Assessing Communication Effectiveness In America's Health Care System

Stephen Burkat

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ASSESSING COMMUNICATION EFFECTIVENESS IN
AMERICA'S HEALTH CARE SYSTEM

BY

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Submitted in partial fulfillment of the requirements
For the Master of Arts in Corporate and Public Communication
Seton Hall University

2003
ACKNOWLEDGMENTS

The author wants to acknowledge the tremendous support and encouragement of my wonderful wife and children, parents, friends, survey respondents and business colleagues during the development of this work. Without the support and patience of these great people, this thesis would not have been possible.

The author would like to acknowledge the leadership of my advisor, Dr. Patricia P. Kuchon, Ph.D. who without her encouragement and support, this work would also not have been possible.

The author would also like to acknowledge Dr. Donald N. Lombardi, Ph.D. who was instrumental in launching many initial thoughts and insights into the creation and development of this work.
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Chapter I
INTRODUCTION

How many times have you expressed dissatisfaction with how your health care insurer communicates with you? Most of us can recall an occasion when we were frustrated with procedures that were not clear or too complicated, referrals were not obtained because the doctor did not agree with the patient, the directory of physicians did not contain the Primary Care Physician (PCP) of choice, or the deductible was very high. According to Korsch (1997, p. 265), patients express their dissatisfaction about not being able to choose their own doctor when they indicate: "I feel trapped in my health plan. I have to limit myself to their doctor, their specialists, and their tests. I can't go anywhere else." This is the first of several examples of how the communication breakdown between patient and insurer has negatively affected the overall health care experience.

This thesis attempts to identify communication factors that have impacted on the quality and effectiveness of the American health care system. It outlines the history of the health care system and analyzes the results of communication breakdowns between doctors, health care insurance systems and patients that contribute to inefficiencies and frustrations for those covered under various types of plans.

A key factor emphasized in this work is the significance and importance of clear communication among those involved with health care. This work will explore communication factors that can create a negative relationship between a patient and his/her doctor, potentially contributing to a sub-standard level of care. The seriousness of ineffective communication between these parties is more widespread than we think. According to Korsch (1997), the
medical profession is based upon technology and science and has developed so rapidly, it has created a situation where physicians are focusing more on these aspects rather than taking the time to communicate with their patients and understanding their problems from a more personable perspective.

The author conducted a survey in which 50 participants indicated their level of satisfaction with their doctors and insurance companies as they related to communication. The results are published at the end of this work. These results will indicate responses regarding factors pertaining to communication, and the quality of health care through textual responses and percentage of respondents. The terms 'patient' and 'subscriber' will be used interchangeably throughout this work as these refer to a receiver of health care services. A key area of focus will be on the prevailing factors that illustrate the flaws of our health care system.

Lastly, recommendations are made as to what communication methods can be used and how present ones can be improved that would positively affect the doctor, the patient and health care insurers.
Research Statement/Purpose of the Study

This study is designed to identify patients' perceptions of how communication breakdowns impact on the effectiveness of the American health care system. It explains the prevailing communication factors and their association with levels of patient satisfaction. These communication factors will be identified and explored to explain how communication breakdowns occur and how they impact the American health care standard. Equally important, is how this is affecting the American people specifically the elderly, working people, and those who cannot gain access to a quality health care plan.

Subsidiary Questions

To understand the impact that managed care (HMOs for instance) has had on health care in America, this research attempts to answer the following:

1. How effective is communication between doctor and patient?
2. How effective is communication between patient and health insurance provider?
3. Can most Americans receive an acceptable quality of health care and be able to communicate/work with their insurer/provider in handling referral procedures (if applicable), claims processing and the like?

Objectives

The objectives of this study are to:

- explore the state of the American health care system from both patient and physician perspectives.
- provide insight into why health care in America needs to improve to a large degree.
- demonstrate how the relationship between doctors, patients, and managed care organizations has been impacted.
· illustrate why Americans are paying such a high price both literally and figuratively to obtain quality medical care when it is needed.
DEFINITION OF TERMS

AMA – American Medical Association

Capitated Payment – A monthly payment/rate per enrollee regardless of the care the individual actually receives. For example, if a doctor charges $75 for a physical exam, the capitated payment might be $45. The doctor would thus not receive the full payment. This benefits the patient but the doctor would lose $30 for each administered exam.

Capitation – providing medical care for a fixed annual fee regardless of the amount of care provided to the patient (sick or well visit) in exchange for that physician being a member of that particular network.

EOB – Explanation Of Benefits – a document sent to the subscriber from a health insurance company after a claim has been processed that explains the service that is being paid for and how much (percentage) of that service was paid or not.

GP – General Practitioner – a physician who practices general medicine, e.g., performing annual physicals and does not specialize in a particular field.

HMO – Health Maintenance Organization – any of a variety of types of health plans that contract with a defined group of providers (usually on a capitated basis) to provide health care to a defined population.

Managed Care Plan/Program – whereby a corporation or private entity manages the health care administration of its subscribers, i.e., HMO, POS, PPO to name a few.

PCP – Primary Care Physician: The physician who the subscriber chooses in the health care that performs general medical exams. The PCP would only refer the subscriber if that patient required services that the PCP was not qualified to perform (applicable to POS model)
**POS** – Point of Service: referrals are needed from PCPs to specialists; partial reimbursement is given for those providers outside the network.

**PPO** – Preferred Provider Organization: referrals are not needed from PCPs. Offers full or high coverage for a defined panel of providers (who accept discounted fees).

**Secondary Referral** – A referral that is administered by a PCP in certain health care plans such as a POS or other similar managed care plan.
LIMITATIONS

This work identifies and addresses specific situations that occur in the health care industry. Some examples illustrate where doctors, patients and insurance companies fail to communicate effectively and the reasons for this ineffectiveness. However, there are too many scenarios and permutations/variations within both the doctor/patient and patient/health insurance company relationships to include in this work. Instead, this study focuses on the current state of health care in America today, as it relates to communication deficiencies, their impact on the relationship between doctors, patients and health insurance companies, and how might it be improved. There will also be a limited number of solutions presented from the viewpoint of the author and cited publications. The survey results will also present a limited number of responses that are not necessarily representative of the general population.
Chapter II

HISTORY OF HEALTH CARE IN AMERICA

Introduction

This chapter describes how our health care system has evolved over the past century and how communication has impacted on the present level of health care.

Contract Medicine

"During the early 20th century, contract medicine placed too much in the hands of third parties thus jeopardizing the three goals of profit, quality and ethics" (http://www.yourdoctorinthefamily.com/grandtheory/section3_1.htm). This is a significant point to focus on since this same model can be applied to today's managed care plans. Third parties do not include the key partners – doctor and patient. This relationship is most important – not third parties such as insurance companies whose main priority is not insuring that patients are communicating with their physicians effectively but if they're able to make a profit. Granted, corporations need to make a profit but at what cost? Should financial gain hold a higher priority to quality medical care and effective communication between the patient and insurance company? It's clear that "contract medicine violated the sacred fiduciary relationship between physicians and their patients" (http://www.yourdoctorinthefamily.com/grandtheory/section3_1.htm) since financial compensation outweighed the importance of this relationship. It was more important from a contract medicine perspective for doctors to earn a living than to be concerned about the welfare of their patients. When earning a living takes precedence over caring for the needs of the patient, then there is a major dilution of this relationship. This model did not take into account the sanctity of this relationship. Without clear communication between doctor and patient, the
quality of care is in jeopardy before it reaches an acceptable standard. As a result, this model was clearly flawed and “by the 1920s, the medical establishment had largely vanquished contract medicine” (http://www.yourdoctorinthefamily.com/gradtheory/section3_1.htm). It was determined that the valued relationship between doctor and patient was more critical than whether the third party payers were able to collect from the patients that were members of this contract relationship.

The 1920s

During the “economic golden era”, the ideal health care system during the 1920s and for a few decades, patients chose the doctors they wanted and paid for those services. However, doctors had little to offer in the way of effective therapies. Also since expectations were low, this ideal system worked very well in spite of these low expectations. So, we need to ask the next logical question, “Why can’t we have this type of model today?” What are the prevailing factors that are contributing to this from a communication standpoint? It’s quite complicated but here are some talking points.

The public had become familiar with a popular myth that “the best possible care should be provided to everybody, and that where health care is concerned, there are no limits. Expectations were created by this myth that ultimately could not be met. Why couldn’t these expectations be met? Why was communication administered in this manner?” Because it sounded attractive to those who heard it even though the long term effects of “all you can eat” services were not known or thought of. (http://yourdoctorinthefamily.com/gradtheory/section3_2.htm) The truth is that corporations wanted to provide as many services to its employees as they could but eventually the amount of money spent between those corporations and the government would eventually reach a breaking point. This is where the quality of health care started to decline.
Companies could not afford to fund the costs and thus could not provide the services they had wanted for their employees.

Specialist vs. Internist

In 1900, medical practice was similar to our current model in that, “a single, homogenous profession exercises a virtual monopoly over the provision of services” (Kaluzny & Smith, 1986, p. 21). Even though referral is being made to the single body of medical professionals, there is a difference. In 1900, approximately 90% of doctors were general practitioners and the remaining 10% were specialists. Today, however, only about 10% of physicians are considered general practitioners also known as internists (Kaluzny & Smith, 1986). A much greater number of physicians specialize in a particular field because it was more lucrative. This doesn’t bode well for the single source of entry into the managed care plan. Patients feel they can better diagnose their problems better than a general practitioner can. This can create negative feelings between the doctor and patient in this particular case. The system isn’t perfect but the idea of managed care is to coordinate patient care with a PCP or “gatekeeper” which was introduced in the 1970s. In several health plans such as PPOs, referrals are not required thus further reducing the number of opportunities for a patient to converse with a general practitioner. “Today, about 20% of physicians now work in group practice vs. in the early 20th century where group practice was unheard of. And a segment of that 20% works in a hospital setting and earns the majority of their income from their hospital practice. However, in 1900, practitioners’ services in hospitals were largely given free” (Kaluzny & Smith 1986, p. 21). This was due to the inability of patients in those hospitals to pay so physicians provided their services on a charity basis.
Physician to Population Ratio and Communication

In 2000, the overall physician-to-population ratio was approximately 203 per 100,000 in contrast to the 115 per 100,000 in 1970. In contrast, the ratio was 160 per 100,000 in 1900. This increase was mainly due to "the growing investment of public funds in medical school produced pressure for expanded enrollments and the increased number of specialists" (Kaluzny & Smith, 1986, p. 21). Also, in a recent article in the New England Journal of Medicine, "the growth in the physician-to-population ratio is attributable to the increased number of specialists" (Bodenheimer, 1999, p. 587).

