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Minutes of the Regular Meeting of the Academic Council

January 18, 2000.

[Correction, Faculty Forum, January issue, p. 7, col. 2, par. 2, line 2: replace "four" with "forty"]

The Academic Council met in called **Special Session** on January 18, 2000 from 3:45 p.m. to 5:40 p.m. in 139 Social Science with Prof. Robert **Mosteller** (Law) presiding.

The **Chair:** We have one item, and that is to discuss the Member Satisfaction Survey of the Duke Managed Care Plan. At a later point in the proceedings, we are going into executive session; at this point, we're in open session. We have four speakers today, Clint Davidson, whom I will introduce first, then Dr. Paul Berger, a gentleman from Mercer Consulting firm, and Ken Spenner, who's chair of the Faculty Compensation Committee.

V-P Clint **Davidson** [using an overhead projector]: I'd like to take five minutes to create a context for the presentation today and to conclude by introducing the backgrounds of both of our consultant representatives. We have spent a lot of productive time over the last several months working with the Faculty Compensation Committee in the design of this survey and then in the review and interpretation of the results. Some of you, I think, were a part of this go- around last time, so you'll notice several changes; but the single objective in each of these efforts to assess our plan is to attain input and perspectives from a number of individuals: faculty, staff, those who have been with us as new employees, those who have been with us for a long time, those who have dependents, and the like. So, many different perspectives were included in the survey design. We wanted to study the perspectives this time by focusing on three different or distinct measurement tools. First of all, a member satisfaction survey, which included a random selection of 1900 faculty and staff. Secondly, a quality care survey or some title here that is looking more particularly in a focused way at the high utilizers, the presumption being that their experience and assessment of our health care plan would be different as a function of their more intense experiences. Thirdly, and in particular the newest element of the assessment process is to go to our physician

providers and to gain their perspective. We assessed the perspectives and experiences of our providers in the focus group, and Dr. Berger will describe that to us a little bit later. From a timing perspective, this effort has taken place over a number of months. We actually selected the samples in the fall of 1998. We prepared our survey samples with announcement letters also beginning in the fall of 1998 [and] the distribution of the survey in the winter of '98 and '99. Our survey response was not as substantial as we initially hoped, so we went back out in early '99 to follow up and to encourage additional responses, and then in the spring and actually up into the summer did the data analysis from all the responses that we received. Ken [Spenner],I know, will talk more from the Faculty Compensation Committee perspective, but an awful lot of discussion and time and effort [were expended] between Human Resources, the Faculty Compensation Committee and involving the consultants as well. There were methodological limitations and shortcomings to the first survey which were really front and center in the design of our effort this year. We contracted with William Mercer to develop the new survey, and in particular looking at customized questions. Some of you who did this before will recall that our last survey will be limited in the focus questions in the design, so we moved away from that in a considerable way and designed questions to fit our plans and our needs here at Duke. We sent the survey only to active employees, not spouses or children. There was a special group of adolescents who received a 'quality of care' survey around pediatric matters. We asked additional questions on mental health utilization, prescription drugs and experiences with pediatricians which was an addition that was directed [at] overcoming some deficiencies of the previous survey. We pretested the survey with several groups of employees to ensure validity and understandability, and we sent a good deal of follow-up notice to the nonrespondents, trying to increase the overall response rate, because I mentioned earlier that we surveyed high utilizers of the plan as a separate and distinct group. All of this effort is really directed at three outcomes. Strengthen plan performance. Pat [Patrick] and Paul [Berger] will share with you data that speaks to the overall plan performance, but our intention is 'how do we get better?' And no matter what the 'satisfaction' or 'high regard' responses might be, our intention is to get better. Secondly, the present design of the Duke Managed Care Plan has now been existence for five years. It has some elements that really have probably been used to its full extent. The usable life may be expiring soon, so in terms of future plan design, how do we use this assessment going forward? And finally, [how] to use this information as a baseline for assessing

