Duke University
Durham
North Carolina
27708-0928

ACADEMIC COUNCIL
304 UNION WEST BOX
90928

TELEPHONE (919) 684-6447
FAX (919)681-8606
EMAIL: ACOUNCIL@ACPUB.DUKE.EDU

MINUTES THE REGULAR MEETING OF THE ACADEMIC COUNCIL

November 20, 1997

The Academic Council of Duke University met from 3:45 until 5:20 p.m. in 139 Social Sciences, Prof. **Leonard Spicer** (BCH, RAD) presiding as Council Chair. Commenting on the pitfalls of a lowered screen on such a beautiful day, with the swarming ladybugs projecting as black dots needing to be disregarded, he saw the day's agenda as rather rich, in the sense not only of some important ongoing business, but for a couple of presentations on topics dear to the hearts of a number of faculty, the Library and the Duke Managed Care Health Plan.

MINUTES

The minutes of October 16, precirculated with the materials for the meeting, were first considered. Were there are any comments or corrections? Hearing none, the **Chair** entertained a motion to approve them as circulated. The motion was seconded and approved by voice vote.

ANNOUNCEMENTS

As a first announcement, the Council was reminded of the election, to be held in February, for **a** new Chair of the Council. ECAC (the Executive Committee of the Academic Council) has appointed a nominating committee, which the Council is encouraged to work with in identifying candidates. Prof. Gregory Lawler (MTH) is chairing that nominating committee, having recently served on ECAC. Other members of the committee are Profs. Roger Barr (BME), Richard Burton (Fuqua), Elizabeth Clark (REL), and Jeffrey Dawson (IMM). They will be working to identify members of the faculty who might be nominated to serve in this position and are expecting to announce those candidates to the Council in January in anticipation of the February election.

Usually, nominating candidates for Council Chair would complete the committee's work, but this year Prof. Donald Fluke (ZOO), has notified ECAC that he does not wish to be renominated for the position of Faculty Secretary for another term. As all know, he has served loyally and with a lot of energy since [1990] and indeed fills many [additional needs] including being master of our Council web site, which the **Chair** hoped members are having

occasion to look at and use. Since we will need to establish a slate for election of a Faculty Secretary later in the spring, and because of the role that this office plays in the functioning of ECAC as well as the Council, ECAC wants to provide for a certain amount of overlap, and will probably move that election forward. ECAC has asked the Council Chair nominating committee to make recommendations about [nominees for] that election as well. By way of information, the bylaw reads as follows: "There shall be a Faculty Secretary of the Academic Council nominated by the Executive Committee from the ranks of the University faculty and faculty emeriti, and annually elected by the Council at its April meeting. The Faculty Secretary will be an *ex-officio* member of the Executive Committee and Academic Council without vote." We may try to identify candidates before the April meeting, to provide for overlap. So please think about this office, and if you have an interest, or know someone who may have an interest in filling that position well, in the spirit of the most recent secretaries, please contact members of ECAC or of the nominating committee with those names.

The **Chair** then called on Pres. **Nannerl Keohane** for additional announcements. Pres. **Keohane** first remarked graciously to the Faculty Secretary that his would "be tough shoes to fill," and that it would be hard to find an appropriate successor. **Fluke** volunteered that he could help persuade somebody of the satisfactions of the office. Pres. **Keohane** then announced one committee that has been formed and another one that will be, shortly. There are procedures at Duke for regular review of senior administrators and deans, and this year is the time for regular review of two of our senior offices in their current five-year terms. The first is Prof. Ralph Snyderman, Chancellor of Health Affairs. Prof. Paul Zipkin (Fuqua) has agreed to chair that review committee, which will also include [as faculty representatives] three other members of the Duke faculty at large and three from the Medical Center. One of the faculty at large is representing ECAC. The review committee will include two Trustee members from the Trustee Committee for Duke University Health System (TCDUHS), since the Chancellor's responsibilities reach out in to the Health System beyond the campus. The review committee will set their own procedures and will operate confidentially, but she was sure they will be contacting a number of members of the community to help in the review. It will culminate in a report to her as President, pointing out areas "in which Ralph's accomplishments are stellar and are to be recognized and areas where he can look to improve."

A similar committee is being put together to review the Provost, John Strohbehn, and Council Chair Spicer and she were in conversation with a potential chair. ECAC is going to put that committee together in the next few weeks, with announcement of its members expected by the December meeting of the Council. She expressed the appreciation all would feel for those who agree to serve in those review capacities.

EXECUTIVE SESSION

The Council was then called briefly into Executive Session (faculty members only) for second consideration of candidates for honorary degrees, introduced last time, and for vote.

At the conclusion of this business the rest of the audience was summoned back into the hall.