In the Napa-Solano area of Northern California, the physician-to-population ratio was one to 3,333 as recently as 1999. In addition, according to a group of 24 doctors and nurses, members of Kaiser Permanente a local HMO, this ratio is staggering and personalized quality patient care is "impossible to provide" (Ted Rohrlich, 2001, www.harp.org/kaiserstrategy.htm). It is extremely difficult to imagine an environment where doctors and patients can feel relaxed and comfortable communicating their needs. Both sides feel stressed due to the difficult time patients had actually getting an opportunity to see a doctor. Even with a reduction in the doctor to patient ratio to 1:2748 in Jan 2001, this statistic is still disproportionate. Rohrlich (2001) further indicates that: "Privately... Kaiser was making it difficult for its Northern California patients to see doctors". Kaiser's culture promoted for many years difficulty for patients to obtain care. This managed care model is an excellent example of how HMOs can make life miserable for those patients caught in the middle between a managed care entity and the doctors they so desire to obtain quality care and jeopardizing their ability to communicate their problems with their doctors.
The Evolution of House Calls

Today, only 16.5% of patients receive house calls (http://www.ama-assn.org/ama/pub/article/2036-2466.html). This is a contributing factor in the high cost of health care, i.e., hospitalization. The AMA recognizes that there are three primary reasons for this low percentage: 1) the financial loss associated with providing this care; 2) conflicting regulatory and legal requirements; and 3) lack of physician education in home care. It is not clear from this article why it would be a financial loss but from a requirements perspective, it is difficult for physicians to oversee the quality of health care when that care is referred to an agency in the case of a patient covered under Medicare. However, physician education programs could be provided. This training would demonstrate home health care techniques that would educate physicians in appropriate care of patients. An important goal here is to reach out to physicians and avail physicians of these training opportunities via specialty societies. Not emphasizing the importance of providing training to physicians to administer home health care will jeopardize that personal touch between doctor and patient in the most important place in their lives – their homes (http://www.ama-assn.org/ama/pub/article/2036-2466.html). This home care training may or may not improve communication between doctor and patient depending upon how much time the doctor has spent with a particular patient. This remains to be seen. Will the increased number of physicians cause doctors to shift their practice away from the hospital causing increased competition between hospital and doctor? Could communication between doctor and patient be improved if more doctors were on their own and not working in a more hectic environment such as a hospital (Kaluzny & Smith, 1986)? Are doctors making more house calls in 2002 than they did in the 1980s & 1990s? Has this resurgence of the ‘house call’ improved the relationship and communication between doctor and patient? Perhaps, but due to the
inadequacy of home care education and cost containment pressures, house calls may not necessarily improve the quality of communication.

In the early 1900s, doctors were paid by private patients (as they were referred to in those days) who were cared for in their own home versus those that were attended to in hospitals. Those doctors caring for hospitalized patients received no money from that group but were instead rewarded by their status at the hospital and provided opportunities for affiliation with teaching facilities thus advancing their professional development.

The balance of these two arrangements between those doctors who worked in hospitals tending to patients vs. tending to those private patients in their homes, is similar to today's managed care model where insured patients subsidize those who receive health care via public assistance, i.e., Medicaid. Has this affected the relationship between doctor and patient? It makes sense that the level/quality of communication would be improved with those patients who foot the bill versus those who do not. Even in the early 20th century, this arrangement existed in addition to capitated payments, which has been defined in this work. These arrangements exist even today.

The idea of capitation in the early 1900s was communicated to recent European immigrants by way of a fraternal lodge. The lodge communicated to the large number of physicians who were struggling that they would be receiving a fixed amount based upon the number of lodge members. This type of arrangement can be compared to a modern day PPO where a PCP is paid a discounted rate for a particular service per patient. It is interesting to note that this type of arrangement was communicated first to lodge members then to subscribers of a PPO under different guises with the same intent but at different times in history (http://yourdoctorInTheFamily.com/grandtheory/section3_1.htm).
In the early part of the 20th century, doctors in New Jersey, for example, had traveled to other states and even other countries to learn about various surgical procedures such as gastric and neurosurgical advances. Cowen (1964, p. 124) specifically references the proud fact that with all the studying of various procedures and with improvements in health care facilities, anesthetics and the like, "there was virtually no kind of surgery that could not and was not performed in New Jersey". Surgeons in New Jersey became quite involved in the advances of surgical procedures and contributed to these advances. Cowen (1964) illustrates two examples of these contributions via the works of Dr. Wells P. Eagleton, Dr. Henry H. Kessler and Dr. George P. Pitkin in the subjects of Brain Abscess, Accidental Injuries and Conduction Anesthesia respectively. In the course of performing research however, there was no evidence that doctors were spending time learning and subsequently practicing the proper methods of communicating with patients.

Physician Medical Training and Education

In 1903, 21% of all candidates who were preparing to receive their medical licenses had already earned academic or scientific credentials compared with five percent a few years before (Cowen, 1964). Clearly, the standards that had to be met in the early part of the 20th century paved the way for physicians to have sufficient education to provide quality care for their patients. Again, however in performing research about the evolution of health care over the last century, there is no indication that doctors were receiving training in techniques to communicate effectively with patients. This is a prime example of doctors only being trained in the sciences and focusing primarily on medical subjects and techniques.
The Abolition of Contract Medicine

Over the last century, according to http://yourdoctorinthefamily.com, the truth is that HMOs are not such recent concepts but those that originated in the lumber and railroad industries even before the beginning of the 20th century. These industries provided health care to employees in those industries who otherwise probably would not have had access to health care. The method of communication of these services was between company, employee and third party payees. These transactions were administered through written practices and verbal agreements. Contract health care organizations placed too much control of third party payers threatening all three goals of profit, quality and ethical standards (http://yourdoctorinthefamily.com/grandtheory/section3_2.htm).

What would happen if that third party was removed from the equation? It would allow the doctor/patient relationship to flourish without the interference of a group that is not central to the maintenance of this relationship. Would that hinder communication between the employer and the employee? Yes, if literature were not written for ease of comprehension and delivered to the patient in a timely manner. The practice of contract medicine was necessitated because of the inability of many people not being able to afford health care. The only way a person could receive health care information is from their employer if they had one. He most certainly could not afford it on his own. There was seemingly no way that unless there was a contractual arrangement in place, health care could not be provided in this manner, which led to this arrangement. Conversely, organized medicine was designed so that physicians could administer health care in such a way that there was no third party and thus maintaining the relationship between doctor and patient. This relationship could also jeopardize the quality of communication between the two parties by having the third party run interference when questions arose regarding the quality of care. As a result, by the 1920s, the medical
establishment had mostly eliminated contract medicine arrangements. This allowed physicians to establish their own organizations thus preventing outsiders from dictating how medicine should be practiced. This communication had been improved since you had a group that was not versed in medical jargon and their expertise was limited at best.

Private Practice vs. Managed Care

During the 1920s, patients paid physicians for their medical health care, chose their doctors and made decisions in partnership with their doctors. This sounds like a good plan but was it really a good arrangement? Not according to the historians, which note: ‘inasmuch as doctors at the time had very little to offer in terms of expensive or effective therapies, and since patients’ expectations were appropriately low, this system worked extremely well from an economic point of view’ (http://yourdoctorinthefamily.com/grandtheory/section3_2.htm). But was this really an effective arrangement? Was the doctor-patient communication relationship effective? And why would patient expectations not be at a high level? Of course they would be and these customers should expect nothing less. Organized medicine looked to foster an environment whereby physicians could practice scientifically and ethically and of course maintain favorable fees (http://yourdoctorinthefamily.com/grandtheory/section3_1.htm).

If patients were making decisions for the health along with their doctors, why weren’t expectations higher? Was patient knowledge limited, thus affecting the way sufficient information was communicated and doctors just told patients what they wanted them to know? Did patients not know the right questions to ask? These questions will be answered to determine if this model could have worked better.
Evolution of Blue Cross/Blue Shield

In the 1930s, partly due to the Great Depression, hospitals began to suffer from patients’
inabilities to pay bills. Blue Cross was formed in the 1930s as the Hospital Service Plan of New
Jersey. In 1942, the Hospital Service Plan (Blue Cross) joined with the Medical-Surgical Plan of
New Jersey to form the well-known Blue Cross/Blue Shield of New Jersey. The intent of this
plan was to merge the sales and administrative arm (Blue Cross) with the medical and surgical
arm (Blue Shield) to allow the needs of patients to be met and doctors to earn an income
(Cowen, 1964). The hope was that this arrangement would not disturb the doctor-patient
relationship. Unfortunately, due to the increased number of indigent patients and increasing
premium rates from the inception of Blue Cross/Blue Shield in 1942 through the early 1960s,
these factors especially the care of the indigent had been passed along to the medically insured.

Blue Cross communicated two points: they would not dictate to physicians how they
should practice and second, bills would be paid on a fee-for-service basis. This arrangement
attempted to maintain an effective doctor-patient relationship and established a reputation to pay
bills on a timely basis. Unfortunately, Blue Cross was paying bills more reliably than patients.
Why was this the case? Is it because Blue Cross wasn’t communicating timely bills or because
patients were ignoring these bills or were indigent? Or were patients unable to pay due to
unemployment. Regardless of the reason(s), this is when and where the downfalls of the health
care system began (http://yourdoctorinthefamily.com/grandtheory/section3_2.htm).
The Patient Visit

An example of a historical perspective to illustrate how the length of a visit between doctor and patient has been affected is as follows: the average visit was 26 minutes in 1943 compared with just 17 minutes in 1985 – almost a 50% decrease. This has negatively affected the doctor-patient relationship. For example, “In one survey half the patients reported having left their physicians office not knowing what they had been told or what they were supposed to do” (Bodenheimer, 1997, p. 586). This is one example of how the sanctity of the doctor-patient relationship has been compromised. Moreover, it is important to note that over the past few decades: “The once-hallowed doctor/patient relationship has been reduced to mere sound bites exchanged during hurried office visits…” (Bodenheimer, 1997, p. 586).

Post-1945

After World War II, employers began offering health care insurance to their employees in lieu of higher wages. Labor unions insisted that companies offered health care plans as a benefit to employment. The government got involved as well and tax laws were changed to make this benefit very attractive to companies. Because of the new tax laws/policies, much of the fiscal responsibility was borne by the government, which is where it still resides. Since the advent of Medicare and Medicaid, 24% of all dollars spent on health care in the 1960s has risen to around 40% in 1990 (http://yourdoctorinthefamily.com/grandtheory/section3.2.htm). When you include tax subsidies for health insurance, approximately 51% of all dollars is spent on health care, accounted for by our government and paid for by taxpayers. This begs the question of why do taxpayers pay such a hefty amount. Even though our government can only tax us so much, the spending continues to rise and any money not covered by tax payments is showing up as our national debt which as of now accounts for approximately three billion in uncollected health care
taxes. So health insurance companies and employers have not done an effective job of communicating this to 65% of Americans. So why was this happening?