performance changes over time? So with this as a baseline of information, as we do subsequent surveys, [we ask] 'what change indeed has occurred?' If change has occurred, how do we use the information to bring those changes forward? So that's the context for the survey. Let me tell you briefly about the William M. Mercer firm, if you're not familiar with them. It is the largest global Benefits Compensation and Human Resources consulting firm in the world. It has 106 offices in 27 countries with almost 9000 employees worldwide. 40 offices in the US with 4600 employees, and Duke is serviced out of the Charlotte office. One of the elements of their practice, that was very attractive to us, is a national survey of employer sponsored health plans that they conduct annually that covers over 2000 employers that have 500 or more employees, so part of our interest was to know not only how do we view our plan, but as we [are] compared with other major employers, how do we stack up? The two individuals who have been working with us throughout the design and in the administration and the interpretation of the survey are with us today. The first presenter will be Patrick. Pat is out of the Charlotte office and is a client manager for the Duke account. He joined Mercer in 1996 and is a practicing Employee Benefits Attorney. He did that for 14 years prior to joining Mercer. He was outside [legal?] counsel for Duke between 1992-1996. Therefore, his experience and background with Duke was particularly valuable to us, and additionally of great value, he worked with [Duke] Benefits Administration on legal issues around the implementation of the present Managed Care Plan, so he has that background as well. Paul Berger, the other presenter from Mercer, is a physician out of the Mercer Atlanta office. He's the national practice leader for the health care provider consulting practice [and] Board-certified in general medicine. Prior to joining Mercer, he was a practicing physician for 9 years as well as the medical director of a national HMO.

Attorney Pat **Patrick:** When we developed the survey, we just had a tremendous amount of issues we wanted to cover and get feedback for employees, so we developed what is a very, very comprehensive survey instrument. That's great, because it provided us with a lot of valuable information on both the health system and HR. Unfortunately, what it's going to mean is, I'm not going to be able to go into the detail that I'd otherwise like with the short time I have today. We can answer some of your particular questions as they come to mind, we can answer those in the 'question and answer' session after we go through all of these other surveys and we'd be glad to do that. We want to talk to you a little bit about the State of Managed Care and what's going on and the different pressures that are on the health

system and the providers and HR in terms of delivering health care to the employees here at Duke. We want to talk in particular about how the results are evaluated and how we came up with the standard by which we evaluate the survey result, and then we'll get into the results of the surveys. As Clint said, we looked at the overall member satisfaction. We were looking at plan design, we were really targeting areas for improvement through the health plan. We also wanted to look for ways where your employees were giving us signals that said maybe we can address this better by managing their expectations; particularly around the dissatisfaction with the amount of time that it takes employees to get an appointment for routine physical care with the provider. We also, of course, wanted to look at how well Wellpath is doing at administering, planning and assisting HR. Clint's already been through the survey information. One thing to note is that when we got back the results of the Member Satisfaction Survey, we noticed that there was a significant increase in the number of the more well educated employees at Duke [responding to the survey]. They were really the ones who answered the survey, and we didn't have the representative body of service employees and minorities and lesser educated employees that we had had in the previous survey. So, after conferring with Clint, we went back out and did a mini-survey. We selected 20 general questions from the overall Member Satisfaction Survey and surveys from additional employees to get their feedback to see what variation there was against the Member Satisfaction Survey as a whole. Clint has already talked about how we developed the Member Satisfaction Survey. I think the biggest thing here is that we were very aware of the comments you made with respect to the previous survey that was done and took those into account. That actually formed a checklist for us to go down when we were developing the survey instrument to make sure that we addressed all of those concerns. Development of the background and the background on the quality of care survey was a little bit different. This is actually a survey instrument that Mercer licenses from the Dartmouth College School of Medicine. It's a survey instrument that has been in place and use in helping providers assess the quality of care they provide for about 11 years. Mercer saw the value of the survey, and said, well, we can take this and use it as a means of helping employers evaluate the quality of care between different health care plans that they may offer. So that's really the intended use of this instrument.

