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ABSTRACT

The Demonstration Training Program (DTP) undertaken by the Detroit Medical Foundation (DMF) was designed for Primary Care Unit staffs (PCUs) or Physician Corporations (PCs), area health center providers under contract to the Michigan Health Maintenance Organization Plans, Inc. (MHMOP). The major goals of the program were to design an appropriate curriculum for the staff of PCU centers (physicians and other health professionals), develop training methodology for implementing it, produce a training manual outlining the procedures for program implementation in other HMOs, and increase PCU staff cohesiveness and levels of knowledge about HMO systems. The report is divided into four major parts. Part 1 describes: MHMOP (with 28,000 enrollees and 19 health centers) the DMF, and the planning, implementation, and evaluation phases of the DTP. Part 2 is the Individual Practice Association model HMO Training Program Manual which was developed during the training process. Part 3 is a process and impact evaluation of the entire project prepared by a sub-contractor to DMF which indicates that the basic project objectives were accomplished. Part 4 contains appended material including major supportive materials used to design and implement the DTP and a list of trainee participants. (Author/MS)

FINAL REPORT OF

DEMONSTRATION TRAINING PROGRAM

DHEW CONTRACT NUMBER: 1-MB-44196

November, 1975

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PREFACE

This final report of the Demonstration Training Program conducted by the Detroit Medical Foundation between July 1974 and November 1975 has been prepared in fulfillment of the contract (Number 1-MB-44196) awarded by the Division of Associated Health Professions, Bureau of Health Manpower, Health Resources Administration, Public Health Service of DHEW. The report has been designed to serve as a staff training program guide for Health Maintenance Organizations in the United States.

The training program undertaken by the Detroit Medical Foundation was specifically a *"Demonstration Training Program to Improve the Capacity of Primary Care Unit Staffs to Function Within an HMO Setting."* By definition, primary care unit staffs are the area health center providers (Physician Corporations or PCs; Primary Care Units or PCUs) under contract to the Michigan Health Maintenance Organization Plans, Inc. (MHMOP.) As a Health Maintenance Organization, MHMOP is a multiple group practice HMO, whose organizational design is based on the Individual Practice Association (IPA) model HMO.

This report has been divided into four major parts. Part I provides a description of MHMOP, the HMO which served as a laboratory for the demonstration training program; a description of the Detroit Medical Foundation, which preceded and planned the existence of MHMOP; and an overview of the planning, implementation and evaluation phases of the Demonstration Training Program.

Part II is the "IPA model HMO Training Program Manual" which was used as a resource information tool and was developed during the training process. The implementation of procedures and methods developed for the demonstration and training program are also discussed.

Part III is a process and impact evaluation of the entire project. It was prepared by Technical Assistance Research Programs, Inc. (TARP) as a sub-contractor to the Detroit Medical Foundation, TARP is located in Washington D.C. Although the evaluation report was prepared as a separate document, some of the information appearing in Parts I and II is repeated in this part for evaluational purposes only.

Part IV contains Appendix 1 through 9, the first eight of which include major supportive materials used to design and implement the Demonstration Training Program. Appendix 9 includes the list of trainee participants in this program.

Many individuals contributed and participated in the Demonstration Training Program without whom the training program would not have been a success. We would like to take this opportunity to thank them all heartily. Their hope and ours is that this report and the training manual which it contains will become of service to other Health Maintenance Organizations.

J.L.L.
and
C.L.M.J.
November, 1975

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PART I

OVERVIEW OF THE DETROIT MEDICAL FOUNDATION DEMONSTRATION TRAINING PROGRAM

BACKGROUND: MHMOP, INC.

Michigan Health Maintenance Organization Plans, Inc. (MHMOP, Inc.) is a multiple group Individual Practice Association (IPA) model HMO, which was organized pursuant to PL 93-222, the federal HMO legislation. An IPA model HMO is an innovation in the structure of a solo practice, fee-for-service, delivery system. This IPA model of the HMO structure utilizes much of the medical capital outlay already in existence within the health care delivery system. This organizational concept began in Detroit, Michigan in May, 1971 through the interests of a group of inner-city physicians and consumers who contributed $400.00 in seed money to establish the Detroit Medical Foundation (DMF), a 501(c) (3) non-profit corporation. As the IPA conceptual model HMO developed, DMF subsequently became the research and development component of MHMOP.

The MHMOP Delivery System

MHMOP provides health services via contractual agreement with Physician Corporations (PCs) whose organizational design is based on the IPA model HMO. A majority of the physicians in these primary care units (PCUs) are members of DMF. These corporate PCUs assume total responsibility for the delivery of primary health services to individuals enrolled for them by MHMOP. Costs of hospitalization, transportation, prescription drugs, and other supportive services are paid for by MHMOP. Presently, there are 19 primary health care centers located in strategic areas of Detroit and its surrounding suburbs that have a contractual provider relationship with MHMOP.

This network of PCU health centers facilitates optimum convenience and accessibility for MHMOP enrollees. There are numerous advantages to this mechanism. First, for example, Medicaid eligible persons who voluntarily choose the option to receive health services from MHMOP may elect to receive these services at any one of the 19 health centers. (Out-of-area medically necessary emergencies are also covered in MHMOP's benefit package.) Secondly, since many of the PC provider groups have previously been the primary providers of medical services in their geographical areas, only minimal interruption in the continuity of care for MHMOP enrollees has been necessary. *In fact, the creation of MHMOP with its affiliated PCU centers has optimized continuity of care by providing a mechanism for total and comprehensive health care services to a medicaid population.* Through the use of the existing health delivery structure and manpower resources, MHMOP has been successful in developing a delivery system which, at the outset, required minimal expenses for facilities and capital investment.

When enrollees voluntarily elect to receive all of their health services from MHMOP and their eligibility is subsequently approved by the Michigan Department of Social Services, they are given a "membership kit". This kit contains a listing of the locations and names of all MHMOP health centers, a list of the physicians who staff these centers, the names of participating hospitals where the enrollee may receive supportive services, and other general information on how to use MHMOP's comprehensive health care plan.

The enrollee may also exchange his Medicaid card for a plastic embossed MHMOP membership card. Since, at the present time, MHMOP does not offer dental services, the Medicaid enrollee subsequently receives a "Dental Only" Medicaid card from the Michigan Department of Social Services. However, as a special service to these consumers, MHMOP maintains a list of dental physicians who have indicated a willingness to serve Medicaid eligible recipients. This list is made available to MHMOP enrollees upon request.

As of September, 1975, MHMOP has 28,000 enrollees. It is Michigan's only multiple group practice IPA model HMO. It is also the only DHEW funded development grantee in Michigan as of September 30, 1975.