After World War II, this seemed like an excellent arrangement where patients were free to select their own physicians and the doctor-patient relationship was not in jeopardy. However, someone else was paying the bills, i.e., the government. The idea of having health care provided by an employer via an insurance company and a physician was flawed because it was not paid for by the insurance company per se – those payments came from government subsidies when they should have come from somewhere else – but from where? That was the challenge before our government and health care system. If the government didn’t pay for the services, what organization would? Some other factors contributed to this downward spiral of quality and the rise in the national debt. First, there is the myth that health care should be available to everybody and there are no limits to that care. Second, since an insurance provider would cover a medical, technological advance, patients demanded these procedures/services thus driving up the cost of health care. Since corporations were involved with this decision-making, these companies felt they had the authority to influence the decisions of the medical profession. This sounds like the third party provider example indicated in a previous section of this work. The idea of “limitless” health care opportunities was doomed to fail. The ability of all parties to communicate to avoid this kind of situation was flawed. Who was accountable for ensuring that an effective method was communicated to avoid a huge national debt? Is it appropriate to expect that Americans are paying for health care in the form of taxes? (http://yourdoctormthfamily.com/grandtheory/section3_2.htm)
The 1950s-1960s

In the 1950s, for example, the doctor-patient relationship was already in jeopardy given the fact that patients were going through long examinations, lab tests, paying for their visits but not following their doctors’ instructions (Korsch, 1997). During that time, for those people that could find a reliable physician through word of mouth, patients would choose a family doctor and have a fee-for-service arrangement and just pay the doctor for the visit. The author remembers a couple of experiences with a house call and remembers a comforting experience in the late 1960s where communication was effective and the doctor was of great comfort. This was due to a lack of distraction and seemingly little pressure to press on to the next patient. In the 1950s, there wasn’t the degree of directive from the insurance company dictating what rates that had to be paid thus forcing the doctor to see a certain number of patients in a given period of time. Physicians knew that their patients would generally pay as much as they could – either most if not the complete fee. The trust between doctor and patient was clearly communicated to some degree by this arrangement without interference from the insurance company. Patients also understood that when they had an appointment, their doctor would usually grant them their individual attention because there was not the need to see a certain number of patients in a given period of time. This arrangement was in place before the plethora of HMOs and managed care plans made their debut, which the capitated payment model was used.

According to David Dranove at: http://pup.princeton.edu/chapters/i6918.html

"Economists have long recognized that it is very difficult for patients to shop for medical care. Patients have poor information about what care is needed and where to buy it…" But why is this so? Dranove goes on to say: "Patients have poor information about what care is needed and where to buy it and also have muted incentives to shop for the best price.” Clearly,
communication is lacking to the consumer about the options available. Who is responsible for providing this information readily and easily to the uninsured consumer or to the consumer who has a plan but is looking for better coverage? This would exclude those who have health care plans through their employer since these consumers are captive audiences for the most part. Dranove (2002) poses a contradictory scenario. In one sense, managed care has saved patients $300 billion annually and health care quality has not been harmed. But on the other hand, managed care has failed to win the trust of Americans and is a favorite target of politicians both conservative and liberal. So if Americans have been saved so much money and health care quality apparently has not been jeopardized according to Dranove, then why is there a significant level of mistrust of managed care among patients? One issue is the unnecessary intrusion of managed care into the physician-patient relationship. This has jeopardized the quality of communication between physician and patient by allowing third parties, e.g., managed care corporations to dictate how many patients the doctor must see and with all the information the patient has to know, deductibles, what’s covered, what’s not covered, pre-certification and referral procedures contributes to this lower quality of communication. Dranove also explains that patients must be able to shop around for the best coverage and not be limited to any particular plan just because. If any of the above barriers are not overcome, health care quality for Americans will continue to fall short of the best possible level of care.

In the 1960s, before the advent of the “gatekeeper” system, a patient could walk into a doctor’s office, pay the doctor his/her fee and then submit a claim to their insurance company and be reimbursed a fixed percentage of the cost. There were no percentages. If the doctor charged $25, for example, to administer an exam and there were lab costs associated with the visit in the amount of $15, that’s a total of $40. The patient would pay the amounts and get
reimbursed 80%. Whereas today, a claim is submitted to the insurance company and depending on the services rendered, the percentage covered may vary depending on the company. For example Blue Cross/Blue Shield, the average percentage reimbursed is 80% for reasonable and customary charges.

For Aetna USHC, the average percentage of reimbursement is 90%. A standard reimbursement amount (percentage) was the case for the most part. Patients knew what they were paying and what they would be reimbursed. There were no capitated payments whereby the doctor would charge $100 for a physical exam but only receive $50 as a capitated payment no matter how many exams he administered – that would be the maximum he could earn for that particular service. The doctor charged $25 for a physical exam for instance and knew that the patient would pay the fee but may or may have been reimbursed a percentage of that fee. In short, the doctor and patient knew where they stood. The doctor knew the full fee would be paid. As long as the patients were satisfied with his services, that doctor wouldn’t have to work so hard to retain these patients. That same doctor today might choose to acquire more patients to make up the difference since that doctor only receives a certain amount of money for his services. The author after having paid a recent visit to his physician found out that a leisurely conversation between doctor and patient was only taking place because his doctor doesn’t have to make a living anymore and could afford to do so. Otherwise, there would be no time to talk about any subject besides, what’s the problem and then here’s what you need to do. This is an example of how capitated payments can potentially jeopardize a doctor-patient relationship since the doctor knows that he cannot earn his full fee for a particular service rendered and would have to see more patients on a daily basis which translates into less time and conversation with a
particular patient. In truth, and as a result of the managed care model (HMOs for instance) doctors today earn less as a result of these capitiated payments.

In the 1960s, there were no in-network and out-of-network Primary Care Physicians (PCPs). Patients could go to the doctor of their choice. So why is it that four decades later, Americans have to choose from a list of PCPs? What factors have led to this restriction? Why can’t we just go to the doctor we want? Why do insurance companies/health care plans limit us? What if these companies allowed their subscribers to go to whomever they want? What would be the harm? These questions will be explored and possible solutions will be presented at the end of this work.

The 1970s to the Present

During the 1970s, managed care organizations such as HMOs and the like began to use a gatekeeper system, which is the current arrangement for some health care plans such as POSs (Bodenheimer, 1999). This method was based on the premise that patients would have to make an appointment to see their PCP to explain their problem. The PCP would then determine if the problem could be resolved at their level office or a referral would have to be administered. Prior to that time, patients could go to the doctor of their choice whether a general or specialist practitioner.

However, did this patient’s freedom, promote communication effectiveness? In the “old days”, a patient could go to whoever was considered appropriate. But was it? According to Korsch (1997, p. 271), “...going directly to a specialist for a specific complaint implies that you as the patient are always able to diagnose the exact nature of your problem”. This is not necessarily the case and can cause wasted time and expense as well as jeopardizing the relationship with the GP. It seems easier to just pay a visit to the GP to see if the problem can be
resolved there. Korsch (1997, p. 271) further explains that, “surprisingly often specialists see patients with symptoms that are not in their area of expertise and that could have been better and more easily diagnosed and treated by a general physician”. When patients do not make the decision to first make an appointment with their GPs, it could jeopardize their relationship. The level of trust between doctor and patient could be negatively affected because as indicated above, patients need to trust their GPs more and thus the level of communication could be improved.
Chapter III

PREVAILING FACTORS AND THE COMMUNICATION BREAKDOWN

It is interesting fact to note is that 20%-25% of patients switch doctors solely because of communication issues (Jackson, 2001). This fact illustrates the criticality of effective doctor-patient communication. This can cost doctors quite a bit of money. For example, it can cost as much as $200 per lost patient (Jackson, 2001). Another interesting fact is that more than 70% of medical lawsuits are based on communication problems, which contribute to the high cost of medical insurance.

In order to understand how these communication breakdowns develop, one has to examine how medical training is administered. Due to the competitive nature of medical school training and the great many hours physicians in training have to spend on their studies, they do not have much time for a social life much less quiet time. Korsch (1997, p. 146) summarizes when she says that:

You must devote all your energy to perform at the highest level. You receive little encouragement to participate in anything other than the requisite hard-core science classes, and you are expected to get nothing lower than A's. Medical students are so terribly busy that they have no free time and very little private life. In addition, by not having this understanding perpetuates not having a relationship formed between the doctor and the patient. This is a key point to note with regard to what has led to the current state of the doctor-patient relationship.

The communication skills of these future physicians are already in jeopardy because insufficient evidence has been found that would indicate that more emphasis is being placed on providing
courses that would educate medical students on effective patient communication skills. This dehumanization is honed during medical school when students have to work on cadavers and can be horrified and afraid. Students have asked themselves, “What am I doing here? I wanted to be a doctor and help sick people; I don’t see how this is getting me there” (Korsch, 1997, p. 148). In fact, the first two years of medical school is replete with courses on anatomy, chemistry, physiology, and pathology and so students may wonder why they are there in the first place. Couple this with the struggle doctors have with either becoming too distant or too close or “overidentifying” with their patients. “Overidentification” is dangerous because a doctor may not be able to perform a procedure on a patient because that patient may remind the doctor of someone they are close to. In one case, a doctor was reluctant to perform surgery on a boy who reminded the doctor of his son. In one sense, this jeopardizes the doctor-patient relationship from a practical standpoint but in another sense, the doctor showed feelings towards the patient but not in a way that would benefit the patient (Korsch, 1997).

Communication Difficulty Between Doctor and Patient

Communication is a relationship that should be maintained between a doctor and his/her patients. Each party is equally responsible for ensuring that information is communicated in a clear manner. So why is it so difficult for doctors and patients to communicate effectively? One reason is because patients don’t always know what questions to ask (Korsch, 1997). It takes time and effort to sit down and decide what questions need to be asked. This effort allows the patient to focus on exactly what he wishes to ask the doctor. The way the questions are formulated should also help to elicit the kinds of responses the patient wishes to obtain from the doctor. The truth is that a patient only has a certain period of time to talk with the doctor. This should be
impetus to the patient to take the time and write out exactly the questions that need to be asked. In addition, the patient needs to ensure that he re-phrases the question if the doctor doesn’t understand it at first or does not provide the type of answer the patient was expecting. This re-phrasing should not be confrontational but it needs to be clear enough so the doctor would be inclined to provide a more pertinent answer (Korsch 1997).