We took a little variation of it here, and what we decided to do was [to] assess the quality of care that the employees received at Duke, and use it really to set benchmarks going forth. So it's [used] a little bit

differently, but it still provides lots of valuable information. I'll go into more detail in terms of the actual questions that were in this survey instrument a little bit later, but really what it does is ask employees and members about their physical, social, and mental well-being, asking primarily whether or not the providers are aware of their physical and emotional problems, have they addressed those, do you understand the explanation for why you're having those problems or the treatment you've received, and also getting assessment from the employee about whether or not that treatment has actually improved that condition. I wanted to get a little bit into the state of managed care because, again, there are so many pressures on the health care provider, on the HR, on everybody that is involved in the health care industry. I'll just touch these briefly. I've seen a lot of press recently in terms of Patient's Bill of Rights, and problems with HMO' s have opened up the door to do away with the [restrictions?] that prevent employees from suing their health plans for malpractice or for denial of care when they think that they need it. That's very much on the minds of a lot of health plans these days. Also, some HMO's have already been sued by many of the same people who brought you the tobacco litigation and they think they can reform the -system that way. Just as a side note, they may reform but it's going to end up costing you and other employees a lot more. [Concerning] other regulatory pressures, I think we've seen more pressure on Congress now for special interest groups that have coverage mandates. [. . .?] That's going to increase too. That's going to influence the cost of care that is delivered to employees, as well as other things. The big one around here is medicare reimbursement rights. Every time [someone] pushes on their limits, that balloon has got to expand somewhere else and the pressure is on the employer. The employers are pushing back too. The managed care industry itself, with the health plans, and here we're talking about what's been going on, impact the business of Wellpath, Avmed, United Healthcare, and the big providers. Since '94, they've been going through a lot of change themselves. They have been acquiring market share, they've been trying to manage information and utilization. They have been trying to, they've been distracted by mergers and they've tried to get their systems integrated, and those types of things have really, in large part, taken their eye off the ball. So maybe they could do a lot better job if they focused on these types of things. And they had to deal with Y2K on top of that. We're going to see a continuing evolution of managed care. You're already seeing in the press where United Healthcare has said that their PPO is going to go to open access and you're not going to have to go to the gatekeeper and get their permission to go to a specialist. You automatically get to go to one. So what you're seeing is that now the health plans, the three primary vehicles for delivering managed care,

traditional HMO's, point of service plans which are like the Duke managed care plans, have PPO's which are basically discounted provider networks. What you're starting to see is that the different health plans for these designs are taking the best practices out of each one and marrying them together.

When you look at what's happened, and this sort of mirrors the distractions that the managed care companies have, you see that here you have the beginning in about 1989, you saw the starts of managed care and the controlling of costs for employers in both the claims and administration of these benefits, and you see they start sliding down. And down here in '93-'97, the managed care companies were trying to buy up a lot of market share. And so in going out, they really bought it. They really bought it at a low price. Bring your 20,000 employees, sign them up with our plan and we'll give you a low rate. Now, [there is] a lot of market pressure on them, so these will probably trade companies, and we're starting to see the uptake on that and the upward trend in the cost of the benefits. [Health Benefit Cost Inflation Returns]: One of the bigger things that is driving this, of course, is going to be the prescription drugs. Medical claims costs haven't increased that significantly, but as you can see, [what with] more and more advertising by the pharmaceutical companies and the name brand drugs, you've got more patients coming in and demanding that particular drug. We've also seen a dramatic increase in drug costs far above the consumer price index, because they've got a lot of patents and they are about to expire, so they want to squeeze all the money they can out of it right now. As a side note, I can make those comments, because my wife works for a drug company. But that's what's happening and influencing the trend, and this is what Clint and these folks have got to deal with health plan enrollment trends. You'll remember back in 1994 and before, Duke had basically an indemnity plan. But as managed care came in, so has the trend in enrollment and indemnity coverage [dropped?] so now it's down to about 11%. Where we see large employers who have indemnity plans, [they] are really left with a catastrophic plan where you have a high deductible or a high co-insurance amount for people who just want that type of coverage and don't want to pay for anything else, or it may be an employer who has employees in rural locations who don't have access to managed care networks. At the same time, you're seeing [a] leveling off from 'point of service' and HMO enrollment, but the PPO's are starting to take off. I mentioned a minute ago that all of these are really borrowing best practices from one another, and that is likely to continue, but by far the preferred vehicle is the PPO.