Identification Of The Need For Training Programs In HMOs

Since the inauguration of the HMO setting, the HMO has represented a major change in the health care delivery system. It entails a change or transition from a fragmented system of health care delivery to an integrated one. This change challenges established patterns of attitudes, behavior, and knowledge of traditionally oriented and trained health manpower. Physicians accustomed to a highly individualized style of medical practice find themselves part of a team of health care providers composed of not only other physicians, but also a variety of allied health professionals. The allied health professionals, who are often long accustomed to being isolated from the mainstream of medical practice, find themselves in a professional setting that offers both the opportunity and challenge to influence and be influenced by physicians. Both physicians and allied health professionals are jointly affected by the apparent complexities of the operational aspects of an HMO program. Hence, the change challenges professional values and norms governing the way health manpower view each other and how they perceive their patients.

Since a change from the traditional way of doing something can present a threat to anyone, it often results in resistance. Resistance to change may be even greater when the person involved is not fully informed or fails to comprehend completely the meaning of the change. Thus, careful training of all professionals and paraprofessionals involved becomes mandatory. However, the vehicle of training can facilitate planned change from the fragmented system of health care delivery into an HMO setting only if it is designed to make impact on the information or knowledge base of the trainees. When this impact is made, attitude changes will occur which should lead to a decrease in the resistance to the planned change.

HMOs that are in the developing stages have problems similar to those in other developing organizations. For example, there is an immediate problem of lack of communication and interaction among staff which creates additional, unnecessary problems, anyone of which might be crucial to the growth and development of the organization. In case of PCU center staffs, they may be completely unaware of current administrative policy because it may change drastically within a short time span, or it may fail to filter out quickly enough to the PCU center staffs. The vehicle of training can be used to facilitate communication and interaction among staff by creating an opportunity for staff to interact with one another and to share jointly communication problems and others commonly encountered in the HMO setting. When training in an HMO setting facilitates communication flow and interaction among staff. it also contributes to building a sound organizational structure.

Need For Training in MHMOP*

The need for training in MHMOP has been no different than the need for training in HMOs generally. However since the HMO process is new to the PCUs who have agreed to perform within MHMOP's IPA model HMO setting, additional special guidance and technical assistance has been required in the transitional phase. For the PCUs, the transition from the traditional fee-for-service environment in which they were working prior to their affiliation with MHMOP requires a special sensitizing and socialization. Thus, the DTP was viewed by DMF and MHMOP's central administration primarily as a vehicle for facilitating this socialization process to improve communication with and interaction between MHMOP's central office staff and the PCU center staffs.

About the time DMF realized the need for training in MHMOP, it also became aware of available health manpower development funds from the office of Special Programs, Bureau of Health Manpower, DHEW. Since these funds were earmarked for health manpower development in HMOs and other prepaid group practice settings, the DMF moved ahead to submit its proposal for a demonstration training program.

Proposal Writing And Award Of Contract

In the initial preparation of the proposal for DHEW funds, it was recognized that there was a conflict between the health manpower development goals of the federal government and the particular MHMOP training goals of DMF. The federal government was making funds available for a demonstration training program which would serve as a guide for other HMOs. The DMF, however,

*For more detail, see Part III, the Evaluation Report, Section III. B.

wanted to conduct a training program which would meet the specific training needs of MHMOP and its member PCUs. Therefore, the goals which were written into the proposal had to be designed to meet the needs of the federal government as well as those of DMF.

The final DMF proposal was accepted and a contract awarded in July, 1974. The four major goals of the Demonstration Training Program (DTP), established in this contract were as follows:

1. Design an appropriate curriculum for the staff of PCU centers.
2. Develop training methodology appropriate to the implementation of the curriculum.
3. Produce a training manual outlining the procedures that should be followed by other HMOs wishing to implement such a program.

The contract also required that the DTP seek to produce two specific effects as a result of its efforts. First, the program was to seek to improve the levels of information and knowledge about HMO systems among the PCU staffs participating in the training effort. The areas specified were health care administration, finance, operations, management information systems, and marketing. Secondly, the program was to seek to increase PCU staff cohesiveness. In order for DMF to implement the contract, the federal government also required that the following be accomplished:

1. Review the State-of-the-Art of training programs conducted in other health care organizations.
2. Specify the curriculum content to be used by DMF.
3. Specify the training methodologies appropriate to implement each segment of the curriculum.
4. Specify the instructional media for conducting training.
5. Develop the training curriculum materials.
6. Develop the evaluation design.
7. Select the primary care units or IPAs for training as control and experimental groups.
8. Select a consumer panel.
9. Determine the logistical arrangements.
10. Establish two training sessions.
11. Prepare an evaluation of the DTP.
12. Produce the required material for the federal government.

Once these 12 charges were further clarified by the federal government, the DMF project staff commenced the DTP.

DTP PLANNING PHASE

During the pre-planning stages of the DTP, it was decided that it was necessary to obtain HMO training needs data on the participating PCUs. MHMOP's management information system collected these data on all PCU center staffs affiliated with MHMOP, and the appropriate data were made available to the DMF team. These data were gathered via two instruments: the special needs assessment and the baseline information protocol.* The needs assessment instrument determined the perceived HMO training needs of the PCU staffs. The baseline information protocol determined the knowledge base among the PCU staffs about HMOs and specifically MHMOP. These data were important because the special needs assessment did not necessarily reveal completely the level of information and an understanding of the PCU staffs. The analysis of both these sets of data facilitated the task of specifying the training curriculum content areas for the DTP.

After the perceived HMO training needs of the PCU staffs were assessed, MHMOP's central office administrative staff was consulted on their perceptions of what the PCU staffs needed to know about IPA model HMOs, and specifically about MHMOP. These data were utilized along with those from the other instruments to develop the training curriculum. In addition, a consumer panel was selected to work as a body of consumer consultants on the training curriculum. The panel was composed of consumers who are enrolled members of MHMOP and were therefore patients at the PCU centers affiliated with MHMOP. The consumer panelists were asked to express their perceptions of what information the PCU staffs needed to have in order to communicate satisfactorily with patients and their families about MHMOP.

Once the data had been collected from these three interested groups the value of the needs assessment of the PCU staffs became even clearer. It made it possible to reduce any potential conflict between their perceived needs and those expressed by the consumer panel and MHMOP's central office administrative staff. The DMF project staff had the task of resolving any resulting conflicts.