Confrontation only causes hostility and wastes time thus preventing the patient from obtaining the answers and resolutions he needs. It is also important to prioritize when trying to obtain information from your doctor – there is only so much time to focus on those issues that the patient wishes to address (Korsch, 1997). By not taking the time to think through what questions and issues to discuss, the integrity of the doctor-patient relationship will continue to be compromised.

When meeting with a doctor, communication breakdown can occur when a patient does not have all the information necessary with regard to symptoms. For example, if the doctor asks: “When did the headache pains become worse or when did the blurred vision begin?” Without keeping a record or medical journal of when symptoms began to develop or become more severe, it is difficult for patients to know exactly when these symptoms began to occur. Therefore, the ability of the patient to communicate this information to the doctor becomes impaired (Korsch, 1997). In addition, communicating with your doctor about subjects for whom he/she has no control does not lend itself to the effectiveness of a relationship with physicians. Some of these complaints could include: climate control in his office, the rudeness of office staff such as the receptionist who answers the phone in a curt manner or in a hospital setting where the cleanliness of the room is below par. The patient’s use of time could be better used focusing on the needs at
hand. But it is human nature to look to the doctor as a source of authority who could solve a multitude of problems that may or may not be within his span of control (Korsch, 1997).

Getting second opinions can have a negative effect on communication in that it can be difficult for patients to ask for these opinions due to the fact that they may feel as though 1) doctors might feel challenged or offended and 2) that health care plans might not allow for these kinds of consultations (Korsch, 1997). For example, if a patient wanted a second opinion, and even if the doctor sent the referral to Blue Cross/Blue Shield and an HMO with which the insured has cross-coverage, the insurance company would have to approve the doctor’s request that the referral was medically necessary. If the insurance company did not approve the doctor’s request, the patient might have to pay the full doctor’s fee unless he/she appealed the decision and it was re-evaluated. If that was unsuccessful, the patient would have to pay the full cost of the service. This would not promote efficient communication between doctor and patient because the PCP might not want to grant the referral and in turn the patient would be aggravated with the physician for not agreeing to do this. Emotions can run high and cause the patient to go elsewhere and have to once again search for another ‘in-network’ doctor.

House Calls

Even though the idea of a physician making a house call sounds like a win-win situation, it doesn’t necessarily turn out that way. Physicians aren’t given adequate training in the area of home care. According to a 1994 medical school survey, only 66 of 123 said they were offered any training in this area (Editorial, 1996, http://www.ama-assn.org/sci-pubs/amnews/amn 96/edit111.htm).
The need for house calls will only increase partly due to the increased number of baby boomers over the next 10-20 years. Will patients benefiting from home health care be affected by inferior communication with their doctors? Unless more training is allotted in medical schools, this situation can only become worse. There should be a continued focus on providing this kind of training for physicians. An important question that remains to be answered is if the "Guidelines for the Use of Assistive Technology" that has been distributed to 50,000 physicians will help in addressing the growing needs for our baby boomers that will begin turning 65 in 2010 (Editorial, 1996, http://www.ama-assn.org/sci-pubs/amnnews/amn_96/edit1111.htm).

The barriers to providing home care to a much greater number of patients are: 1) financial loss associate with providing this care; 2) conflicting regulatory and legal requirements; and 3) lack of physician education in home care. These areas will need to be addressed and until they are, there won't be a wider effort made to bring physicians to homebound patients (http://www.ama-assn.org/ama/pub/article/2036-2466.html).

Health Care Plan Standardization and Ineffective Communication

No one likes to call their major medical insurance company, wade through all the prompts only to contact a representative who is discourteous and/or apathetic if not downright incompetent. Moreover, when an insured makes a call to inquire about a particular claims filing procedure or pre-certification rules, the last thing he wants to hear is 'I'm not sure, I'll have to check with my supervisor and call you back'. Or just as frustrating, having to call three different representatives and receive three different responses to the same inquiry.

There is also the problem of non-conformity / uniformity with regard to how insurance companies present their health care plans. In short, health care packages are not standardized. There is no one organization that provides leadership and guidance to the health care industry on
how these companies should present their plans and clearly communicate these plans to their subscribers. Some recent conversations with colleagues and friends revealed that they would like to see more clear/concise information mailed to the home and that there are insufficient details provided for when payments are refused. It seems as though part of the problem with the health care system is how these packages “communicate” with the patient. Moreover, there is clearly a breakdown in how health care programs are presented to uninsured Americans for example. This is a serious matter. How can “approximately 45 million Americans” receive adequate communication on what health care opportunities are available to them” (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000, pp. 7-8)? We have not always done a wonderful job of “producing health” and providing effective communication through community outreach programs to do just that (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000).

A recent conversation with a colleague revealed that she does not appreciate her health insurance company promoting the idea of providing information predominantly on the Internet. She does not received printed matter from her insurance company with any regularity. Her argument is that not everyone has a home computer and even if they did, she does not want to take time out to get on the Internet and access this information. It’s easier for her to just take out a binder or folder and find the desired information. Another example illustrates this issue of providing information in bulky mailings that are time consuming to review. A patient was looking for an easy-to-read quick reference guide that condenses the information to answering the most frequently asked questions. The reference guide would then illustrate appropriate sections to access for more detailed information. 

Due to the increased consolidation of both the insurer and health care provider components and the fact that even with capitated payments, providers have little incentive to
become involved in community health improvements because the provider does not cover it.

One situation that has resulted because of services that Medicare does not cover is as follows.

There is a program called MDVIP based in Boca Raton, FL. This is a program whereby a doctor decides to close his practice then re-establish that practice with a smaller list of patients. The patients on this list agree to pay $1,500 each or $3,000 per couple. This annual fee according to the doctor covers those procedures not covered under Medicare. Believe it or not, one of these “not covered” services is the annual physical. This is hard to believe. Medicare does not cover this preventive service. According to Dr. Edward Goldman, the CEO of MDVIP, since Medicare does not cover the “executive” or complete physical, we are giving people the opportunity “to use their own money to pay for preventive services that are not available under the current system” (Singer, 2002, p. 3B). But some Democratic members of Congress are looking to stop the proliferation of these types of programs, which are illegal under Medicare law. Why should subscribers be covered under Medicare yet have to pay an additional premium for VIP health care when Medicare should be covering the ‘executive’ physical. Here’s yet another example of health care inefficiency not providing and adequately communicating quality services to its subscribers. There was the case of a female patient on Medicare whose doctor of ten years decided to join MDVIP. He sent a notice to his patients that he would accept 600 of his 2,400 patients at $1,500 per year. This annual fee would cover those services not covered by Medicare such as a complete physical. This change jeopardized the relationship with her doctor. As it turns out, the patient decided not to continue with her doctor. This type of arrangement sets doctor-patient communication behind in that those patients who decide not to join programs such as MDVIP lose faith in their doctors and then question whether the next physician could follow the same path.
Since there is higher level of mobility amongst Americans, a health care provider is far less likely to invest in anything that may benefit its competitors (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000). But what about those who move to a different part of the country? That person could very well end up having to join/subscribe to another plan. So there is truly a problem with communication in that health insurance companies need to have a method of communicating a subscriber would be able to stay with their same plan no matter where he lives. Since there is so much dissatisfaction regarding the level of cost cutting, limited choice, variations in service quality, and outcomes of care associated with managed care, new opportunities need to be sought out to increase and create higher levels of value. Also, new and creative methods to communicate these improvement opportunities need to be examined as well. How will these communication methods be used (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000)? Health care professionals need to “think out of the box” and develop plans and processes to arrive at a high quality set of solutions that will benefit both patients and their physicians. The challenge facing the industry is, since the current state of providing care for being ill, to concentrate on a communications program for health care providers to keep patients well. Health care providers, e.g., PCPs would be paid for how healthy their subscribers remain. This form of accountability would have to be communicated in an effective manner (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000). But on the other hand, even if most patients knew of this policy, they might question if doctors are not referring those patients in a POS plan because that would affect their compensation or bonus if you will. More importantly, physicians should take every opportunity to suggest ways patients can practice preventative medicine and healthy lifestyle practices thus reducing the chances of being afflicted with a chronic illness or life-threatening condition and not because that doctor would benefit financially.
Communication breakdowns with regard to health care providers and the administration of patient policies and procedures have contributed to "unneeded costly variations in clinical practices as well as error rates and defects in treatment that would not be tolerated by most other sectors of the economy" (Shortell, Gillies, Anderson, Erickson, Mitchell, 2000, p.13). So then why is it tolerated and what communication failures have contributed to this situation? It is tolerated because financial gain has taken precedence over the patients' health. Why does the health care industry not have much accountability for the way in which money is allocated and spent? Clearly, over the last several years, capitation has been a systemic problem in that doctors being salaried members of managed care plans are pressured to see more patients to earn a living. The more patients who use managed care knowing that they will pay a nominal fee for a visit to their physician will result in rising costs and a less time for doctor and patient to communicate. Today, we have a managed care model that includes tax subsidies and 51% of health care that is subsidized by the government and employers via health care plans.

(http://www.yourdoctoristhefamily.com/ grandtheory/section3_2.htm).

Communication Inefficiency Of Health Insurance Companies

Health insurance companies are also to blame for some of the inefficiencies with regards to communication in processing and paying claims. Recently a Department of Banking and Insurance audit found 84,000 cases where Cigna (an HMO based in Jersey City) failed state standards on handling claims in 26 percent of the cases that were reviewed. Most of this percentage was attributed to claims processed by those workers outsourced by Cigna. The article goes on to illustrate that 37 percent of cases contained unexplained adjustments. Why couldn’t Cigna explain these adjustments? This is a prime example of the lack of communication between a health insurance company and its patient. In addition, Cigna couldn’t find 36 of 66
claims cited for non-payment or repeated denials. This is related to feedback received regarding
denials of claims where valid reasons were not given for why claims were not paid or that it took
multiple submissions to ensure claims were paid. As a result, the Medical Society of New Jersey
"sued Cigna and four other major health [insurers] saying they routinely delayed and denied
payments for necessary care" (Ress, 2002). This sounds too much like a gross inefficiency and
an inability of these insurance companies to communicate effectively with their subscribers by
not providing timely claim status. There is a potential communication flaw when companies
such as Cigna do not have their own employees handling claims. Granted it is cheaper to hire
contractors but at what cost? And, there is the issue of employee loyalty, which does and/or may
not necessarily exist when contractors are hired for a particular function. Perhaps these
‘outsiders’ do not understand the communication provided by Cigna employees when training
occurs. There is the tendency that employees would not only make more of an effort to learn the
job because they have a vested interest in the company versus outside workers who are only
hired for a limited period of time. This example has been seen in other companies where
functions that had been performed by employed were placed in the hands of outsiders and overall
results were not favorable.
Chapter IV

THE CURRENT STATE OF COMMUNICATION FACTORS IN THE HEALTH CARE INDUSTRY

Background

Research was conducted using a variety of sources including articles in books, on the World Wide Web, newspapers, and periodicals that illustrated the current state of the health care industry as it related to the relationship between doctor and patient, the hassle of having to obtain referrals from PCPs, and the limited choices and communication factors between doctor and patient. What the author found was a plethora of chapters and articles containing information focusing primarily on doctor-patient communications and relationships in a variety of situations. Some of these situations will be described in this chapter/section.