Getting more specific and looking at North Carolina, you see the lower enrollment in indemnity plans and much [a] higher

[enrollment] in PPO's. [Concerning] the foundation of the Duke Managed Care Plan, all of you as Duke employees have seen the press coverage and how highly regarded the hospital is. You've had terrific recognition in the US News and World Report and that's gone on for a large number of years. You' ve got the Consumer Choice Award for the top hospital in the Triangle and even WellPath has stepped up and based on the numerous satisfaction ratings, it got the top rating in the state of all managed care plans. When you then break down the US News and World Report information further into specialties at Duke and compare it to the other two major academic hospitals in North Carolina, you see that only Duke has any rating in the top 10. Nine of the 15 that Duke had recognized were rated in the top 10, all 15 were in the top 20. Whereas UNC and North Carolina Baptist only had 2 in the top 20. None of the specialties that were recognized at Duke were bested by any of their peers at the others. What this really says is that Duke has got a great reputation, WellPath is on the way to building a great reputation, or is trying to. But that's saying, that's our snapshot of the way things are right now. If you haven't seen this before, this is actually the cover off of the pamphlet that contains the Duke hospital's strategic agenda. If you can read it, it says "Making a Good Thing Even Better." And I think this is what Clint [Davidson] alluded to, and I think it's recognition by the hospital saying that 'we know we have a good reputation, but we know that we can be better.' The reputation speaks to how good we are today, not how good we could be. A lot of this is foundation, and I'm going to tie this into the survey results. This is not a smokescreen, by any means. The dots will connect a little bit later. We've got the hospital's strategic agenda. That says the hospital wants from 90% of the patients that leave, a rating of "excellent," at least 90%. What the PDC has promised you is that when a patient comes in, they're going to understand and participate in the health care in order to achieve better results. Then the physicians are going to communicate accurately to their patients [relevant information], and this information is going to be conveyed in a way the patient can understand. So remember, that's the promise that is conveyed. Now, the survey results are going to provide a lot of valuable information, but it's only one small piece of information that could be used by HR, that could be used by the health care leadership to drive medical excellence. It's not going to happen, however, unless there's some accountability and unless the systems and guidelines are built in to take this information and say 'here are areas where we can improve, here is what we are going to do and you have got to be accountable for that.' If the accountability is not there, despite the fact that maybe we've identified some areas where you'd like to see some improvement, it doesn't matter. The accountability has got to be in the equation.

OK, let's get to some results. First thing, about how we evaluated the results, and because Duke is Duke, we took a little more conservative approach to how we evaluated the results. Because the hospital says we want a 90% excellence rating, we said, ok, only the two highest answers are going to be considered favorable. So, even though we said please rate your provider and the scale is excellent, very good, adequate, fair and poor— even though 'adequate' to a lot of members may be a satisfactory answer— for purposes of our evaluation and survey results, we said that's not good enough for Duke and that's not a favorable answer for our evaluation. So, if anything, we perhaps skewed the numbers a little bit on the low side. So, that's one caution in [comparing?] these results to other surveys that you may see out there. It's important also to understand where the members are coming from with this. We asked a lot of questions, [such as] give us your perspective, what's important to you in terms of your health care concerns for you and your family, and how do you define the quality of care? If I asked this room, how would you define quality of care, I [would] get a lot of different definitions, because everyone has a different viewpoint on this. But we wanted to see that because [of?] certain areas of the plan administration, for example routine care. We heard a lot of negative feedback about ' I can' t get an appointment, I don't have access to that care.' Well, we wanted to test it to see how big a priority is that in terms of your concerns for health care. We first asked the members, which health care issues are of the greatest concern to you, and we gave them 8 possible choices, and we said list your top 3. But what they want is #1, they want to receive quality care. They want to know that they've chosen the right primary care provider, they want to make certain that they're getting referred to the right specialist. They want to make certain that they understand the treatment alternatives that are presented to them, and fifth, even though, again, [there are a] lot of rumblings in the system about this, cost shows up only as number 5. So, you can see that [certain other] things are a lot more important to the members than this, the co-pay for an office visit to a primary care provider. So they are much more concerned with these other factors and other concerns than they are about the cost. We said OK, help us define what quality care means to you. We gave them 11 possible choices again here and we said how important is each of these to you in determining quality of care, and the scale went from 'extremely important, "very important,' 'somewhat important' to 'not at all important.' So, taking just the two favorable results, 'extremely' and 'very favorable,' this is the ranking that we got. The most important thing is being able to get to see the doctor for urgent care and getting that appointment. Understanding the treatment results and the doctor's explanations came in second and third, and doctor's understanding of the problem that you're facing is number

four. At the lower end of the scale, we find waiting time for basic appointments, treatment costs and the routine appointments. So here, again, some of the things that we have heard in building the survey instrument that are problems within the system come out as lower priorities for the employees. So this is not to say that it's insignificant, because you're still contending in terms of a high percentage of number of people who say it's important, but it's much lower in the scheme of things.