APPOINTMENT OF A FACULTY OMBUDSMAN

The **Chair** reminded the Council that it is the responsibility of ECAC to identify a candidate for Faculty Ombudsman and make the appointment, customarily relying on the advice of the Council in a meeting. ECAC proposes to reappoint Prof. Emeritus Carl Anderson (ENG) for the next two-year term as Faculty Ombudsman. Information about Prof. Anderson's background of accomplishment for this position had been circulated with the agenda, including his service on ECAC and as Council Chair, and on both the Faculty Hearing Committee and its predecessor Hearing and Grievance Committee. Discussions of this proposed reappointment have been quite favorable. In view of Prof. Anderson's long service as Ombudsman already, the Chair had discussed that specific matter with him, finding that he is willing to serve another term, at least for this period. By way of clarifying Council opinion of the proposed reappointment the **Chair** invited further nominations [there were none], invited and then entertained a motion endorsing the intention of ECAC, and then put that motion to voice vote. It **passed,** without discussion or dissent.

PROPOSED CHANGE IN NAME OF THE DEGREE MASTER OF HEALTH SCIENCE IN BIOMETRY TO MASTER OF HEALTH SCIENCE IN CLINICAL RESEARCH.

The **Chair** reminded the Council that at the October meeting Vice Chancellor Gordon Hammes (Academic Affairs) had introduced a proposed change in the name of the Master of Health Science in Biometry to Master of Health Science in Clinical Research, with opportunity for preliminary discussion. The resolution of approval is ready for further discussion and vote at this meeting, with V. Chan. Hammes present to respond in any further discussion of the resolution. The **Chair** re-read the resolution:

> **"WHEREAS, the degree Master of Health Sciences in Biometry is an existing approved degree in the School of Medicine and the School is requesting the name be changed to Master of Health Sciences in Clinical Research; and**
>
> **"WHEREAS, this name change has the support of the Medical School Policy Advisory Committee, the Academic Priorities Committee, the Provost and the Executive Committee of the Academic Council; and**
>
> **"WHEREAS, it is expected that the program of study leading to the degree Master of Health Sciences in Clinical Research will be reviewed at the end of three years;**
>
> **"NOW, THEREFORE, BE IT RESOLVED that the Academic Council endorses the request that the Master of Health Sciences in Biometry degree be renamed the Master of Health Sciences in Clinical Research and**

that this endorsement be forwarded to the Academic Affairs Committee of the Board of Trustees for approval.

Calling for further discussion and finding none, the **Chair** called for a vote on accepting the resolution of endorsement, which **passed,** by voice vote with no dissent.

A STRATEGIC PLAN FOR THE PERKINS LIBRARY SYSTEM, 1998-2001

The **Chair** remarked that remainder of the agenda has two discussion items dear to the interests and hearts of the academic community. The first is a discussion of "A Strategic Plan for the Perkins Library System," which will be led by University Librarian David Ferriero, who is also Vice-provost for Library Affairs. V. Prov. Ferriero initiated this study soon after coming to Duke, to engage the Library in a special time of thinking forward, and over the summer he has stayed in communication with the ECAC and the Council Chair about his progress. He has indicated numerous times that as this study reached the level of a discussion draft he'd like very much to talk with the faculty about it, knowing what a major impact it will have and should have on faculty research and the educational mission of the University. Only the cover page and table of contents from this discussion draft were pre-circulated, in view of the length of the draft, but the full draft is available on the web at URL <http://www.lib.duke.edu/dukeonly/plan>. [Faculty Secretary: it's now also linked to the Academic Council web page under the section on Information.] Hard copies are available at the Academic Council Office (304 West Union Tower) and also at Perkins Library.

Coming to the lectern, V. Prov. **David Ferrerio** said that the effort, begun late March, for a strategic planning initiative was an early priority and also "a tremendous learning experience" for him. The team was chaired by Connie McCarthy, who has since moved on to the College of William and Mary, and included Tim West, Elaine Druesedow, MaryBeth Schell, Deborah Jakubs, Kenneth Berger, Ashley Jackson, and Kitty Porter from the Perkins Library staff. They were joined by Prof. Alex Roland (HST), "who has become [virtually] a member of my staff," following the process very closely. He has been there for every planning session. "I gave him leave this afternoon because he's having heater problems at home or he'd be in the room with us today." The aim was to develop a plan and also a planning process. As a first mandate we had to have some sense of the environment in which we operate, our context, looking at what's going on in higher education, the economic [basis of] society, culture, and scholarly communications. Where should we be positioning ourselves in three to five years? His metaphor was a remark by ice hockey player Wayne Gretzky [the Great One], who says "I skate to where I think the puck will be."

Consultation included people on campus and off, the literature, talking with our colleagues around the country, and especially talking with our Library Advisory Board, some thirty Duke grads from various walks of life, to get their sense of where the world is going in their professional fields in that time frame. A set of assumptions emerged on which the

group based their recommendations: that our focus on a diverse University environment will continue, that that environment will be constantly changing in terms of those fields in which libraries exist, that information and its [modes of] availability will continue to be complex, and that information will continue to be [inflating in cost]. We've had double digit inflation for library materials over the last ten years. The group also thought about the mission of their libraries, and where they were going. In support of Duke University's mission, we provide a place for self-education and discovery, we promote scholarship and good citizenship through information literacy, we acquire, organize, preserve, and deliver information resources and assist users in their respective use, and we create "A Great Library for a Great University," [the subtitle of the plan].