The needs assessment and the baseline information protocol data on the PCU staffs were analyzed with the help of a curriculum consultant, and curriculum objectives were stated. From these, a curriculum flow chart was designed to outline each segment of the training curriculum and the two training sessions that were agreed to in the contract. A curriculum training staff to be responsible for specific segments of the curriculum content was then selected. It was composed of members of MHMOP's central office staff only, in the belief that PCU staff trainees would be more receptive to them than to outside trainers. Furthermore, it was believed that the use of outside trainers would not create as great an opportunity for communication and interaction between PCU staffs and central office staff.

After the curriculum training staff was identified, the development of specific training methodologies appropriate to implement each segment of the curriculum was initiated. This consisted of the selection of effective instructional methods (e.g., lecture, seminar, group discussion, etc.) and instructional materials for disseminating the curriculum content area detail to the trainees.

The instructional media included a role play slide film of four major activities which occur between the consumers enrolled as members of MHMOP and the central office staff of MHMOP. The slide film also included commonly held concerns about the PCU staffs and the MHMOP organization. The instructional media additionally consisted of other slides developed and used by the curriculum training staff during their presentations. An information manual was designed for the trainees and was included in an information packet at registration.**

As required by the contract awarded to DMF, a review of the "State-of-the-Art" was conducted.*** This activity was subcontracted to the Technical Assitance Research Programs, Inc. (TARP). A review of the literature on training programs in health care organizations was conducted to provide the DMF training project staff with models or examples of various types of training activities which had been conducted in other health care organizations. Unfortunately, the literature review did not prove to be very useful because very little has been written on training programs conducted in health care facilities which was directly applicable to the HMO setting.

Criteria for the selection of the PCU centers which would participate in the DTP were developed simultaneously with the curriculum. Due to budgetary and logistical constraints, it was not possible

*For text of "Special Needs Assessment" Form and "Baseline Information Protocol," see Appendices 1 and 2.
**For text of *MHMOP Information Manual*, see Appendix 4
***For text of "State-of-the-Art Review," see Appendix 3.

to include all 19 PCUs affiliated with MHMOP. Only eight of the 19 PCU centers were included in the DTP. Six of the eight actually participated in the DTP (the experimental group), and the remaining two (the control group) did not, so a comparison of change in knowledge base and attitude could be conducted after the training sessions. The PCU center selection criteria consisted of the following:

- Maturity of the PCU center.
- Willingness of PCU staff to cooperate in the project.
- Size of PCU staff.
- Size of PCU enrollment.
- Lack of PCU staff conflict.

Once the participating PCUs were selected, logistical arrangements were initiated for the DTP. At the beginning of the DTP, consistent with the contract requirements which indicated there should be two training sessions, it was decided that there would be an out-of-town weekend session and an in-town follow-up session. Meals, transportation, and hotel rooms were provided for the trainees for the out-of-town weekend session, and arrangements were made during both sessions for coverage of emergent patient care needs of enrollees assigned to the participating PCU centers.

Prior to the implementation of the out-of-town weekend session, the curriculum training staff was requested to prepare and submit a draft of their presentation to the DMF staff for review and comment. Accordingly, the presentations were amended for a dress rehearsal held one week before the out-of-town weekend training session. This gave the DMF staff and the curriculum consultant the opportunity to assess the presentation delivery style of the training staff and make helpful comments. Some of the curriculum training staff members played the role of group leaders for small group discussions. Prior to the first training session, these training staff members were informed of the role they were to play as facilitators of small group discussions, focusing on specific topics.

DTP IMPLEMENTATION PHASE

To implement the DTP, means had to be identified to stimulate the interest of the trainees to participate in the program. Arousing interest required a great deal of time and effort. Direct personal contact was made with each of the participating PCU centers by both DMF staff and individuals of MHMOP's staff to explain the purpose of the DTP and the benefits one would derive by attending the training and follow-up training sessions. Constant reminders of the training sessions, such as telephone calls, letters, flyers, etc., were sent to the participating PCU staffs to arouse their interest and to help ensure their attendance. The selection of a convenient time and place for the two sessions aided considerably.

Prior to the commencement of the training sessions, various onsite arrangements were made. These arrangements included coordination of registration and all registration materials, coordination of the instructional media, and provision of an emergency telephone for the physicians in attendance and a message board.

A decision was made to have an onsite conference coordinator who would be responsible primarily for facilitating the process of adhering to the training agenda time schedule. In addition, the conference coordinator oriented the curriculum training staff to the meeting facilities.

DTP EVALUATION PHASE*

The DTP was evaluated from the two standpoints of process and impact. To avoid contamination and bias in the evaluation of the DTP, the responsibility for the evaluation phase was subcontracted to TARP, the independent corporation which had already done the "State-of-the-Art Review." The evaluation report prepared by TARP does not necessarily reflect the opinion of the DMF staff in all project components evaluated.

The process evaluation consisted of a detailed narrative documentation of all aspects of the origins, planning, and implementation of the DTP. It also consisted of a critical review of these aspects which highlighted significant problems encountered by the DMF team, how they were resolved, and what their implications might be for the planning and development of training programs by other HMOs. In this process evaluation, however, process by which the curriculum had been developed was not included.

To implement the impact evaluation, a classical experimental research design, a control group of PCU centers had been selected during the planning phase. Thus, a comparison of the "before and after" statuses of participatory and non-participatory center staffs was possible. The comparison was thought to provide the evaluators with a measurement of impact or change. The data used were gathered by MHMOP's management information system and made available to DMF for an analysis to be conducted by TARP. In addition, data were also collected by MHMOP's management information system for evaluation by TARP on how well the experimental group liked the format of the out-of-town weekend training session.**

After the evaluation was well underway, the DMF staff and TARP agreed that it was not necessary to have selected an experimental and control group of PCU centers. A "before and after" assessment of knowledge and attitude change would have been sufficient. Selecting a control and experimental group of PCU centers was not effective because many of the PCU centers shared staffs which made it difficult to invite certain staff of a center to attend the training sessions without inviting the others. Those PCU centers which were identified as control groups, but did not share staffs with an experimental PCU center, still heard about the training sessions and assumed they were invited to attend. When they found out they were not, they had problems understanding why. Since the most important task of the DTP was to train as many PCU center personnel as possible, the DMF might have been better advised to include more staff in the training session.

*For more detail, see Appendix 5 "Evaluation Design" and Part III, the "Evaluation Report."
**For text of "Your Opinion Please Questionnaire," see Appendix 6.

SUMMARY: DTP CONCLUSIONS AND RECOMMENDATIONS

The DTP conducted by DMF can be viewed as a success in that both the informational and socialization aspects of the project were addressed successfully as has been documented in the evaluation report. A positive change in attitude on the part of the staff in the experimental group of PCU centers toward MHMOP took place. This change was determined through the administration of the follow-up baseline information protocol questionnaire and through observations by DMF staff. A two-way channel of communication between these PCU centers and MHMOP's central office was initiated as a result of the DTP.

