this research. This feedback suggests that the HAP survey information is applicable to the client's goals and complementary as related to other sources of organizational information.

♦ HAP survey findings that are consistent with other healthcare research or sources of data/information also demonstrate concurrent validity in the current research.

♦ Since this is a tracking study, we are able to monitor results to individual questions over time. When these questions provide highly consistent significant relations with client satisfaction, it supports the predictive validity of the survey as it relates to the survey's goal of effectively measuring satisfaction.
3. Alternatives for Expanded Validity Testing

Again, with the necessary caveat that more sophisticated validity testing techniques often require a significant commitment of time and budget, we can further demonstrate validity with the following techniques:

♦ Assess the survey's internal consistency and redundancy through statistical techniques (Cronbach’s alpha, factor analysis)

♦ Correlational analyses to demonstrate further the concurrent validity of the 2000 HAP Subscriber Satisfaction Study

♦ Statistics (regression, t-tests, ANOVA) to test predictive validity of HAP performance

♦ Collect additional data (questions) to assess divergent validity

We trust that this response will be consistent with your needs and expectations. We are also available to respond to any additional questions you might have. Thanks for the opportunity to share our ideas on this important research topic.