Related to mission, and for his acquaintance, it was important to have staff agreement on organizational values: a balance of tradition and innovation in delivering information to our users, collaboration and communication in meeting challenges, integrity and mutual respect in all interactions, and a recognition of the importance of honesty, trust, tolerance, diversity, and humor in going about our work. The recommendations in this discussion draft, are in four categories: 1) the Library as a shared center of the University's intellectual life; 2) the Library as a center for research and teaching; 3) a bundle of things around collections and access; and 4) infrastructure issues. There's also in the full report a very good paragraph on the vision of the future, giving a sense of what life at Duke will be like in the next three to five years.

To highlight a few of the recommendations in each area, in terms of the Library as the center of the University intellectual life there's a richness of conversation that takes place, readily apparent just in walking around Perkins, in the Perk and the spaces where people gather. How to capture and facilitate that richness was one of Prof. Roland's special interests, how to program bringing people from around campus together in this intellectual center. We need small group areas, large group areas, an auditorium, and a better job with the Perk concept, a whole set of recommendations making the physical space match the intellectual crossroads that Perkins provides. In addition, the use of Lilly Library needs to be rethought in terms of the opportunity on an all first-year campus to train entering students about research libraries and finding information.

In terms of the Library as a center for research and teaching, on the collections side the recommendations call for rethinking our collection pattern, resource allocations, and staff deployments around our current collection development, making sure that our resources match the University's strengths in terms of programs, some not revisited in many years. The TRLN agreement needs timely review in terms of relevance to the current teaching and research programs here at the University. We need to beef up our endowment to be competitive, and to supplement the current budget for increased funding for both traditional and electronic collections. Serials, especially, have inflated by double digits in cost over the past ten years, and monographs by around 5-7%. Electronic information has inflated by 15-30% in some cases, in an infant industry in disarray about how to price such information.

On the services side, we need a complete rethinking of our [document] delivery system, including interlibrary loans. Document delivery suffers by an increased demand not met by staff increases or appropriate technology. A cluster of recommendations involve our experiences in introducing technology into the curriculum with things like databases, electronic full-text sources, and especially electronic reserves. Our efforts in integrating technology into the classroom need to be dovetailed with work in the Center for Teaching and Learning and other ways of incorporating instructional technology. There's a collaboration with OIT (the Office of Information Technology) in team teaching and in web-based technologies. Our services support for the science branches needs to be strengthened, where extraordinary levels of work are done without needed staffing flexibility. And last under services, there is our outreach into the Durham community. A grant from AT&T lets us do some innovative work with middle school teachers here in Durham in terms of technology training for the teachers. We'd like that to be a model for other activities in the Durham public schools.

For the third set of initiatives, which center around collections and access, there is foremost a preservation initiative. A 1989 study found that some 50% of our collection is on acidic paper and in need of help. We're about the only research library in the country without a preservation program. We need to get serious about this very rich collection that's deteriorating. Preservation of electronic information is a new area we need to be thinking about, a whole new arena for us, long-term access to [archival] electronic information that we now require. There's a set of recommendations about shelving and storage. Perkins and all the branches are full. We need the relief of compact shelving in Perkins basement, the only floor in Perkins that can support the weight. Thinking is underway about a new storage facility to replace [and substantially augment] the old DOSS (Duke Off Site Storage) that is not only full, but leaking when it rains. Back room things among this set of recommendations include completing our retrospective conversion project, getting everything into our online catalogue. We will complete the first pass, everything that's easy to do, in December, and then go on to non-Roman alphabet titles and funny formats, like microforms, and also our journal collection. We have a significant catalogue and backlog of such materials we need to get through, in a university that prides itself on international programs and globalization, and needs to make these relevant materials readily available to users.

Most controversial in this cluster of issues is to resolve the question of reclassification from the Dewey decimal system to the Library of Congress system, where we're calling for [continued] discussion. There's a clear message from the staff that we not do it, but we need to have that discussion about the pro's and con's of what's involved in a major retrospective conversion process. For those perhaps new to this matter, we're one of just three major research libraries in the country that are still using the Dewey decimal system, along with Northwestern and Illinois.

The infrastructure cluster of recommendations includes a major thrust in collaboration with OIT to solve some problems of configurations and maintenance strategies for the resources that we are now providing. OIT studies of salary inequity problems in terms of

information technology [personnel] are relevant to the Library also. And, as OIT has done, we need to develop some disaster recovery strategies where they have expertise. We need to be working with OIT to exploit Internet II potential, and in rethinking our equipment purchase *vs.* lease approaches. In our business operations there's need to be smarter than we now are in how we do things, taking advantage of procurement advances and adapting our internal operations for them. There's a cluster of recommendations on staff development; we need to hire, develop and train proficient staff and we're fortunate to have on board a new Personnel Librarian to help with some of those areas. A last item is maintaining an efficient and appealing workplace, not only on the users' side in Perkins, but on the staff side also.