The DMF team learned a great deal about the process of planning and implementing a training program in an HMO setting. They have attempted to document this process in Part II, *Manual For Conducting An HMO Training Program*. The DMF team learned that the training design selected to conduct a training program should only be presented if it can be operationalized in the setting being used for the training ground. It is not recommended that participants be selected and divided into control and experimental groups merely because it is thought that a control group will make the task of conducting an evaluation easier. To the contrary, only one group of participants given a simple pre and post training assessment for changes in knowledge base and attitude should prove to be sufficient. If a control and experimental group are selected from the same HMO setting, it is likely that they will not remain as separate entities throughout the training effort.

Conducting some form of a needs assessment with the potential trainees is highly recommended for several reasons. The first and foremost is that and certainly not sufficient, to define their training needs for them. Secondly, by conducting a needs assessment with the trainees, they will know that some of their ideas have been included in the decision making process for the training effort. In the process, curriculum designers may address some of their expressed needs. A needs assessment with the trainees can also serve as a means of opening up communication and stimulating curiosity which helps to set the stage for the training session.

The utility of a literature review, which summarizes documented data on training programs conducted in settings similar to an HMO, proved to be marginal. There is very little documentation in the literature on this subject and perhaps a wider search should be made. However, the cost of conducting a wider search may be much greater than the benefits gained.

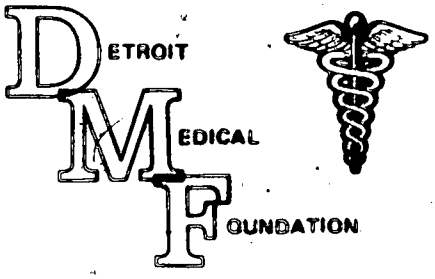
Training should be an ongoing activity within an organization if a significant and lasting impact or change is desired via the vehicle of training. Training that is conducted as a "one shot" activity has marginal results and is not likely to result in change in behavior because reinforcement is lacking. This DTP effort was not designed to address change in behavior directly, but to initiate socialization in the HMO setting and to present needed information to participating PCU staffs. Changes in the behavior of staff which will lead to more effective and efficient delivery of health care services should be the ultimate goal of health manpower development training programs.

Training should create and/or reinforce two-way flow of communication between the central office staff of an HMO and its PCU center staffs. An established and accepted means of communication will better ensure that dissemination and retention of information takes place. It will also open up channels for feedback from the PCU center staffs to the HMO central office staff and vice versa, so that both groups can keep apprised of one another's perceived bottlenecks in the HMO system. There is limited utility in the use of lectures as the primary instructional method for the training effort if the lectures do not allow for two-way flow of communication and informal interaction. Both two-way flow of communication and informal interaction should be created and reinforced throughout the training effort.

Finally, if the training effort is to be successful, a strong commitment must be made to the effort. A strong commitment to the training effort includes not only the employment of a full time staff personnel, but participation on the part of the PCU center staffs and the administrative staff of the HMO in the design of the training effort. If a strong commitment is not made to the training effort, the benefits are likely to be marginal and the costs will be high.

PART II

MANUAL FOR CONDUCTING AN HMO TRAINING PROGRAM



DEMONSTRATION TRAINING PROGRAM

INDIVIDUAL PRACTICE ASSOCIATION (IPA) MODEL HMO TRAINING PROGRAM

MANUAL

FOR IMPROVING THE CAPACITY
OF PCU STAFFS TO FUNCTION WITHIN AN HMO SETTING

CONTRACT NUMBER: 1-MB-44196

November, 1975

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DEMONSTRATION TRAINING PROGRAM

INDIVIDUAL PRACTICE ASSOCIATION (IPA) MODEL HMO TRAINING PROGRAM

MANUAL

SUPPORTED BY
CONTRACT NUMBER: 1-MB-44196

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INTRODUCTION

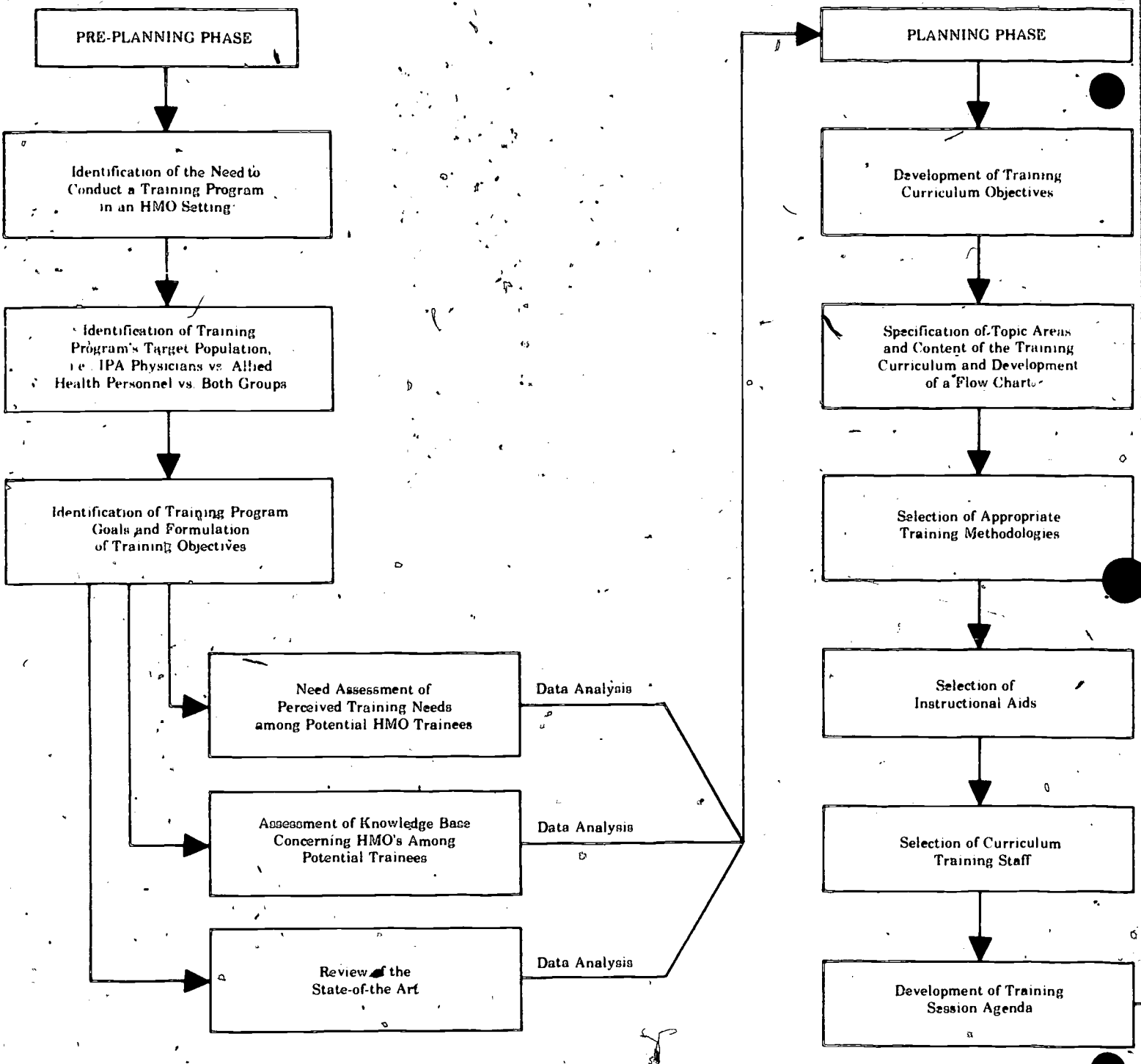
The purpose of this manual is to provide Individual Practice Association (IPA) model Health Maintenance Organizations (HMOs) with a training program design which may be developed to facilitate the transition of medical, para-medical and other health professionals into an IPA model HMO setting.