Finally, this slide really carries a lot of importance for HR because we asked employees, out of these 6 choices, what are the ones that influenced you the most, had the most influence on your physical health? Job came out as number one. So, I think this ties into a lot of the work that Clint has been doing with work culture, and this is some useful information from here. Emotional wellness came in as just second. Surprisingly, caring for a child and caring for spouse came in much lower. Getting into the overall member satisfaction, we gave the employees a number of general statements to assess the overall member satisfaction and asked them to agree with the statement either 'strongly' 'agree' or 'neutral,' or 'disagree' or 'strongly disagree.' We said first, does the plan provide good protection for you and your family members? And we came up with 82% of those who said yes, that they agreed or strongly agreed with that sentence, and that's a pretty high ranking for the employee sense. That says the employees perceive the health plan as being a valuable benefit to them. In terms of the affordability, the out-of-pocket costs, here we saw a lesser percentage, but still a lot of satisfaction with the affordability of the care. The affordability [category?], of course, did show some variance for members with families who make less than $50,000, the cost for accessing the health care was a little bit harder on them. Finally, in terms of satisfaction with the drug benefit, we saw about a 72% approval rating there. Next, we asked, are you satisfied with the selection of the primary care providers that are available under the plan, are you satisfied with the specialists under the plan? Here you see the ratings there, the specialists that they thought they had a little bit better selection of than they did primary care providers of the plan. The largest amount of dissatisfaction within the plan, one of the largest, I should say, is satisfaction with WellPath member services. We broke these questions down and we asked about the services, their courteousness, their responsiveness, their understandability, the answers they got when they called WellPath and it was pretty much along this area [of the graph], or maybe just a little bit lower, because there's not a lot of satisfaction, and the satisfaction grew as the education level did. There's a little bit of variation in certain measures based upon job location. You can see that employees of the hospital were mostly [satisfied?] with the

selection of specialists and with Wellpath's services, [but] as far out there as those on campus were least pleased with the specialists, [but] interestingly, most pleased with the drug benefits, but sort of in the middle with WellPath. When we looked at member satisfaction, we said we looked at it [from] inside within Duke, but how does it stack up with some of the recorded member satisfaction surveys, satisfaction reported for other types of health plans, other point of service plans that are like the Duke Managed Care Plan, and even though we graded the Duke plan a little more conservatively, it still showed a better member satisfaction rating than the point of service plan of United Health Care Partners or Blue Cross and Blue Shield. With respect to the communications that the employees receive about their health care benefits, we asked them, 'do you have a good understanding of your health care benefits?[7] and we got about a 65% response. They also said that the benefits are presented in a clear manner and they are understandable, but yet at the same time when we ask more specific questions that said tell us about your level of understanding about these specific types of services and procedures that are available under the plan, we saw a much lower response. So there was a little bit of disconnect there. It's interesting that when we were up above and speaking in more general terms, we got higher marks than we did when we really drilled down. So, I think there's really some room for some improvement along these lines. As you might expect, the level of understanding for the lower paid employees, [shows] a bigger gap and less of an understanding of the benefits.