Discussion of the Strategic Plan for the Library System

With that very quick overview of the recommendation strategies outlined, V. Prov. **Ferriero** invited questions, and in opening discussion the **Chair** noted that V. Prov. Ferriero would be back to talk more specifically about the reclassification matter and also the Library's goal in information technology and teaching and learning. V. Prov. **Ferriero** asked just to say, before discussion, what the next steps were. There has been internal discussion with the staff, then with the Library Council, which is about one-third the way through, and with the Library Advisory Board. He had met with ECAC and with the Deans' Council, and would be meeting with ITAC (the Information Technology Advisory Council). He had been working with Ben Kennedy (Duke Student Government V. Pres. for Academic Affairs) and with focus groups of students to talk about the strategies. He invited Council suggestions about where else to have these discussions.

Prof. **Steven Baldwin** (NS&M) said that Chemistry had talked at length recently about this question of electronic journals and the relationship between written and electronic [modes], what's going to evaporate or not. A clear issue in that discussion is that prices are skyrocketing, and how do we handle this? V. Prov. **Ferriero** said that Chemistry Librarian Kitty Porter had reported that discussion, which he was happy to have taking place. Chemistry is very fortunate in that the American Chemical Society has made a permanent commitment to full electronic text, while with some commercial publishers it's unclear. For Chemistry and Physics we're in pretty good shape, but the problem varies significantly by discipline.

Prof. **John Staddon** (NS&M) expressed his concern about some matters of style. Why in these administrative reports do we have this sort of "pillowy" self-congratulation? We are a great university if somebody <u>else</u> says so. Do we need to say so? And some things should be edited out. For example, maintaining a backlog-free environment just means getting rid of backlog. It would be nice if these kinds of things [could be tightened up]. On the matter of cost of journals, including electronic journals, why doesn't a consortium of universities get together and basically hijack some of these very overpriced journals? There [must be competitive opportunity out there] to form journals that are run by the people who actually use them, at universities and so on. It would take a kind of

collective action among universities to do it, but it should be thought about, because some of these journal prices can only be compared to a hijacking.

V. Prov. **Ferriero** said that TRLN, the UNC-CH and NCSU campuses and Duke especially, were actually talking about that, interested perhaps in setting up a center for scholarly communication with new models for grabbing back that scholarship. Provost **John Strohbehn** added that a small group within the AAU (Association of American Universities) is beginning to try something like that, working with the research universities. Council **Chair Spicer** said that some of that discussion arises naturally as well for the matter of archiving [of electronic materials].

Prof. **Rytas Vilgalys** (NS&M) asked about campus talk over the years about building a science library. Biology is very spread out. V. Prov. Ferriero said there were no plans to do that, short term. He was interested in it, but it's a major undertaking in terms of resources. With all enthusiasm for what a science library would do for the sciences at Duke we're not ready for that yet. He hoped that as electronic information and our access tools become better we can reduce some of the frustrations that exist right now, especially in interdisciplinary work, hampered by the physical separation of the collections. He had come from an environment where wandering among the materials and being exposed to other disciplines prompted discovery. He was looking for electronic alternatives to that [opportunity] here, but we don't have them yet.

In relation to the mentioned renovation of Perkins, Prof. **Craufurd Goodwin** (SocSci) asked whether there might be a larger Perkins in our future. V. Prov. **Ferriero** said it was unclear at this point; it could be but he was hoping that some of the clever things that we're doing, including perhaps moving Technical Services to the storage site, will reduce the amount of add-on we have to do to Perkins. Technical Services doesn't need to be physically in Perkins, although the architect should look at that assumption. The move will reduce the overall cost of anything we [may then] do to Perkins.

Prof. **Richard G. Palmer** (NS&M) saw the goal of strengthening the Library as a shared center for intellectual life as wonderful, but it wasn't clear to him that it need be in the Library, in effect displacing book space or journal space with cafes or the like. Could the idea be clarified? V. Prov. **Ferrerio** answered with the impression that no other place seems to be serving as well; the Library really is a crossroads. Even limited programming attempts have been very successful in bringing disciplines together, encouraging that kind of dialogue. We're looking for other ways of creating such opportunities. Prof. **Staddon** asked in follow up to that question what in fact are the priorities? Among so many things what would be the first priority, say? V. Prov. **Ferriero** listed three: Perkins, as a building, collections, and technology [in that order].

There being no immediate further discussion the **Chair** moved on to the next item on the agenda, noting that the Council could expect continuing discourse about the Library in this time of rapid change and deferred needs.

MEMBER HEALTH SURVEY RESULTS FOR THE DUKE MANAGED CARE PLAN

Introducing the next agenda item, the **Chair** said that ECAC felt that it was important to bring these Member Health Survey data to the Council as early as something was available, in some form that could be interpreted, although more thorough discussion would need to extend through the December meeting. The goal at this time is primarily to present the data, with Assoc. V. Pres. for Human Resources Clint Davidson present to lead that presentation, and with an Executive Summary hot off the press. We'll continue at the next meeting after more opportunity to digest the results. This is a hot-button item for faculty, judging from his e-mail. This first survey is also only one part of a larger process which should ask similar questions of the care providers, who are also our colleagues on the faculty. This is to be seen as a start, delayed from last year. It's also serving two purposes, into one of which we as faculty had some minor input.