The training program methods and procedures suggested are the result of the experiences of the staff of the Detroit Medical Foundation (DMF) in the implementation of DHEW Contract No. 1-MB-44196.

The contract title *"Demonstration Training Program to Improve the Capacity of Primary Care Unit Staffs to Function within an HMO Setting"* (DTP) was awarded to the DMF in July of 1974. The contractee was the Division of Associated Health Professions, Bureau of Health Manpower, Public Health Service of the Department of Health, Education and Welfare (DHEW).

". . . Primary Care Unit Staffs . . ." (PCU) referred to in the contract title are the staffs of the contract health services provider groups of Michigan Health Maintenance Organizations Plans, Inc. (MHMOP), the only DHEW funded HMO development grantee in Michigan. MHMOP is an IPA model HMO.

A graphic flow chart presentation of the training program design is shown on pages II-ii-iii. This manual describes in detail the four phases of the DTP approach outlined in the flow chart. This manual also represents part II of a final report prepared by the DMF in compliance with the DHEW contract.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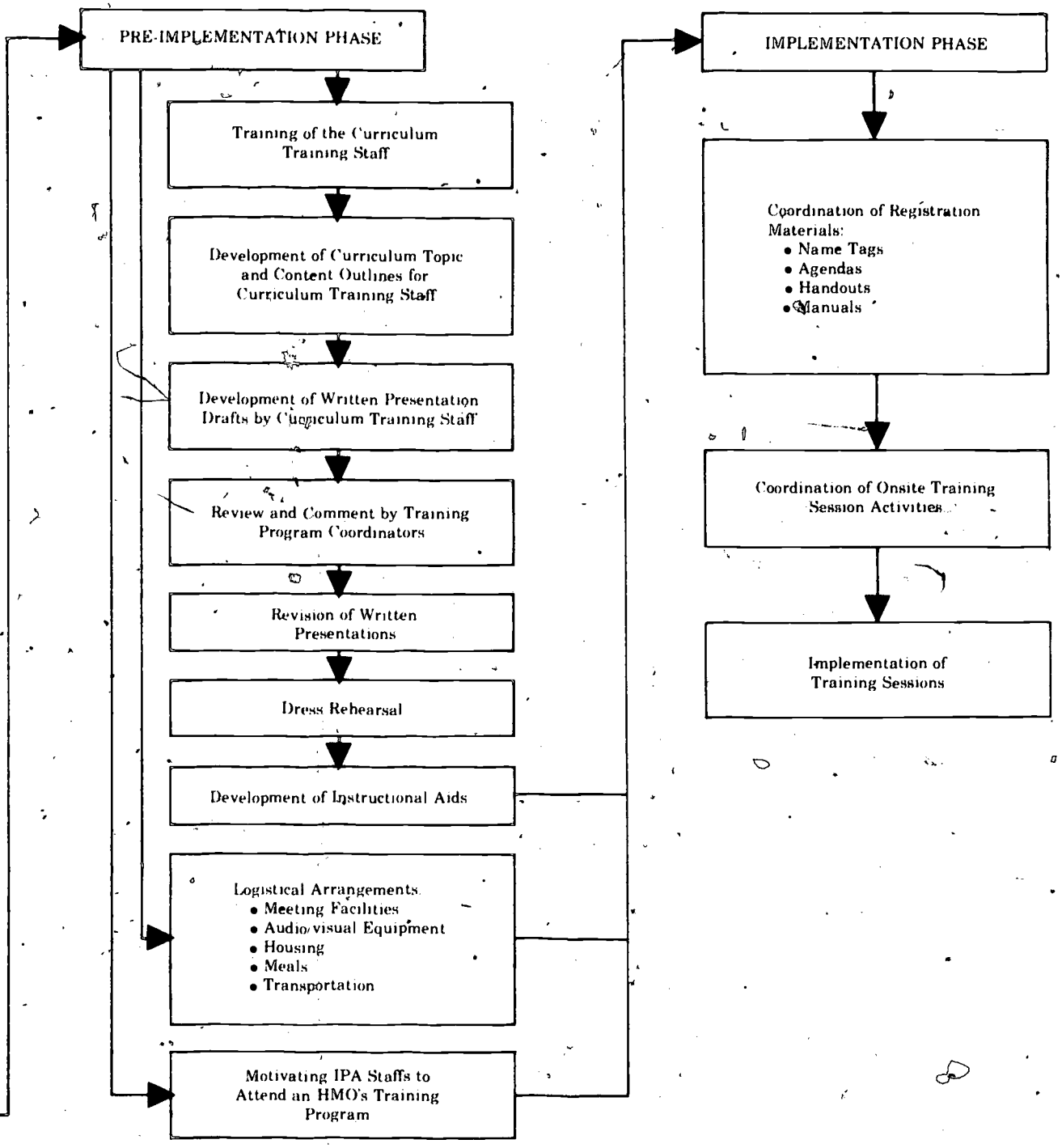
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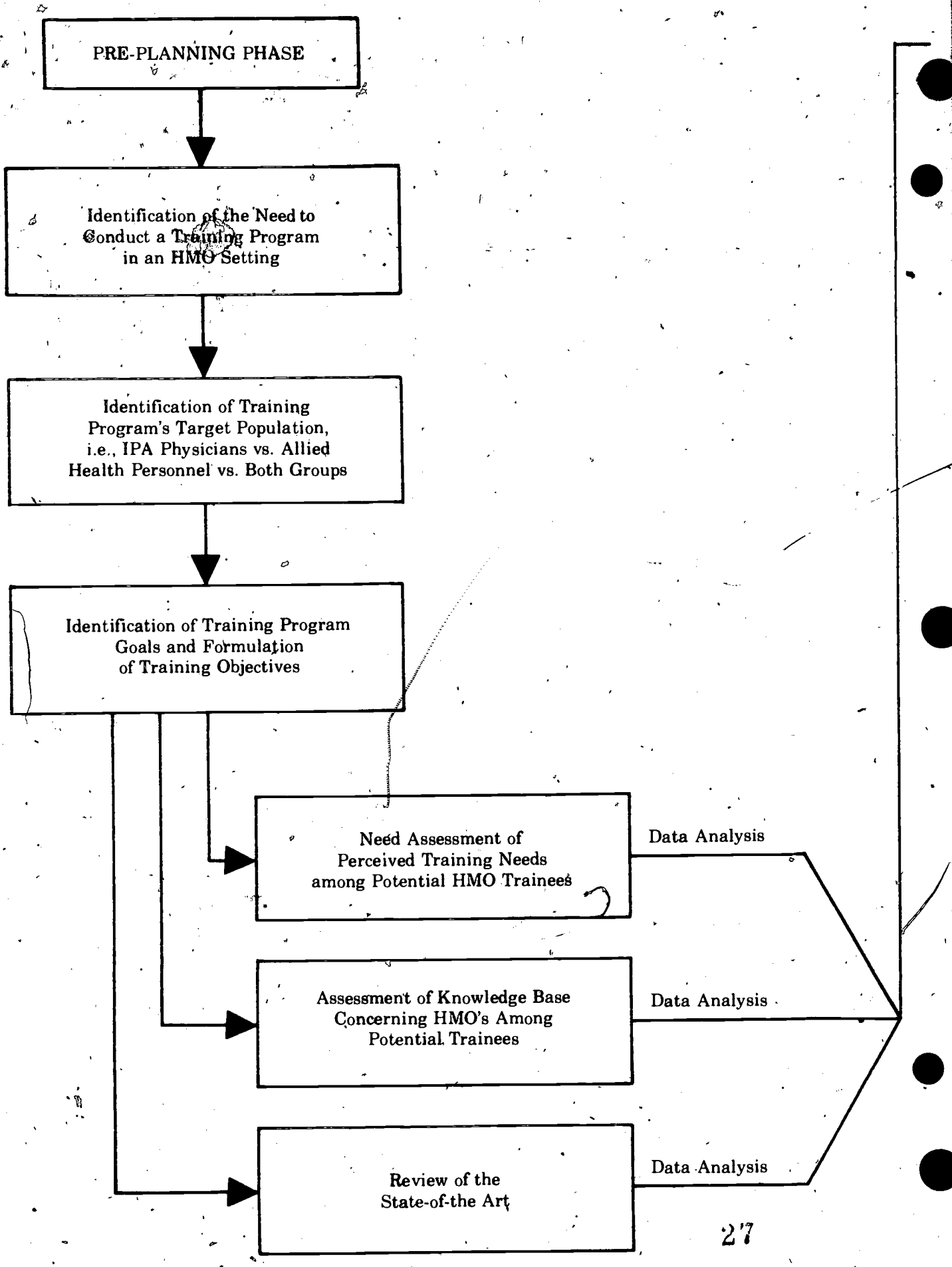
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SECTION I: PRE-PLANNING PHASE