Patient Referrals

An ever-growing issue is that patients do not like to obtain referrals. According to information provided in the Medical Risk Management Advisor located at: http://www.national.com/news/advisor/SafeRefQ1998.htm) the process of referrals by physicians to their colleagues is changing partly due to cost-conscious policies of managed care medicine, and the shift from small medical practices to large multi-specialty medical groups.

According to an excerpt in the "Statement of Ethics in Patient Referrals to Ancillary Services located at: (http://www.facs.org/fellows_info/statements/st-7.html)"
The college believes that professional income should be derived from the services that physicians personally provide or supervise, not from goods or services they prescribe for their patients (in this case, referrals). Referrals made to ancillary health care facilities in which a referring physician plays no role in ensuring the quality of services, yet which result in a profit to that physician, clearly run contrary to this ethical standard.

This is yet another demonstration of why health care has become a more profit vs. patient care arrangement and contributes to a deterioration of the doctor and patient relationship thus negative impacting communication quality. This article further indicates that in cases where physicians refer patients to outside facilities where they have a vested financial interest, i.e., limited partnerships whereby physicians provide investment capital, which could result in potential profit gains for these partners. These physicians may be provided financial reward for referring their patients. These limited partnerships create incentives for physicians to perform these referrals thus causing unnecessary usage of additional resources and in the aggregate, driving up the costs of health care. If a patient knows that a doctor may be referring them to another physician when that doctor could handle the patient’s problem, that patient would feel as though the doctor is more interested in financial gain than the quality of his patient’s care.

There are several key causes for referrals that are not handled well according to the Medical Risk Management Advisor located at: [http://www.promotional.com/news/advisor/SafeRef101998.htm](http://www.promotional.com/news/advisor/SafeRef101998.htm). The first is inadequate communication, which is key to ensuring that all information in the referral documentation is presented and is understood by the referring physician. There have been cases where a report was not sent in a timely manner if at all. Also there have been cases where reports were incomplete whereby information was missing. This caused some serious
problems since in one case three drugs that were prescribed were not indicated on the report.

Another part of this problem occurs when patients are referred to a specialist but do not return to their PCP for a follow-up visit. It is not appropriate for the specialist to take over treatment or convince a patient to transfer to another GP for a particular reason. This is not only unprofessional but can cause confusion with regard to documentation that’s communicated to the specialist. For example, when reports are incomplete (missing information because dictation was not understood) or are not read, or when referrals are not made on a timely basis or when there is inadequate information, this causes breakdowns in communication. These consist of prescription errors, erroneous assumptions about who was managing a particular problem and potentially damaging delays or oversights in care as well as resident doctors who are sleep deprived and cannot provide the best quality communication and is far more likely to make a potentially dangerous error (Trevino, 2001). Two examples of these breakdowns is first, an ambiguous referral from emergency departments to specialists. Instead of being vague and just saying ‘Follow-up with the family doctor’, it would be more effective to say ‘Call your family doctor now for an appointment to see her within 48 hours and second, not documenting a patient’s failure or refusal to obtain a recommended consultation and was told that the patient was told of possible consequences (http://www.pronation.com/news/advisor/SafeRep1998.htm).

There was the case of a five-year old girl who had asthma and couldn’t get her PCP to refer her to a pediatric pulmonologist because he didn’t think she needed it. He felt that the girl’s hacking cough did not warrant the referral. The parents of the child asked an associate of this PCP if she felt a chest x-ray was necessary. She said yes and we ended up going to the specialist paying for the doctor’s visit and x-ray out of pocket and submitting to the insurance for reimbursement. As it turned out, the parents received much less because it was ‘out-of-network’
thus reducing the benefit significantly. Could the patient have communicated to these physicians more effectively in order to convince him that this referral was essential? Possibly. If the parents had had an alternative to have this procedure approved by possibly having the specialist call the PCP to try and convince him to agree? Who else could have supported the patient in convincing the doctor that the referral was necessary? How does one deal with a situation such as this? The answer lies in research and adjustments in how communication is delivered.

Limited Choices and Lack of Communication

In addition to not wanting to obtain referrals, patients don't like to be limited by a network of physicians. As a result, patients don't appreciate a higher deductible (for example, a $1,000 annual deductible for a Aetna USHC subscriber) for those physicians that are 'out-of-network'. The deductible is less if a subscriber uses an 'in-network' physician. Even so, a patient should be able to choose the physician of his choice regardless of whether or not the physician is in the network. This is a fundamental flaw of our health care system. It's frustrating that a patient cannot choose the doctor of her choice. What if there are no doctors on the 'in-network' list that the patient is familiar with? That patient can then select any doctor she chooses but will pay more out-of-pocket costs and a higher deductible. In contrast, in the 1940s, a patient could choose a physician, receive services from him and switch if not happy with those services. There was the case of the woman who was looking to have acupuncture treatments but was on Medicare and couldn't get it covered. Why? Because her insurance plan would not cover it. The only way she would receive this coverage if she paid for it 'out-of-pocket'. The patient checked to see if the procedure was covered — it was not. It was fairly straightforward to find out if the procedure was not covered. But what governing body decides what procedures are
covered? Shouldn’t there be a patient representative group that sits on the board of the insurance company that decides what procedures are covered. This would allow for more effective communication between subscriber and her health insurance company to determine what services should be covered. By not having the patient’s voice heard contributes to a limited level of communication between insured and patient. The subscriber is the insured’s customer. If a business wants to satisfy their customers, there needs to be a forum to listen to their customers’ needs. As it turns out, Aetna and Blue Cross/Blue Shield of New Jersey have such boards. They are designed primarily for the purpose of reviewing procedures and determining if these need to be modified to meet subscribers’ needs. These boards also serve to address patient complaints and determine courses of action.

According to an article on: http://www.doctorinthefamily.com patients need to understand the health care system as it applies to their particular situation. Unfortunately, there is so much misinformation and lack of communication. Communication barriers such as why don’t more patients know the Patients’ Bill of Rights or not knowing the right points to discuss with your PCP play into the mix, or not keeping a medical log. Communication is two-way and too many doctors and patients are not able to communicate effectively. A doctor doesn’t necessarily communicate well with patients because “he has not been taught how to communicate effectively. He may not know the first thing about how to talk to patients because nobody ever taught him” (Schwartz, Jimenez, Myers and Solomon, 1998, p. 3). Additionally, doctors can use ‘doctorspeak’ to talk ‘at’ a patient vs. ‘with’ a patient. A problem can occur when doctor’s emotions are hidden behind ‘doctorspeak’, it can be more difficult for patients to make ‘good’ decisions regarding their care (Schwartz, Jimenez, Myers, Solomon, 1998). Another communication conflict can arise because patients converse with drama and emotion.
This is the antithesis of the method that doctors use to communicate — in medical terms with little or no emotion (Schwartz, Jimenez, Myers, Solomon, 1998).

The high cost of health care has increased due to a variety of factors such as new technologies such as CAT scans, diagnostic tests. The cost of new technology has contributed to a higher cost of health care not only for those who receive tests using this sophisticated equipment but also for those who do not. This is because we the insured ultimately pay for these types of services. One reason for this is that someday we may need to undergo tests using this same equipment. This is why we have medical insurance and pay accordingly. It's analogous to having auto insurance and paying the annual premium. A driver may not have an accident for 15 years but has to pay not only for his own coverage but also for those who have many more accidents than the state average and/or who are not insured. Do most Americans know this information and has it been communicated effectively? There isn't clear evidence as to whether the majority of insured are aware that equipment/new technology contributes to the higher cost of health care. The author wasn't aware of this until further research was performed. There has not been sufficient evidence to determine whether health insurance companies have communicated this information effectively. This is not to say they haven't — the question beckons: Is the insured public aware of this? If a patient pays a visit to the doctor and has a procedure performed, that patient would still pay a nominal fee but the cost of the visit may be quite high.

Financial compensation also plays into the state of our health care system. For example, the growth of capitated payments has slowed. How has capitation contributed to the current state of the health care system? Since physicians receive this lower fixed payment or capitation for a given service regardless whether or not it is for a general or specialized visit, they need to see a
larger number of patients to offset the loss. This poses the question as to why doctors do not seem to be able to spend as much time with a patient as they would like. One answer is because they are looking to see as many patients as possible to compensate for receiving capitated or contract payments for the particular patient service. This results in less time between the physician and patient thus compromising the doctor-patient relationship. This has also jeopardized the quality of communication in that doctors have too many patients to see in a day and cannot usually dedicate the time necessary to discuss patient concerns adequately. This also negatively impacts the communication vital information that a patient might need to know regarding her care.

The doctor-patient relationship has clearly suffered over the last several years. Because of the way doctors conduct their business today under the auspices of managed care organizations, there are policies that dictate how many patients the doctor must see on a daily/weekly basis so as to make a profit and what services that doctor can or can’t provide to her patients. In addition, morale among doctors has deteriorated. A recent survey (Campbell, 2002) has shown that doctors are not as happy with their profession as they were five years ago (as many as 87%). In fact, six out of 10 say their own enthusiasm for practicing medicine has declined over that same time period. These doctors blame their unhappiness on paperwork and administrative hassles not to mention loss or autonomy and respect for the profession. Not surprisingly, managed care lies at the center of this discontent and three-quarters of doctors surveyed recently feel as though managed care has negatively affected the way they practice medicine and on the services they provide to patients. Sadly, “forty-five percent said they would not recommend the profession to a young person today” (Campbell, 2002, p. unknown). Doctors feel as though managed care is not working. Yet despite this input, 84 percent are satisfied with
“the continuity of their relationships with patients” and “79 percent are satisfied with the professional challenges” of their careers. So even though doctors feel frustrated by an inefficient managed care system, doctors are able to maintain good patient relationships and still find challenges in their profession. So, from a communication standpoint, managed care is jeopardizing the doctor-patient relationship from a financial and medical services perspective by not always accurate claim information and denial of services. But on the other hand, doctors are making a concerted effort in maintaining as good a relationship as possible with their patients and working as well as they can within the confines of a system fraught with many problems.