Assoc. V. Pres. **Clint Davidson** (Human Resources) wanted most of the allotted time to be available for Mr. John Erb, who was closer to the survey, but did provide a brief introduction. The survey was administered in February and March of this year after about a year and a half of experience with the plan in operation. The survey was designed by the NCQA (National Committee on Quality Assurance), with some modifications to meet needs particular to our plan and to our faculty and staff here at Duke. An outside firm, William M. Mercer [formerly known as Foster-Higgins], was chosen to do the survey for us, for more objectivity in analyzing the plan by their not having been involved in setting it up, and for more confidentiality. After John Erb there would be opportunity for comment by Prof. John Payne (Fuqua) in behalf of the Faculty Compensation Committee (FCC), and then some opportunity of floor discussion, he hoped.

From his perspective, as a recent arrival at Duke, he was impressed by the very substantial planning, design, and implementation effort to move Duke to a managed care environment, with this survey as one element in that process. This survey is to help us get better, by revealing what's going well and also what needs strengthening. It begins an ongoing feedback process, working closely with the FCC and our health system administrators. Discussion is already underway with the PDC (Private Diagnostic Clinic), and others, about additional standards and other needed improvements. He expressed thanks to the entire FCC for their work with the much larger body of the report, especially Prof. John Payne as FCC chair, and Prof. Kenneth Spenner (SOC), who helped design our enhancements to the questionnaire. He then introduced Mr. John Erb, Senior Consultant with William M. Mercer, a nationally respected resource on managed care.

Mr. **John Erb** (Mercer) started with the survey methodology. Human Resources and its Benefits Administration section decided early on to engage an employee benefit firm rather than a market research firm to assist in the survey design, application, and analysis, in order to focus more on Duke faculty and staff reaction to the plan than on the plan itself. Focus on managed care plans as such tends to overstate user satisfaction, as many will know from published examples. Their firm, brought in toward this end, solicited input from the

FCC and individual faculty members, including Dr. Spenner, with his knowledge of statistics and surveys. There were initial focus groups, which proved quite lively. They were chosen at random among Duke faculty and staff to help decide the scope of the questionnaire. One indication from these groups was that people were more impressed with problems they heard others were having with Duke managed care than they were from their own experience of it, and the survey was adjusted to pick that up, to identify problems that were circulating as rumors at least. The written instrument used was designed by the NCQA, an independent not-for-profit organization sponsored by employers, not health plans. NCQA is responsible for accreditation of health plans. There was quite a bit of press last year about health plans failing to meet NCQA accreditation, and this is that same organization. What they've done is design a standardized written questionnaire that will be administered across the country to managed care programs. The main purpose [of their survey effort] is to establish normative data. That's the good news. The bad news is that Duke was the first major employer sponsored plan to use the questionnaire. "So in effect, you folks are becoming the norm, at least for this year."

We selected a random sample of all adult Duke managed care plan members, including faculty, staff, and/or spouses. Everyone who uses the plan was [represented] in the sample. We had a 62% response rate to the written questionnaire, and in his fifteen years of experience in employer surveys he'd never had anything approaching a 62% response before. This response resulted from the wonderful campaign developed internally to encourage response. NCQA requires only a 30% response rate to include the data in the normative database, so essentially we doubled that.

The analysis was conducted by Mercer, not the University, to avoid some political influences and concerns. What he was telling the Council was therefore what Mercer thinks, as a firm, from their experience in these matters.

To go through some of the data, represented in a handout Executive Summary of several pages, there were almost 100 survey questions, all related to the members' perceptions of the plan, and not intended to measure performance of care-giving physicians or administrators of the plan. One area looked at was quality of the medical care delivered in terms of perceived access to physicians. Is there enough access? Is there too much? Another area is communications about the plan. Do the users understand the plan? Still another area is claims payment. And then there is the out-of-network opportunity and how that is working. Finally, what is the overall satisfaction with the program with all of those components?

To start with the quality of care and services ~ for the Duke plan, the Medical Center, the PDC, and the medical faculty — the first question asked was "how much do you feel you were helped by the medical care you received?" On a 5-point scale 81% said that the care they received was good, very good, or excellent, 4% said poor, and about 15% said it was fair. The response pattern is similar as we go through the questions about quality of medical care. An indication from the focus groups was that physicians in the managed care

program "just don't have the time to spend with us in their office. We go through like cattle, you know, two minutes, etc." The survey response is that 75% of the faculty, staff, and spouses said they were satisfied with the amount of time spent with the doctor. Some 7% said the amount of time was poor and 18% said it was fair, not perfect. Going down the survey question areas, 83% gave a favorable rating to the degree of physician attention to what they had to say, 4% rated that attention unfavorable, and 13% said it was fair. For thoroughness of treatment received, again, 84% said good, very good, or excellent, 4% said poor, and 12% were on the edge. For overall quality of care and services, 80% felt that it was good, very good or excellent, and only 5% felt that it was poor.