The need for health manpower training in an HMO should be identified during the initial stages of the organization's development. Early identification allows the maximum benefits of training to occur. Once the need for training is identified, broad objectives of the training effort should be formulated and serve as a basis for developing the training program.

Just as important to the training effort is the presence of a full-time training program director. This director should possess the appropriate academic credentials and capability to work with both physicians and allied health personnel. It is this writer's opinion that the training effort may generate more active support of the physicians affiliated with the HMO if the training program director is perceived as, or in actuality is, subordinate to a physician at the administrative level of the HMO. After an appropriate training staff director has been identified and reporting paths established, the regular activities of the pre-planning phase can begin.

IDENTIFICATION OF THE TARGET POPULATIONS

It is important that the target population be identified and defined during the pre-planning phase. This facilitates the collection of relevant data for use in the curriculum design. The target population of an IPA model HMO training program may consist of the HMO's contract PCU physicians only; its allied health personnel only; or a combination of both allied health personnel and PCU physicians. Based upon the objectives of the training program three basic types of data should be collected and analyzed before the training curriculum objectives can be formulated. The three types of basic data are:

1. Needs Assessment
2. Baseline Information Protocol
3. Review of the State-of-the-Art

NEEDS ASSESSMENT OF POTENTIAL TRAINEES

Before an HMO training program curriculum can be effectively designed to meet the needs of potential trainees, their needs must be assessed. An attempt should be made to gather training needs data regardless of potential trainee's prior exposure to the HMO concept.

A needs assessment is conducted with potential trainees allowing them to express freely their perceived training needs. This process is meaningful only if confidentiality of the trainee's response is assured.

The recommended design of the needs assessment to be conducted with potential trainees is the following:

STEPS	PURPOSE	MATERIALS NEEDED
1. Self introductions of all present.	1. Provides an opportunity for each group member to become acquainted with all present.	
2. Explanation of the needs assessment activity to the group.	2. Provides legitimacy to the activity; helps those participating to understand the activity; contributes to participant cooperation.	
3. Administration of the Special Needs Assessment Form.*	3. Helps focus the attention of the group members on their perceived HMO training needs, thus saving time. Provides written documentation of individual needs of group.	3. "Special Needs Assessment Form."
4. Individual reporting of comments made on the special form.	4. Provides group members an opportunity to participate in the group discussion revolving around the individual training needs of group.	4. Resource to record answer.
5. Group discussion of the comments.	5. Provides group members an opportunity to express opinions or seek clarification on comments made by other group members and request additional information.	
6. Group establishes an order of importance for comments; thus sets priorities for training.	6. Provides training team with the group's assesment of its training needs in order of priority.	6. Resource to record answer.