In terms of preference on how you would like to receive your benefits information, we asked them to please name the three most effective ways to receive information about the managed care. Number 1 was receiving mail at home, and this was by far the only one that really stood out for a group [which] was the preferred method to receive information by people with masters or a doctorate. Otherwise, it was pretty much across the board. 74% of the masters and doctorates said they preferred to receive that at home, but otherwise, it's spread out. There are some surprises in here. The [faculty?] member handbook was second, the Benefits Office was third, which means there is a lot of reliance on the Benefits Office to answer questions for the employees, even though there's not that great an understanding of the benefits, employees still go to their co-workers and that's where the grapevine comes in. That's the fourth most popular way of getting information. After that is mail, the HR website is down to about 22%. I think, probably in the coming years, you'll see a lot more emphasis on that. There's a lot of information that can be put there to help you with your benefits, and WellPath is being helpful [but] as being a source of information is ranked only sixth. For the lower paid

employees, actually those without a college education, I should say, their preferred way of receiving information is actually through the Benefits Fair which is ranked just after. Looking at the quality of the health care providers, we saw significant satisfaction with the quality of the providers themselves, with the specialists being ranked much higher than the primary care providers. And we also saw that there is also a lot of satisfaction with the quality of care that is received from the providers. Again, one of the questions I didn't mention at the beginning is [that] the member satisfaction survey did not go out to the highest utilizers of care within the system. We did the quality of care survey, we took the people who use the health system the most, and in cases, for example, where we asked active employees about the quality of care that they received from their primary care provider, to qualify to receive a copy of the survey, in that case you had to have seen a primary care provider at least 8 times in the previous year. So what we did with both of those surveys— because we knew we were taking the high utilizers out of the membership satisfaction survey pool— [was that] we cross-populated both survey instruments with questions from each survey, so we could do this type of comparison. So the high flyers, the high utilizers are in the red and you can see that they rate the primary care providers higher, but yet when they came down to the specialists, the people who hadn't used the specialists quite as much, [they] rated them just slightly lower. But now, while the quality of care and the providers themselves are rated highly, we see a lot more dissatisfaction with choice of providers. I think this is largely attributable to having to select a provider out of the network and making the choice, whether or not the person they really want to see is in the network; location here might be an issue with a lot of employees living outside of Durham and perhaps living in Wake County and having to come to Durham to receive care, that's an inconvenience for them and may, in fact, impact their choice of providers, their satisfaction with [them].

We also saw ratings that were perhaps a little bit on the low side on the ability to access medical care when an employee and their family member needed [it]. A favorable rating there ended up only at 48%. We also saw a significant decline between 98% and 97% as far as the members' perceived ability to receive the treatment that they and their physicians thought they needed. What we may see here, I think, is an underlying dissatisfaction with managed care, and there has been a lot in the media about that, but there also may be some other factors that are coming into play here. But that is a pretty big problem from one year to the next. As to quality of care outcomes, again, while there is very high regard from the providers, the members rated the overall quality of the medical care and services and the outcome of the treatment and

how much they were helped by the prescribed treatment as much lower than they did the providers themselves. Waiting times for appointments: this is one of those areas where there has been a lot of feedback from Benefits Administration and WellPath about not being able to get to see a physician when they need to, and we did see a significant increase in the routine care, but again this is one of those areas where employees didn't rate [that] as high a priority to them as opposed to receiving quality of care. For example, some of what you saw now is that in 1997, to get routine care, in 1997 44% of the employees were saying that they had to wait 31 days or more to get an appointment for routine care, and that number was up to 59% in 1998. There were only slight increases for waiting times to get appointments for minor illnesses, conditions and urgent care. Back to the increase for routine care; it's really not that surprising that we would see that when you think about the population growth in the Triangle area, the number of employers who sponsor plans who want to include Duke in their network, if not for the primary care providers, at least for the specialists. So, the success of the health system is going to have an adverse impact on the ability of your employees to see the physicians, unless you add a tremendous number. Again, [there is] some increase in the waiting times at providers' offices, but not that significant. One interesting point is— and this is again one of the points that is feedback for HR— that employees are reporting difficulty in scheduling around work hours. The problem there is that they put off a treatment, and then when they finally do get sick and they are out of work, they are a lot sicker, and it makes it harder for them to return to work. In terms of provider communications and interactions between the providers and the patients, we asked a lot of questions and this is a big area of improvement for the providers. Tell us about the information, the communications between you and your provider and information and education that you received about examinations, preventive care, about illnesses and injuries and their treatments, the side effects of prescription drug interactions, the problems you're having and your health problems and how they impact your daily activities, your emotional health, your social activities and life and employee education beginning with the specific types of problems you have. All of these didn't score that well, and really it's a target area for improvement. That's, this is kind of a breaking point, that's the end of the member satisfaction survey, but I've got a lot more to go. That's the member satisfaction survey.