There were components to the enquiry about the perceived value of the Duke managed care plan as a benefit: the $5 co-pay per visit, and the value in relation to the premium paid. For the $5 co-pay, in comparison effectively with free care or perhaps with care involving a deductible and 20% co-insurance, 76% felt this was a good value, 6% said it was a poor value, and 18% rated it just about what every other employee in the area finds. For the value of the health care coverage in relation to the cost in premiums, 67% had a favorable perception, 9% saw it as a very poor value, and about 24% saw it as about average for what everybody else is getting in relation to cost.

We then asked about physician access, a matter of great concern during the time of survey planning and preparation, when there was an impression that there were not enough doctors to choose from and that it was very difficult to get the doctor the user wanted. Remembering that this survey is a snapshot, and one taken almost eighteen months after the inception of the plan, much of that initial difficulty in physician access had abated: 72% saw it as good, very good, or excellent, and 12% as poor. One thing not developed at this time is to relate these data by demographic information. In looking for such correlations of the answers we found that in many cases people who used the service a lot, with ten or more physician visits per year, had a poorer perception of the plan. Asked about ease in choosing a personal physician, 70% of these higher users were satisfied, 13% rated it poor, and 17% fair.

Going beyond the charts in the handout Executive Summary, how long does it take to get an appointment? What is the user's impression, apart from any measures of plan operation? For routine care, specified as a check-up, 3% said they were able to get an appointment the same day that they called, but almost 50% said it took 30 days or longer. We don't know how this compares with the time before Duke managed care, but a weighted average within the categories is a bit over a month for a routine care appointment. Taking next a minor illness, specified as a sore throat, 38% were able to get an appointment the same day, with an additional 54% able to do so within 3 days. That's 92% overall within three days.

At this point some discussion erupted from the floor, someone asking if that was 3 or 7 days [for that 92%], and Mr. **Erb** corrected it to 7 days. The questioner continued, asking whether that was the user's own physician they got to see and **Erb** said that it was indeed the

user's Primary Care Physician (PCP). Continuing, for chronic illness, specified by example as diabetes, 16% said they were able to get an appointment the same day, and an additional 36% said in about a week, or somewhat over a week as a weighted average. The final category for physician access was how long it takes to get an appointment for urgent care, not specified by example and hence anything from "a sucking chest wound to a back pain that someone has been experiencing for twelve years and suddenly couldn't stand it anymore and needed to see a doctor today." In answer, 77% said they were able to see their doctor the same day and an additional 20% said within a week. Now, there are industry standards for the amount of time a patient should have to wait to get an appointment, standards that ought to be specified and adhered to by the providers and the administrators, but these answers show the current state of affairs.

We then asked, perhaps getting to the question just raised, how often an appointment resulted in seeing the PCP selected; 42% said they always saw the doctor they selected as their PCP and an additional 31 % said most of the time that was whom they saw. Only 7% said rarely or never, and an additional 12% said sometimes. In asking how many have used the plan in comparison with those who have not [yet] used it, 92% of Duke faculty and staff have used the plan during the course of [its first] year. Everybody uses the plan, so these opinions are based on experience of actual use.

How long a wait, once at the physician's office, to see the doctor? He had been associated with the Duke program for about ten years now and this has always been voiced as a problem, but interestingly enough, 70% said they waited 30 minutes or less. Prof. **John Staddon** (NS&M) then interjected the comment that for many people, <u>something</u> happens within 30 minutes, but it may not be seeing the doctor. Mr. **Erb** indicated that the question was on an overhead, verbatim, evidently using the word "provider," which **Staddon** said he considered a vague term. **Erb** pointed out that only 6% said that they waited more than an hour to see their provider, whether that was a physician, a nurse practitioner, or a physician's assistant.

How about getting PCP referral for seeing a specialist? It was his impression that gatekeeper function is the chief dissatisfaction with managed care. Some call that gatekeeper role a road block instead. For having a problem getting to see a specialist that they wanted to see, 75% said that it was not a problem, 14% said it was a small problem, and 11% said that it was a big problem. Prof. **Maura Belliveau** (Fuqua)] spoke up to ask if that was the response just of people who wanted to see a specialist? **Erb** answered no, and **Belliveau** pointed out that the 75% could then be the people who never wanted to see one. **Erb** said that was correct. Because the NCQA questionnaire is a standardized instrument, requiring that their questions not be altered, sometimes there is a loss in precision, as in this instance. But all in all, 92% did see a physician at some point, even though we don't know what percentage of them wanted to see a specialist. But typically it seems if you want to see a specialist, it's not a big problem. It was asked whether those data allowed seeing what percentage of those responders were faculty? **Erb** said no, they did not have those identifiers, beyond their being plan members.

Continuing, in relation to the high response rating Prof. **Belliveau** asked whether any of the non-respondents were people that had serious medical problems while Duke faculty or staff. Were there any data on whether a respondent had had a serious illness in the last year, or on any actual medical experiences? **Erb** answered that the breakout was by the respondent's perception of their own health in general, in three categories: good, fair, and poor. Pressed further he said that about 1 % characterized their own health as poor. **Belli** veau: so those most likely to be in need of specialized care may not even be in the sample? **Erb** answered that a focus on people with serious illnesses would be another survey, distinct from this random sample approach. **Belliveau** was concerned about a potential systematic non-response, and **Erb** said that for the incapacitated a family member or friend could respond, but there were very few who needed that help. But the concern is valid.