But the truth is according to Mollyann Brodie, an executive in the Kaiser Family Foundation who conducted this survey said that: “If two key players (in health care) do not have a good view of each other, it suggests the system as a whole is not working” (Campbell & Stewart, 2002, p. unknown). This is a paramount concern in today’s managed care crisis that needs to be addressed. There was a situation recently where The Medical Society of New Jersey sued five HMOs over the fact that these companies delayed and/or denied payment for medically necessary procedures. The main concern was the insurance companies were not paying claims within the prescribed interval depending upon whether the claim was electronic (paid within 30 days) or hard copy (paid within 40 days). The truth is that these types of lawsuits drive up the cost of health care premiums (Campbell & Stewart, 2002). In another example, the Department of Banking and Insurance cites the Cigna health plan for being late on 84,000 claims in 2000. Considering there are 100,000 subscribers with Cigna, that’s quite a staggering figure (Anonymous, The Star Ledger, 2002). This is significant evidence that health care insurance companies need to re-evaluate their claims processing procedures and what services should be
covered. If this re-evaluation fails to occur, it will continue to negatively affect the relationship between the provider and patient.

According to (Dranove, 2002), even though managed care is saving patients over 300 billion dollars per year, it has not won the trust of Americans. Why? Because they feel it is an intrusion into the doctor-patient relationship. Some factors that have contributed to these intrusions are: 1) power struggles between large buyers and providers, 2) unreliable health care data across providers, 3) quality measurements need to be improved and 4) patients have great difficulty shopping around for medical care. This is largely due to inferior data about what care they need, where to buy coverage, and have unclear incentives to shop around for the best price. Until those health care needs are addressed, the public's perceptions of managed care will not improve.
Chapter V

SURVEY OF OPINIONS

DESCRIPTION OF THE SURVEY

A survey was sent to 50 participants/respondents with a 100% return rate. The survey consisted of 17 statements and eight questions. The first 17 statements required a response ranging from ‘Excellent’ to ‘Poor’ with three of these having an option for the respondent to indicate ‘Not Applicable’ (N/A). There were cases, however, where respondents did not respond to a statement or wrote ‘N/A’ on their own which in turn were not measured since there was no way to tell how the respondents felt about a particular statement. This reflected that respondents may not necessarily: 1) require a referral from their PCP, 2) have cross coverage between two insurance plans and 3) required pre-certification prior to hospitalization. ‘Excellent’ means the respondents feel the quality of communication between them and their doctors/insurance providers is superior. ‘Good’ means the quality is very satisfactory. ‘Average’ means the quality is (just that) of an average nature. ‘Fair’ means the quality is ‘Below Average’ and ‘Poor’ represents an inferior quality of communication. After a review of these statements and questions, it was determined that the responses varied in all five categories and there were percentage breakdowns of ‘Yes’ and ‘No’ responses. Finally, there was a section where participants could opt to write in their comments. Overall, a variety of comments were made ranging from great satisfaction with service to great dissatisfaction.
Sample/Purpose

The goal of this survey was to gain responses from 50 participants who were either a subscriber to a health care plan through their employer or through Medicare. The responses reflected the true reactions that subscribers have with regard to the quality of communication among themselves, their doctor and insurance company. The main purpose of this survey was to illustrate the quality of communication being administered among subscribers, their doctors and insurance companies.

Analyzing the Results of the Survey

The author gathered data from the 50 respondents to assess views about their physicians and health insurance providers. The survey results were tabulated using a combination of a five-point scale and definitive (yes/no) responses including a ‘Not Applicable/No Answer’ (N/A) response. These responses were not tabulated because they did not indicate a degree of satisfaction. The results were measured using this scale and percentages. These results are published in Appendix B.

Survey Statement #1: Quality of communications between you and your insurance provider.

For this statement, seven respondents (15%) felt that the quality of communication between the respondent and their insurance provider was ‘Excellent’ (Answer 5). 17 respondents (33%) felt that the quality of communication was ‘Good’ (Answer 4) and an equal number of respondents (33%) felt that the quality of communication was ‘Average’ (Answer 3). There were four respondents (9%) who felt the quality of communication was ‘Fair’ (Answer 2) and five respondents (10%) who felt the quality was ‘Poor’ (Answer 1). All respondents chose one
of the aforementioned which resulted in no respondents choosing (Answer 0). This represented that either the statement was not applicable to the respondent or was possibly overlooked.

The majority of participants (66%) responded that they feel the quality of communication between the respondents and their insurance providers was 'Good' (Answer 4) to 'Average' (Answer 4). Statement one measured 3.34 on this five-point scale.

**Survey Statement #2: How the choices of Primary Care Physicians (PCPs) are communicated.**

For this statement, six respondents (11%) felt as though the method with which the choices of PCPs are communicated was 'Excellent' (Answer 5). 18 respondents (34%) felt the communications method was 'Good' (Answer 4). 13 respondents (24%) felt the method was 'Average' (Answer 3). Six respondents (14%) felt the method was 'Fair' (Answer 2). Three respondents (8%) felt the method was 'Poor' (Answer 1) and four respondents (9%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (58%) felt that the choices of PCPs were communicated in a 'Good' (Answer 4) to 'Average' (Answer 3) manner. This represented that the respondents feel the quality of communication is 'Good' (Answer 4). Statement two measured 3.12 on the scale.
Survey Statement #3: The method with which accurate and timely billing statements/claims are communicated and explained.

For this statement, nine respondents (19%) felt as though the method with which accurate and timely billing statements/claims are communicated and explained was ‘Excellent’ (Answer 5). 12 respondents (24%) felt the communications method was ‘Good’ (Answer 4). 18 respondents (36%) felt the method was ‘Average’ (Answer 3). Five respondents (10%) felt the method was ‘Fair’ (Answer 2). Six respondents (11%) felt the method was ‘Poor’ (Answer 1) and no participant (0%) felt the statement was not applicable (Answer 0) to their situation.

It can be determined that the majority of participants (60%) felt that the method was with which accurate and timely billing statements/claims was communicated in a ‘Good’ (Answer 5) to ‘Average’ (Answer 4) manner. Statement three measured 3.26 on the scale.

Survey Statement #4: The method by which the referral process from your PCP to a specialist is communicated (if applicable).

For this statement, eight respondents (18%) felt as though the method with which the referral process from your PCP to a specialist is communicated (if applicable) were ‘Excellent’ (Answer 5). 19 respondents (40%) felt the communications method was ‘Good’ (Answer 4). Thirteen respondents (24%) felt the method was ‘Average’ (Answer 3). One respondent (1%) felt the method was ‘Fair’ (Answer 2) and two respondents (2%) felt the method was ‘Poor’ (Answer 1) and seven respondents (15%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement. One reason for this could be that some health care plans such as PPOs, do not require a referral.
It can be determined that the majority of participants (64%) felt that the referral process from their PCP to a specialist (if applicable) was communicated in a ‘Good’ (Answer 4) to ‘Average’ (Answer 3) manner. It can also be determined that approximately 15% of the respondents do not have a plan that requires the participant to select a PCP. Statement four measured 3.69 on the scale.

Survey Statement #5: Quality of clear and effective communication between you and your PCP.

For this statement, 10 respondents (20%) felt as though the clear and effective quality of communication between the respondents and their PCPs was ‘Excellent’ (Answer 5). 21 respondents (41%) felt the communications quality was ‘Good’ (Answer 4). 11 respondents (21%) felt the quality was ‘Average’ (Answer 3). Three respondents (8%) felt the quality was ‘Fair’ (Answer 2) and one respondent (1%) felt the method was ‘Poor’ (Answer 1). Four respondents (9%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement. It can be inferred that these respondents chose not to answer or perhaps did not have to select a PCP under provision of their medical insurance plan.

It can be determined that the majority of participants (62%) felt that the quality of communication between the respondents and their PCPs was ‘Good’ (Answer 4) to ‘Average’ (Answer 3). Statement five measured 3.78 on the scale.

Survey Statement #6: The degree of clarity which your total deductible and balance is explained on benefit statements (sometimes called EOBs).

For this statement, 10 respondents (20%) felt as though the method with which the degree of clarity which your total deductible and balance is explained on benefit statements (sometimes
called EOBs) was ‘Excellent’ (Answer 5). 14 respondents (29%) felt the explanation method was ‘Good’ (Answer 4). 17 respondents (33%) felt the method was ‘Average’ (Answer 3). Four respondents (9%) felt the method was ‘Fair’ (Answer 2). Three respondents (7%) felt the method was ‘Poor’ (Answer 1) and two respondents (2%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (62%) felt that the degree of clarity which your total deductible and balance is explained on benefit statements (sometimes called EOBs) was of ‘Good’ (Answer 4) to ‘Average’ (Answer 3) quality. Statement six measured a 3.50 on the scale.

**Survey Statement #7: The method with which cross-coverage is communicated and managed between plans.**

For this statement, two respondents (2%) felt as though the method with which cross-coverage was communicated and managed between plans were ‘Excellent’ (Answer 5). Eight respondents (16%) felt the communications method was ‘Good’ (Answer 4). Eight respondents (16%) felt the method was ‘Average’ (Answer 3). Four respondents (9%) felt the method was ‘Fair’ (Answer 2). Four respondents (9%) felt the method was ‘Poor’ (Answer 1) and 24 respondents (48%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

The results indicated that nearly half of the respondents are not in a situation where they have a family member who is a subscriber to another health plan, which would allow the respondent to have cross-coverage.
It can be determined that the majority of participants (80%) can be categorized into two groups. The first group felt that the method with which cross-coverage is communicated and managed between plans was 'Good' (Answer 4) to 'Average' (Answer 3) manner. The second group consisted of nearly half of the respondents chose 'Not Applicable' (Answer 0) or did not respond since these participants do not have cross-coverage with another insurance plan. Statement seven measured a 3.00 on the scale.

Survey Question/Statement #8: How well is the pre-certification process communicated and reinforced prior to in-hospital stays by PCP/health care provider (if applicable)?

For this statement, zero respondents (0%) felt as though the method with which the pre-certification process is communicated and reinforced prior to in-hospital stays by PCP/health care provider (if applicable) were 'Excellent' (Answer 5). 17 respondents (33%) felt the communications method was 'Good' (Answer 4). Seven respondents (15%) felt the method was 'Average' (Answer 3). Eight respondents (16%) felt the method was 'Fair' (Answer 2). Two respondents (2%) felt the method was 'Poor' (Answer 1) and 16 respondents (32%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (65%) felt that the method with which the pre-certification process is reinforced prior to in-hospital stays by PCP/health care provider (if applicable) is communicated is 'Good' (Answer 4) or the situation did not apply to the participants at all since their health care plan may not require pre-certification prior to a hospital stay. Statement eight measured 3.15 on the scale.
Survey Statement #9: Ease with which appointments can be scheduled with PCP.