The recommended needs assessment design, commonly referred to as the "round robin" method, facilitates the task of getting all group members involved in the discussion. The DTP design begins with steps 1 and 2 of the recommended design. This is followed by the distribution to group participants of the special needs assessment form. (Step 3.) Participants are asked to record their responses on the form and at the same time assured that their comments will be discussed without identifying their origin. After the forms are filled out, the discussion process is initiated by the project administrator. This process begins by soliciting a volunteer or randomly selecting a group participant to make the first comment. Each participant is given the opportunity to provide additional comments. The comments made by individual group members are recorded in a manner which allows visibility and review by the entire group, i.e., blackboard, easel, etc. As the discussion progresses, the project administrator tabulates similarity of comments, recording the number of group participants who indicated similar comments on their special needs assessment form. This tabulation can be used to identify the number of participants having a particular training need.

The project administrators monitoring activity may also be accomplished by a request that each group member record on index cards their perceived training needs. The tabulation method and/or the index card recording method will result in specificity of training needs.

*"Special Needs Assessment Form," see Exhibit 1.

OTHER NEEDS ASSESSMENT CONSIDERATIONS

Consideration should be given to "when" and "how" the needs assessment is conducted. This is important in an IPA model HMO setting because the needs assessment group sessions may conflict with scheduled clinic operating hours. On the other hand, if the sessions are not scheduled during normal clinic operating hours, the sessions will probably not be well attended.

How the sessions are conducted is important as well. For example, the presence of both allied health personnel and staff physicians in the same needs assessment session may inhibit free and open discussion by both groups.

A comprehensive needs assessment should address the perceptions of both the HMO administrative staff and the HMO enrollees. Knowledge of the administrative staff's perceptions of the affiliated PCU's training needs, as well as the enrollees' view of the HMO's services represents invaluable input during the needs assessment process. The enrollees' input may best be garnered by the use of a consumer panel comprised of a random selection of HMO enrollees.

SUMMARY

In summary, it is recommended a needs assessment activity address the perceptions of potential trainees, HMO administrative staff and HMO consumers. This approach reduces the probability of inadequacies in the training program curriculum design. While analysis of needs assessment data may reveal conflict between the three groups, the identification and resolution of this conflict prior to the implementation of the training program is critical to the development of an effective training program.

Baseline Information Protocol

The "baseline information protocol" was the second assessment tool used. Its purpose was to identify the knowledge level of potential trainees relative to HMOs. This data collection instrument affords the identification of content areas which should, or should not, be emphasized. A variety of methods may be used to identify these content areas:

1. Assessment of questions commonly asked of the HMO's administrative staff by the HMO PCU staff.
2. Determination of areas of conflict relative to information exchange.
3. Evaluation of reporting mechanisms between the HMO administrative offices and the PCUs.

A questionnaire may be used to collect this data from potential trainees.

Scheduling problems and assurances of confidentiality for respondents are also pertinent to the administration of the information protocol. Prior to the administration of the information protocol, questionnaire respondents should be advised of its purpose, the confidential manner in which their responses will be tabulated and assured that they are not taking a "test." The questionnaire design must also acknowledge the awareness level of its anticipated respondents.

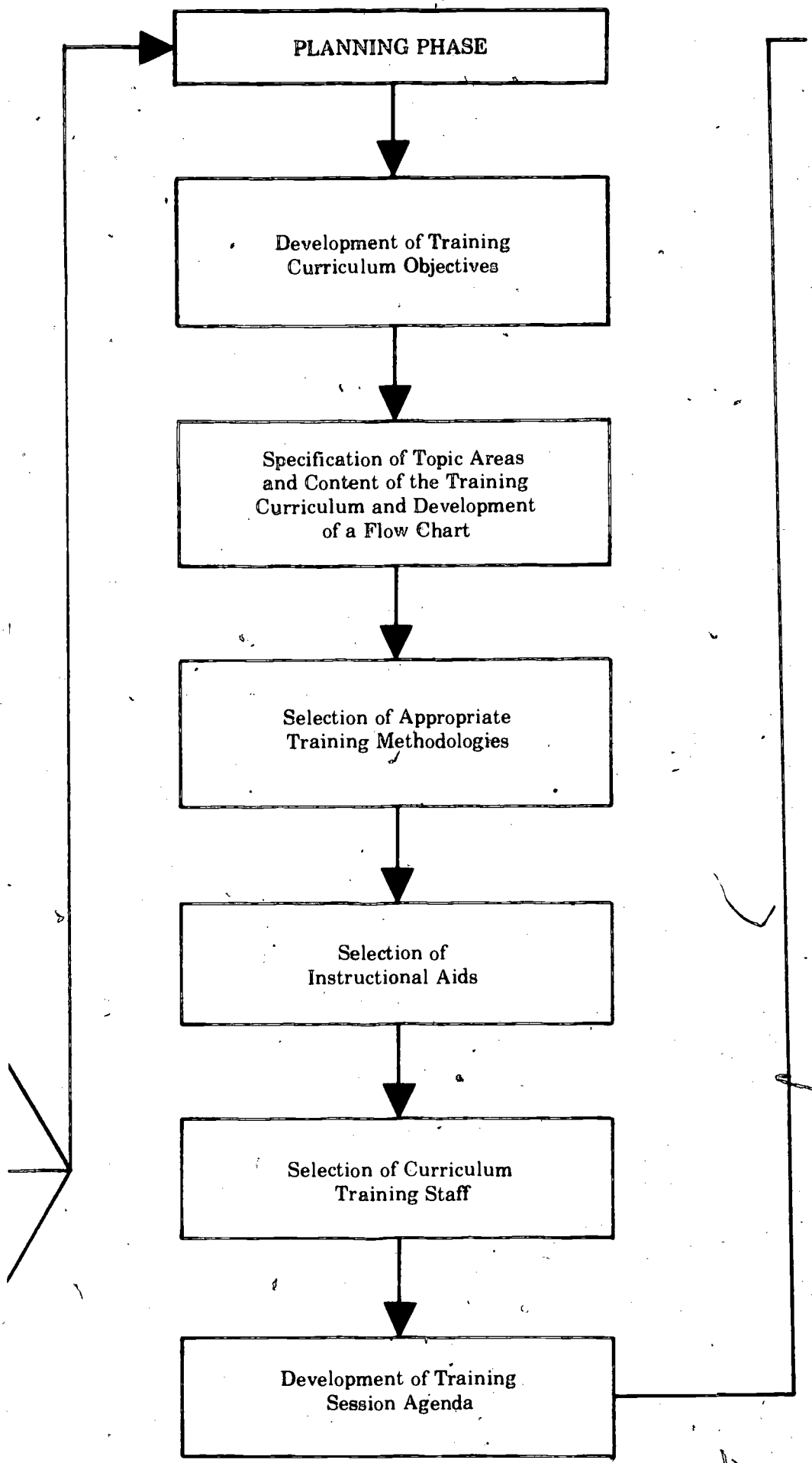
Planned group discussions may be used as an alternative to a written instrument. The discussion content should focus on the same issues addressed in the written instrument. Responses are recorded by the discussion leader.