Prof. **Staddon** asked further about having to use the questions in [the NCQA form]. If Duke is evaluating its own health plan, why not use whatever questions it wants? **Erb** reiterated the dual purpose of the survey, an evaluation of perceptions and also NCQA accreditation, a policy decision made by the University. The **Chair** commented that it was a good question, but was concerned to have **Erb** finish his presentation before more questions, but Prof. **Lawrence Evans** (NS&M) wanted to clarify that of the 75% expressing no problem in seeing a specialist, some unknown fraction never asked to see a specialist. **Erb** said that was correct. **Evans:** It could have been all of them? **Erb:** Yes.

Prof. **Peter Burian** (Humanities) felt that the interpretation of that 11% as "having a big problem" [seeing a specialist] was a sort of sanguine characterization, and **Erb** apologized for any such impression; he was just presenting the data. Parenthetically, and although "data is not the plural of anecdote," he had used [a generally similar] survey for a point of service plan for a client two years ago which had an overall satisfaction rate of 30%, and it was abysmal in terms of referral to specialists. So finding 75% saying it not a problem had him looking first for data error, and [a hint of that unexpected degree of satisfaction, on his part] has been picked up, by "especially as picky an audience as you folks are. You're a tough group."

Prof. **Staddon** asked why we should care about accreditation. It doesn't make any difference to the quality of care we get. **Erb** said that there are few national measures of quality, and NCQA does not measure outcomes yet, although they're trying to. Their immediate concern is whether a managed care plan has the proper infrastructure to at least monitor quality, one of the reasons why they proposed a common instrument.

Assoc. V. Pres. **Clint Davidson** wanted someone to quickly answer why that policy decision was made for Duke and someone prompted Prof. **Robert Califf** (CliSci) to answer that there are two reasons for doing it this way. NCQA accreditation is critical as time goes by and people are selecting [from a wider array of] health plans, outside Duke. And second, unless you have some bench mark to compare your responses against, you don't really know where you stand. This is a national survey done by a not-for-profit "Consumer Reports"

type organization. But he was also disappointed that we didn't delve deeper because our real problems are with sick people, not those who don't really want to see a specialist. "They want to stay away from doctors." To have some kind of follow up beyond the standardized questionnaire is critical to us for two reasons. [There's a concern to attract] customers into the Duke Health [Plan]. We need accreditation, an external OK, just as does Ford in the automobile industry, and second, as physicians we want to see where we stand in relation to other health plans. And you can't do that unless you ask the same questions.

Prof. **David Smith** (NS&M) asked what Prof. Spenner's input to the survey was "if the questions could not be improved upon," which the **Chair** saw as a very good question. That was a point of friction concerning the Council, the faculty, and the FCC, something that we ought to talk about next time. Last fall, these things were supposed to be put together into our own questionnaire but then there was this urgency for accreditation coming forward from Human Resources at that time. They were saying that we needed that accreditation. In their estimation mounting both efforts was too much for any one time period. It was a very frustrating question, one that ought to be up for discussion for the continuing look at what we're doing. We need a more thorough penetration, say from the point of view of finding the subpopulations. The main concern right now is just to get these survey results out and know what they are so that we can then go forward. In due course he would ask Prof. John Payne to comment about the FCC view relating to this question of competing purposes, looking especially to discussion next time. **Erb** ventured that what Dr. Spenner actually told him was to go ahead and do a lousy questionnaire and the faculty would never notice anyway. "Just kidding, Dr. Spenner."

Continuing, **Erb** said that one area of significant dissatisfaction, almost 25% of the plan participants, involved going out of network, an option open to everyone enrolled. When you seek a provider outside of the Duke managed care plan, can you complete the claim form, is the claim processed accurately and paid accurately, and is it done in a timely manner? Under the old system, this was really the area employers focused on. For that 20% out-of-network group we now find only about 50% satisfied, with fairly high levels of dissatisfaction especially in the timeliness of the claim payment, an area for future focus. Interestingly, on whether the claim form was easy to complete, there were two groups having significant problems with it, those with less than an eighth-grade education and those with more than four years of college. Everyone in the middle seemed to have no such problems. [The tape turned as] he went on to remark that [referral outside the network] was confusing, in a survey finding that folks are fairly confused anyway. That kind of confusion does not really clear up until everybody has used every service in the plan, probably beyond our lifetimes. In fact, [joking] when 100% understand it, it may be time to change plans, since a way to save money in a managed care environment is to trick everybody so they can't get their services. "I'm just being sarcastic."