For this statement, 14 respondents (28%) felt as though the degree of ease to schedule appointments with their PCPs was ‘Excellent’ (Answer 5). 18 respondents (34%) felt the degree was ‘Good’ (Answer 4). Eight respondents (16%) felt the degree was ‘Average’ (Answer 3). Four respondents (9%) felt the degree was ‘Fair’ (Answer 2). Two respondents (4%) felt the level of degree was ‘Poor’ (Answer 1) and four respondents (9%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (62%) felt that the ease of scheduling appointments with their PCP was ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4).

Statement nine measured 3.83 on the scale.

Survey Statement #10: Satisfaction with level of health care concern expressed by your PCP.

For this statement, 13 respondents (28%) felt as though the level of health care concern expressed by their PCP was ‘Excellent’ (Answer 5). 26 respondents (52%) felt the communications method was ‘Good’ (Answer 4). Five respondents (10%) felt the method was ‘Average’ (Answer 3). Two respondents (2%) felt the method was ‘Fair’ (Answer 2). One respondent (1%) felt the method was ‘Poor’ (Answer 1) and three respondents (7%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (80%) felt that the choices of PCPs were communicated in an ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4) manner. Statement ten measured 4.02 on the scale.
Survey Statement #11: Satisfaction with level of health care concern expressed by your health plan.

For this statement, nine respondents (19%) felt as though the satisfaction level of concern expressed by their health care plan was ‘Excellent’ (Answer 5). Fourteen respondents (28%) felt the communications method was ‘Good’ (Answer 4). Fifteen respondents (30%) felt the method was ‘Average’ (Answer 3). Five respondents (10%) felt the method was ‘Fair’ (Answer 2). Six respondents (12%) felt the method was ‘Poor’ (Answer 1) and one respondent (1%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (58%) felt that the satisfaction level of concern expressed by the respondents’ health plan was ‘Good’ (Answer 5) to ‘Average’ (Answer 4). Statement 11 measured 3.31 on the scale.

Survey Statement #12: Satisfaction with level of financial support by your health plan.

For this statement, seven respondents (15%) felt as though the level of satisfaction of financial support by their health plan was ‘Excellent’ (Answer 5). Eighteen respondents (35%) felt the communications method was ‘Good’ (Answer 4). Fifteen respondents (30%) felt the method was ‘Average’ (Answer 3). Four respondents (9%) felt the method was ‘Fair’ (Answer 2). Five respondents (10%) felt the method was ‘Poor’ (Answer 1) and one respondent (1%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (65%) felt that the level of satisfaction of financial support by the respondents’ health plan was ‘Good’ (Answer 5) to ‘Average’ (Answer 4). Statement 12 measured 3.37 on the scale.
**Survey Statement #13: Responsiveness of PCP to health care questions.**

For this statement, 11 respondents (21%) felt as though the responsive of the PCP to health care questions was ‘Excellent’ (Answer 5). 24 respondents (49%) felt the responsiveness was ‘Good’ (Answer 4). Seven respondents (15%) felt the responsiveness was ‘Average’ (Answer 3). Five respondents (10%) felt the responsiveness was ‘Fair’ (Answer 2). No respondents (0%) felt the responsiveness was ‘Poor’ (Answer 1) and three respondents (5%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (70%) felt that the choices of PCPs were communicated in an ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4) fashion. Statement 13 measured 3.87 on the scale.

**Survey Statement #14: Responsiveness of health care provider to questions.**

For this statement, 11 respondents (21%) felt as though the responsiveness of their health care provider to questions is ‘Excellent’ (Answer 5). 21 respondents (41%) felt the communications method was ‘Good’ (Answer 4). Ten respondents (20%) felt the method was ‘Average’ (Answer 3). Three respondents (8%) felt the method was ‘Fair’ (Answer 2). Five respondents (10%) felt the method was ‘Poor’ (Answer 1) and there no respondents (0%) selected (Answer 0).

It can be determined that the majority of participants (62%) felt that the responsiveness of their health care provider to questions was ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4). Statement 14 measured 3.60 on the scale.
Survey Statement #15: Level of comfort in asking questions of your PCP.

For this statement, 11 respondents (22%) felt as though the level of comfort in asking questions of their PCP was ‘Excellent’ (Answer 5). 21 respondents (42%) felt the level was ‘Good’ (Answer 4). Six respondents (14%) felt the level was ‘Average’ (Answer 3). One respondent (1%) felt the level was ‘Fair’ (Answer 2). There were no respondents (0%) who felt the method was ‘Poor’ (Answer 1) and eleven respondents (21%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (64%) felt that the level of comfort in asking questions of their PCP was ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4). Statement 15 measured 4.08 on the scale.

Survey Question/Statement #16: Your PCP receptiveness/responsiveness to interview questions during your first meeting.

For this statement, 13 respondents (28%) felt as though the PCP's receptiveness/responsiveness to interview questions during their first meeting was ‘Excellent’ (Answer 5). 26 respondents (51%) felt the responsiveness was ‘Good’ (Answer 4). Two respondents (2%) felt the responsiveness was ‘Average’ (Answer 3). One respondent (1%) felt the responsiveness was ‘Fair’ (Answer 2). One respondent (1%) felt the responsiveness was ‘Poor’ (Answer 1) and eight respondents (17%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (79%) felt that their PCP’s receptiveness/responsiveness to interview questions during their first meeting was ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4). Statement 16 measured 4.21 on the scale.
Survey Statement #17: Is your PCP receptive/responsive to questions in general?

For this statement, 16 respondents (32%) felt as though the PCP’s receptiveness/responsiveness to questions in general was ‘Excellent’ (Answer 5). 26 respondents (53%) felt the responsiveness was ‘Good’ (Answer 4). One respondent (2%) felt the responsiveness was ‘Average’ (Answer 3). Two respondents (3%) felt the responsiveness was ‘Fair’ (Answer 2). No respondents (0%) felt the responsiveness was ‘Poor’ (Answer 1) and five respondents (10%) felt the statement was not applicable (Answer 0) to their situation or may have overlooked the statement.

It can be determined that the majority of participants (85%) felt that their PCP’s receptiveness/responsiveness to questions in general was ‘Excellent’ (Answer 5) to ‘Good’ (Answer 4). Statement 17 measured 4.24 on the scale.

Survey Question #18: Are you familiar with the Patients’ Bill of Rights?

For this question, 31 respondents (61%) responded positively (Answer #3) that they are familiar with the Patients’ Bill of Rights. 19 respondents (39%) responded negatively (Answer #2) that they are not familiar with the Patients’ Bill of Rights. There were no respondents (0%) who selected ‘Not Applicable’ (Answer 0).

It can be determined that the majority of participants (61%) were familiar with the Patients’ Bill of Rights.
Survey Question #19: Do you keep a medical log? If yes, do you know what to record?

For this question, 10 respondents (20%) selected ‘Yes’ (Answer #3) that they maintain a medical log. 39 respondents (79%) selected ‘No’ (Answer #2) that they do not maintain a medical log. One respondent (1%) selected ‘Not Applicable’ (Answer 0).

It can be determined that the majority of participants (79%) do not maintain a medical log. It can also be determined that the one responded who selected ‘Not Applicable’ either chose not to respond or the respondent overlooked the question.

Survey Question #20: Do you know when it is necessary to obtain prior authorization from your insurance company for medical care (if applicable)?

For this question, 33 respondents (65%) selected ‘Yes’ (Answer #3) indicating they know when it is necessary to obtain prior authorization from your insurance company for medical care. 11 respondents (21%) selected ‘No’ (Answer #2) indicating they do not know when it is necessary to obtain prior authorization from your insurance company for medical care. There were six respondents (14%) who selected ‘Not Applicable’ (Answer 1) because the question did not apply to their situation or the respondent could have overlooked the question.

It can be determined that the majority of participants (63%) know when it is necessary to obtain prior authorization from their insurance company for medical care.

Survey Question #21: Do you know that some of your medical records can be destroyed without your permission? Do you know how to have them preserved?

For this question, five respondents (10%) responded positively (Answer #3) that they knew that their medical records could be destroyed without their permission. 45 respondents
(90%) responded negatively (Answer #2) that they are not familiar with the Patients’ Bill of Rights. There were no respondents (0%) who selected ‘Not Applicable’ (Answer 0).

It can be determined that the majority of participants (90%) did not know that their medical records could be destroyed without their permission.

**Survey Question #22: Do you know if there is a maximum lifetime benefit for your insurance plan (if applicable)? Do you know what that means?**

For this question, 18 respondents (38%) responded positively (Answer #3) that they knew if there is a maximum lifetime benefit for their insurance plan? Do you know what that means? 29 respondents (59%) responded negatively (Answer #2) that they did not know that there was a maximum lifetime benefit for their insurance plan. There were three respondents (3%) who selected ‘Not Applicable’ (Answer 0)

It can be determined that the majority of participants (59%) did not know that there was a maximum lifetime benefit for their insurance plan.

**Survey Question #23: Do you practice preventive medicine?**

For this question, 43 respondents (88%) responded positively (Answer #3) that they practice preventive medicine. Six respondents (11%) responded negatively (Answer #2) that they do not practice preventive medicine. There was one respondent (1%) who selected ‘Not Applicable’ (Answer 0).

It can be determined that the majority of participants (62%) do practice preventive medicine.
Survey Question #24: Do you know how to find the correct specialist to treat your illness?

For this question, 45 respondents (90%) responded positively (Answer #3) that they know how to find the correct specialist to treat their illness. Five respondents (10%) responded negatively (Answer #2) that they do not know how to find the correct specialist to treat their illness. There were no respondents (0%) who selected 'Not Applicable' (Answer 0).

It can be determined that the majority of participants (90%) did know how to find the correct specialist to treat their illness.

Survey Question #25: Do you know how to assess your doctor’s qualifications?

For this question, 28 respondents (58%) responded positively (Answer #3) that they know how to assess their doctor’s qualifications. 21 respondents (41%) responded negatively (Answer #2) that they do not know how to assess their doctor’s qualifications. There was one respondent (1%) who selected ‘Not Applicable’ (Answer 0).

It can be determined that the majority of participants (58%) know how to assess their doctor’s qualifications.