Now we did the Quality of Care Survey. Let me flip back and do more background as far as the quality of care surveys. We did six panels. [First], we looked for the high utilizers among the active employees and their interaction with their primary care providers. The second panel was active employees

and we asked them about the quality of care they received from their specialists. We asked retirees to tell us about the quality of care they received, [either from] their primary care provider or their specialist, and then we had three panels, pediatric care ages 2-4, 5-12 and adolescents 13-18 where we asked them to tell us about the pediatric care they received through the plan. As I mentioned, the instrument focuses on the physical, the social and the mental health, and [the question] 'is the physician aware of the most disturbing problems the individual is having?' 'Can they explain the condition and the treatment in an understandable manner, and have they improved the health problem with the prescribed treatment?' We take the information through all the questions and we basically look at them in terms of 6 categories: their awareness, the comprehension, the sense of improvement, the receipt of preventive services, but those were really poor in the Dartmouth instrument, and then Mercer wanted to know two more in terms of productivity, how helpful is the physician in [bringing about the] early return of the employee to work, and how well is the physician [doing] returning the employee to normal productivity.

There was a supplemental set of questions and I've largely gone through and discussed these in the context of the Member Satisfaction Survey, because this is where we cross-populated the questions, and I'll touch on these a little bit more individually for the pediatric group, but we looked at the continuity of primary pediatric care question, the global satisfaction with primary care providers, we touched on satisfaction with specialty care and access communications. So, if you look at these measures, we saw a lot of awareness with the problems, the physical, the social, the emotional problems that individuals may be having, but as we said with the provider communication that showed up there, there is less comprehension on behalf of the members with the course of treatment that is being recommended and the instructions that they are providing. It's fairly good ratings as far as the symptom improvement they receive, and they're getting good instruction as far as preventative care. Some improvement can be made in terms of early return to work and focusing the physician on helping the employees on return to normal productivity. For the pediatric group, the comprehension again, this is another area that could stand some improvement. Otherwise, the ratings as far as improving the symptoms and receiving preventive care were pretty high, as you might expect, particularly for adolescents when they're going in on a regular basis like my son.

In conclusion, what we're looking at and what feedback we've gotten from the survey instrument, [and] we're really talking about [is that] employees do perceive the plan as providing a good benefit. 82% of them feel that it's good protection for

my family and me. We saw an increase in overall member satisfaction from the last survey to this one. We saw a decrease in the strong dissatisfaction with the plan. Finally, we saw a lot of satisfaction with the quality of the primary care providers and the specialists and the hospital here at Duke. Areas for improvement [concern the need to] target the communication structure. This is a tremendous challenge for Clint's group. This is a very diverse employee population here at Duke, probably most of you here have your doctorates, but then, again, you have a lot of service workers who probably haven't finished high school. That's a tremendous challenge for HR, because each is going to need a different level of communication, a different means of communication, and that's an expensive proposition to get the message across the whole work force. It's not just one booklet that can be printed and sent out to the masses. It's going to take a lot of different avenues to get the message across about how to access your benefits, to make sure you have a good understanding of that. There are also some areas that are targeted in here that you can see where there is a lot of criticism of the health system and the plan in terms of things like routine appointments and the access to those. When we were reviewing the results with the health system leaders, someone would come in and say why can't we do as good a job in managing appointment times for physicals as dentists do when you're going to go in and get your teeth cleaned? You finish there, you go to the appointment desk, six months later, you're making an appointment for six months later, you get a reminder card, and you know to go. It's a little more complicated here, because there are varying degrees of when you need [care], it's not every six months that you need a physical, it's not every year that you need a physical, and it's not every single study that you need done every year and every other year. There's a lot of variation there, but I think that there's some room here to do some communications to help manage employee's expectations, and then clearly in terms of working with WellPath and improving the member services they provide. Thank you.

At this point, the **Chair** announced that the meeting would go into **executive session** to hear the remainder of the survey results and the report of the Faculty Compensation Committee on managed care at Duke.

Submitted for consideration by the Academic Council,

A. Tilo Alt, Faculty
Secretary