Moving on to urgent care approval procedures, say your son has an earache and it's Saturday night, can you get approval for care? How do you arrange for hospital precertification, use the network, know the policy on referrals and the consequences of going

out of network? As high as 31% don't understand how to get emergency treatment approved. Again, some of this emergency problem will resolve by learning, with experience of the plan, but there are more efforts the University can make to inform people how this complex plan works. As a last bit of data, given all we've just seen, including areas of relative satisfaction and strong dissatisfaction, in terms of the claim payment procedures and communication and things of that sort, all things considered, how satisfied are the users with the current plan? In this case, a 7-point scale was used, from completely satisfied, and there were a few, unexpectedly, to completely dissatisfied, allowing a lot of room for gradations of opinion in between. The snapshot of what was happening in February and March of 1997 showed about 2/3 feeling at least satisfied with the program. Assuming that the 8% who hadn't yet used the plan were fairly neutral, about 21% expressed at least some dissatisfaction with the plan, at least in some aspects. Given the level of conversation in late 1996 about the plan, from his experience in implementing managed care plans, and remembering that the Duke plan is still very young and that the Duke faculty and staff were coming from essentially getting any medical care wanted for free at any time, and trying to avoid being sanguine [deep breath], this is not a shockingly low level of dissatisfaction. The other client spoken of had a 30% level [of dissatisfaction] in these three categories.

All in all, this is how the Duke managed care plan was perceived by its users in February and March of 1997. Access, appointments for routine care, communications, and problems with administrative portions of the plan seemed to be the biggest dissatisfiers, and on the medical care side, referral to a physician. Even there it wasn't double digits who felt that it was a problem. Other than that, there was overall satisfaction with the plan.

Prof. **Mariano Garcia-Blanco** (BasSci) asked why, in characterizing the 5-point categories, good is lumped with excellent. In academic practice that's quite a difference one would be making, in recommendation. **Erb** said that they can be separated, and indeed were separated on the overhead projection, although recognizing that they weren't in the Executive Summary given the Council members.

The **Chair** seized the opportunity to end the presentation of the data, thanking Erb and Davidson, and called on John Payne to speak in behalf of the FCC, which had worked very hard both in trying to evaluate whether this survey could be effective and then in contributing to whatever understanding could be gained from it, "and then we can open the floor." But the Council is encouraged to think about this also over the interim until the next meeting and opportunity to go over these matters more thoroughly, after study of the printed material as well.

Coming to the lectern, Prof. **John Payne** (Fuqua, FCC chair) did not propose to go into any detail about the results just heard, but to quickly give the FCC take on what the survey was saying and some ideas communicated to Assoc. V. Pres. Davidson and other officers of the University, and to ECAC and the Chair, about where we need to go next. First, in spite of the flaws pointed out, the survey does contain some useful data. Once you get in to see your PCP you feel pretty good about the quality of care that you receive.

That's the good news. But clear areas of need for improvement have been highlighted. Access, particularly for routine care, is not satisfactory, and access in terms of geographical location. Those who live in Wake County are not happy. There are some other issues that relate to comprehension of the plan and those things are very clear. „

One of the FCC hopes is to go beyond the sort of analysis we've had so far, to do some additional analysis of the data, showing kinds of responses made, given some responses to other questions. The FCC has talked with Assoc. V. Pres. Davidson about that and is hoping to work with Human Resources and John Erb along those directions. He thought it fair to say that the FCC saw the methodology of the survey - having gone back and forth on the exact wording here — as minimally satisfactory. It gives some information, but it is not what we would be comfortable with. For some of the questions the answers are hard to interpret. Some things, like how people felt about pediatric care, were not covered. Prof. Spenner spent an enormous amount of time on that [omission], as did others, trying to improve the [survey questionnaire], as noted. But these efforts very much constrained by this matter of NCQA accreditation.

One FCC recommendation is that we're going to state what we've got here, try and get as much as we can from it, but definitely move forward [to something better serving our needs]. The survey as it's designed really doesn't give us the information we need about access to specialists. Some of the questions are encouraging, but a number are really hard to interpret. Beyond the need for some additional analysis the FCC views this survey as a starting point [at least] on a continuing and extensive effort to try and collect data on how this plan is working. We've recommended to the [senior officers of the University] and to ECAC and the Chair, who has already mentioned this, the great value of surveying our primary care providers, getting their sense of how things are working. There's a need to do some surveys at the level of pediatrics and other care. There's some additional, harder data we can get on waiting time.

More generally, a recommendation already forwarded to Assoc. V. Pres. Davidson, the [senior] officers, and to ECAC and the Chair, is that the University allocate money toward really putting into place an ongoing and extensive effort to collect the kind of data that we need to have to be comfortable with the quality of care we're getting from the Duke managed care program. That will take some money, but something learned from being on the FCC is that from the many millions of dollars this University spends each year in providing health care benefits for the faculty and staff a percentage could well be spent on collecting the kind of data that can clearly identify those areas where improvements can be made to get the kind of health care plan we should have here, in the FCC view. Not just satisfactory, or good, but the best managed care plan possible given the constraints of managed care. We're not looking for just satisfaction, we're looking for the best.

Prof. **Staddon** took the opportunity of asking, "How about a great health plan for a great University?" Prof. Payne thought this [ironic flourish] was "wonderful." Prof.

Kenneth Knoerr (NSOE) hoped that the proposed survey of health care providers would include specialists as well as those in primary care, which **Payne** agreed was a good idea.

With, the late hour, and consequent, erosion of the audience, the **Chair** accepted the adjournment of the Council.

Prepared for consideration by the Academic Council,

Donald J. Fluke, Faculty Secretary of the Academic Council.