Conclusion

The statements and questions that evoked the most significant responses in the following statements were as follows. The survey revealed that in statement seven, nearly half the respondents (24) did not have a cross-coverage arrangement with another insurance company. The survey also revealed that in statement eight, 16 respondents did not answer indicating they did not require pre-certification with a hospital before being admitted. Due to these responses, it was discovered that for those who participated in this survey, a significant number did not have
to contend with the extra steps in coordinating cross-coverage or be concerned with obtaining authorization prior to hospital stays.
Chapter VI

SUMMARY

HOW COMMUNICATION CAN IMPROVE THE QUALITY OF HEALTH CARE

Survey Findings Interpretation Discussion

The survey results in the previous chapter illustrated some interesting and notable results. In statements one and two, comparable percentages of respondents felt as though the quality of communication with their insurance providers and physicians respectively was ‘Good’ to ‘Average’ which indicates that the overall quality was acceptable. This finding reinforces the concept that the results will not necessarily be indicative of the issues facing the health care industry. It was interesting to note in statement seven that the sampling of respondents indicated that nearly half do not have cross-coverage which did not allow for an accurate measurement of the level of satisfaction or dissatisfaction. If the sampling of respondents had consisted of many more instances where participants had cross-coverage, a more accurate assessment of the quality of communication as it applies to cross-coverage between two insurance providers would have been possible. A similar scenario exists for question eight where it was difficult to gauge an accurate assessment of the respondents because those that do have medical insurance coverage do not require pre-certification before a hospital stay. If there had been more participants who had to obtain pre-certification, a more accurate assessment of the level of satisfaction might have been obtained. In the case of statements 13 and 14, a comparable percentage of participants responded that the responsiveness of PCP and health care provider to questions was ‘Good’ to ‘Average’ which again supports the concept that the sampling of respondents may not necessarily indicate that the quality of health care is as inferior as the research has shown in this work. The same situation also applies in statements 15 and 16 where the level of comfort in
asking questions of PCPs and their responsiveness to interview questions in a first meeting was also ‘Good’ to ‘Average’. In all of these cases, it resulted in fewer unfavorable responses that were not received. However, as was indicated, there was no guarantee that the ‘desired’ responses would be obtained.

It was interesting to note however, that in question 18, nearly 40% of the respondents were unfamiliar with the Patients’ Bill of Rights. This indicates that these respondents did not know their rights as patients, which affects communication in a negative way by not knowing for example that patient confidentiality must be maintained and being aware of grievance and appeals procedures.

It was disappointing to find that in question 19, nearly 80% of the respondents did not maintain a medical log. This could affect doctor-patient communication in the following ways. If accurate records are not kept for example, of doctor visits, history about illnesses, and types of medicine that has been prescribed, patients may not be able to answer intelligently if questioned by their PCP. This would clearly jeopardize the level of doctor-patient communication for example, if a patient had visited a specialist without the PCP’s knowledge or there was an entry omitted in the patient’s record by the PCP’s office staff. A similar situation existed in question 21, where 90% of the participants responded that they were not aware that their medical records could be destroyed without their permission, which could also jeopardize the doctor-patient relationship by not having a complete picture of a patient’s medical history from birth to the present. A final example of a case where patients were not aware of an important provision in their medical coverage was evident in question 22 where nearly 60% of the respondents indicated that they did not know if they had a maximum lifetime benefit for their insurance plan and may or may not have known what it really meant to them. Here are three instances in the
survey—where a majority of respondents were unaware of important aspects that affect the quality of communication between themselves, their doctors and insurance companies.

Much information has been covered in this work. The topics ranged from the pitfalls of inferior communication between doctor and patient as well as between patient and health care provider.

After illustrating some of the factors that contribute to inferior communication between doctors, patients and their insurance companies, recommendations will be presented in this chapter to illustrate improvement opportunities in the way that these groups can conduct themselves in more effective ways.
Recommendations

Recommendation #1 – Doctors and Patients Need to Work as an Effective Team

Realize that a doctor-patient relationship is a two-way street. Make an extra special effort to get to know your doctor. Don’t feel intimidated about asking questions about statements your doctor makes. That is, clearly state that you don’t understand what is being said and don’t settle for an explanation that you only partially understand. Ensure you understand everything completely and even take notes during the discussion if you feel the need. Patients need to make concerted efforts to let their doctors know that if they don’t understand something or if it hasn’t been explained to their satisfaction, that their doctors need to clarify what was said. According to an article in the Star Ledger, a relationship between a patient and doctor is a two-way street. It is the responsibility of patients to ask questions and to ensure that clear and honest communication is maintained (Unnamed author, The Star Ledger, 2002).

Recommendation #2 – Take the Necessary Time to Review Benefit Literature

Make an extra effort to take the time and review all material received from your health care provider at enrollment time or when new literature/materials arrive. After noting the areas in the literature that are unclear, call a representative from your health care provider and let that person know what questions you have. If at all possible, ask for an e-mail address and send your questions to that person or the supervisor of the department. Ask when can you expect to receive a response from that person. After receiving a response, take the time once again to review the information to ensure you understand fully. If not, respond that you still need further explanation. This is uncomfortable but it will avoid unnecessary stress and aggravation when
dealing with a situation that you already knew the particulars and will handle much better. An example of this would be an awareness of pre-certification before a hospital stay or how much is covered for a particular procedure. Without knowing this information, it can present an embarrassing scenario upon receiving the bill.

Recommendation #3 – Physicians Participate in Team Building Conferences/Meetings

Doctors can meet in focus groups where they can discuss ways to improve their communications skills and rapport. These groups meet at retreats that could last anywhere from one to several days. For example, one group met for five days at the Mount Olivet Retreat Center in Farmington, MN (Jackson, 2001). Among the benefits reviewed were to discuss various ways that they could reach their patients by listening more attentively and can possibly avoid prescribing tests that could contribute to a more costly visit for the patient. One benefit of attendance is reduced insurance rates for physicians. This can contribute to lower rates for patients but it is up to each doctor to take the initiative to attend one of these workshops. Another benefit is improved listening skills, which could avoid some tests/procedures. This could result in savings for insurance companies as well as out-of-pocket costs for patients.
Recommendation #4 – The Use of Surveys to Gauge Communication Effectiveness

Doctors (PCPs) and insurance companies could mail periodic surveys to their “customers” to determine if their needs are being met. An example is a member survey that Aetna US Healthcare sends on a periodic basis that is mailed to subscribers to gauge the level of patient satisfaction.

These surveys could also take the form of a questionnaire that would elicit ‘Yes’ or ‘No’ responses. However, these surveys need to allow the patient to elaborate further on the symptoms in addition to the doctor needing to make the time to listen to the patient’s description of these symptoms (Rosenfeld, 2002).

Recommendation #5 – Patients Need to Know Their Rights

Patients have the right to choose the doctor they feel comfortable with. If a patient has to change doctors, it is incumbent for that patient to do their homework and interview the doctors they’ve selected from the directory before making a commitment. Patients have the right to know their complete health status and ask questions about all the options that are available before making a decision. Don’t make any decisions before knowing these options – it’s in your own best interest. If you feel you’re not happy with what your doctor has diagnosed, you have the right to a second opinion. Don’t feel hesitant about doing this because you might offend your doctor. If your doctor welcomes this second opinion, then you know you’ve probably selected a good one. Ensure that you have a physical exam every year or every other year. Ask your doctor so you’ll know the proper interval. These are all scenarios where effective communication between doctor and patient is critical (Rosenfeld, 2002).
Conclusion

Doctors and patients both need to focus on maintaining and focusing on what’s important for each other. Too often, doctors do not have sufficient time to spend with their patients thus jeopardizing the doctor-patient relationship. Doctors need to spend what precious time they can with the patient given the constraints imposed on them by the managed care organizations with which they belong. These limitations place undue strain on the relationship between doctor and patient by not providing adequate time for patients to ask the right questions and express their concerns with adequate detail.

Patients need to question the doctor if there is anything that is not clearly understood. This is another example of how communication can be compromised when vital information is not obtained. Extra effort needs to be made to ensure the quality of communication is satisfactory so that patients feel their doctor expresses adequate concern and takes appropriate action.

Patients also need to take charge of their own medical and physical well being by obtaining annual physical exams, maintaining an adequate exercise program and eating properly. In this age of managed care programs, people are essentially on their own for protecting their health and well being (Rosenfeld, 2002). If not, the quality of communication will be compromised between doctor and patient.

This work has provided examples of how the quality of communication has been jeopardized with regard to doctor-patient communication and the interaction between medical insurance companies and their subscribers. Examples have been provided to illustrate how difficult it can be for clear and effective communication to be maintained.


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Appendix A – Survey
Survey of the American Health Care System and its Effectiveness of Communications with Patients

This survey will assess a sampling of opinions regarding the quality of communications between health care providers and their patients/subscribers.

Please indicate your response to each item by circling the appropriate rating.  
Key: E = Excellent  G = Good  A = Average  F = Fair  P = Poor  N/A = Not Applicable/Did Not Answer

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<td>Quality of communications between you and your insurance provider.</td>
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<td>How the choices of Primary Care Physicians (PCPs) are communicated.</td>
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<td>The method with which accurate and timely billing statements/claims are communicated and explained.</td>
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<td>The method by which the referral process from your PCP to a specialist is communicated (if applicable).</td>
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<td>The degree of clarity which your total deductible and balance is explained on benefit statements (sometimes called EOBs).</td>
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<td>Receptiveness/responsiveness to interview questions during your first meeting with the PCP?</td>
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<td>Do you know what that means?</td>
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<td>Do you know how to find the correct specialist to treat your illness?</td>
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<td>Do you know how to assess your doctor's qualifications?</td>
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Additional comments/reactions


OTHER INFORMATION
Gender (circle): M F

Age Group (circle):
18-29 30-39 40-49 50-59 60-69 70-79

Name of health insurance company: _______________________________________

What do you like most about how your provider communicates with you?

________________________________________________________________________

________________________________________________________________________

What do you like least about how your provider communicates with you?

________________________________________________________________________

________________________________________________________________________

What areas for improvement would you recommend to your provider regarding the methods by which it communicates information?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix B – Survey Analysis
### Survey Analysis (Part I) – Statements 1-17 (Five Point Scale)

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*Participants who responded with (Answer 0) were not counted in the results because they did not measure a degree of satisfaction.*
Survey Analysis (Part II) – Questions 18-25
(Definite Answer (Yes/No) or Did Not Answer/Not Applicable)

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** Question did not apply to respondent or there was no answer provided.

Ratings for Survey Analysis (Part I):

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<th>Rating</th>
<th>Score Range</th>
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<tr>
<td>Good</td>
<td>3.1 – 4.0</td>
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<tr>
<td>Average</td>
<td>2.1 – 3.0</td>
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<td>Fair</td>
<td>1.1 – 2.0</td>
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<tr>
<td>Poor</td>
<td>0.0 – 1.0</td>
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