Review of the State-of-the-Art*

Ideally, a review of the current available health manpower training literature would provide guidelines in the design of a training program for the IPA model HMO. To provide maximum benefit, the review should be initiated and completed prior to the planning of the training program. However, we found limited published material pertinent to HMO manpower training, since the HMO concept is relatively new.

It is our expectation however, that this manual will be a meaningful addition to the literature as a guide for those attempting to conduct an HMO health manpower training program in an IPA model HMO setting.

*See Exhibit 3, DMF Demonstration Training Program "State-of-the-Art Review"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Formulating Training Curriculum Objectives

A training program curriculum can be developed once the following data have been collected and analyzed:

1. Needs Assessment conducted with an HMO's
    a. potential trainees
    b. administrative staff
    c. consumer representatives.
2. Baseline Information Protocol conducted with an HMO's potential trainees.
3. Review of the State-of-the-Art.

Training curriculum objectives should be based on the objectives of the training program, as well as the data bases which are collected via the needs assessment and baseline information protocol. Formulation of the training curriculum objectives may be directed towards: (1) increasing levels of knowledge, and/or (2) changing attitude, and/or (3) changing behavior.

The following are samples of training curriculum objectives:

1. To improve the levels of knowledge among PCU staffs about the differences between HMOs and traditional forms of health care delivery.
2. To improve the ability of PCU staffs to identify the major divisions and division responsibilities of the parent HMO.
3. To improve the level of understanding of the HMO enrollee benefits and rights.

Specification of Training Curriculum Topics and Content

The topics and content of the the training curriculum are developed directly from the curriculum objectives. These objectives should determine the specific directions for the training.

An illustration of possible topics and content for an HMO training curriculum is presented below. As stated earlier, these should be based on the needs of the potential trainees, HMO administrative staff, and consumer representatives. (Curriculum content topic areas are the outline headings, content area detail are the specific elements addressed.)

1. **What is an HMO?**
    A. Definition.
    B. Description of how HMOs differ from other health plans.
    C. Types of HMOs.
    D. Patient Rights within an HMO setting.
2. **How Michigan Health Maintenance Organization Plans, Inc. Operates**
    A. Description of major departments and divisions of the HMO Plan and their major areas of responsibility.
    B. Identification of department and division heads of HMO central office.
    C. Services provided to the HMO enrollees.

1. Basic and supplemental health services covered by the HMO Plan.
2. Special enrollee services, i.e., emergency services, grievance mechanism, etc.

D. Enrollment process.

E. Enrollment orientation process.

F. Financial Structure of the HMO Plan.

1. Capitation payments.
2. Fee-for-service payment mechanism.
3. Risk-sharing.
4. Hospital payment mechanism.

Development of Training Curriculum Flow Chart

A curriculum flow chart should be developed and implemented to facilitate the organization of all training program components. Exhibit IV is an example of this type of chart. The curriculum flow chart defines and outlines all major components of the training program and training curriculum which may include:

- Training program objectives
- Training curriculum objectives
- Curriculum topic areas and content
- Training methodologies
- Instructional aids
- Curriculum training staff
- Time schedule for training presentations and discussions.

Selection of Training Methodologies

Once the curriculum content topic areas and content area detail have been defined, the appropriate instructional methods for conveying the content detail may be selected. The perceived training needs expressed by potential HMO trainees are important to keep in mind when instructional methods are being selected. For instance, analysis of the needs assessment data may reveal the need for potential trainees to engage in two way communication with administrative staff of an HMO. In such a case, instructional methods selected for the training effort should not prohibit two way communication and, indeed, should enhance it.

There are several formats which may be used for training sessions. The following are examples:

TYPE	PURPOSE	CHARACTERISTICS
Lecture	Provide information	Primarily one-way flow of communication; curriculum training staff serves as the resource.
Small Work Groups	Solve hypothetical problems and/or discuss mutual problems	High participation; opportunity to engage in face-to-face interaction; trainees and curriculum training staff both serve as resources.

TYPE	PURPOSE	CHARACTERISTICS
Seminars	Exchange information or opinion	High participation; experience sharing, face-to-face groups; trainees and curriculum training staff are both resources; training staff serves as leaders and content experts.
Conference	Provide a variety of training experiences over an extended period of time	General sessions; some face-to-face groups; curriculum training staff provides most resources.

The exclusive use of lectures as the instructional method is not recommended. Retention of information disseminated through lectures will be greater if trainees are given an opportunity to discuss information which is addressed in the lectures. Communication is enhanced via participation in small groups and special seminars.

Selection of Instructional Aids

Instructional aids, both printed and audio visual, may be developed as supplements to the training curriculum. Aids may include, but are not limited to, handouts, charts, slides, films, and manuals. While instructional aids can be effectively used to facilitate dissemination of information to trainees, it is important that they be well coordinated with the presentations for which they are designed. If audio visual aids are poorly selected, prepared, and integrated into a training program, they can be confusing and distracting for the audience. Conversely, a movie or slide film well selected to illustrate or address a portion of the training curriculum can add to the pacing and variety of a training session. If it is decided, instructional aides will be used for training, sufficient lead time should be allowed for their development.

An HMO information manual similar to the manual prepared for this project may be prepared as a supplement to the training curriculum.* This type of educational tool may be very useful to the trainees as a continuing reference. If it's determined an HMO information manual will be used, the manual should cover the major topic areas and content of the training curriculum. The manual should be indexed for easy reference.

Curriculum Training Staff

Selection of a curriculum training staff should occur after the selection of appropriate training methodologies and instructional aids. Since the selection of competent trainers is crucial to the effectiveness of a training curriculum, the process by which they are chosen is important. Project staff must give careful thought to criteria for the selection of training staff. These criteria should include: (1) potential training staffs' competency in the training methodologies chosen for the training curriculum and (2) previous experiences as trainers or group leaders. Consideration might also have to be given to the ethnicity and sex of the trainers.

*See Appendix 4, DMF Final Report, *"MHMOP Information Manual."*

The curriculum training staff may consist of either professional trainers or staff members of the HMO's central office. It is to be noted that one major disadvantage of using trainers who are not members of an HMO's staff is that the trainees may not be receptive to a trainer perceived to have no formal work responsibilities in the HMO setting. Once the staff is selected, they should be thoroughly briefed on how to effectively play their specific roles as curriculum training staff members.

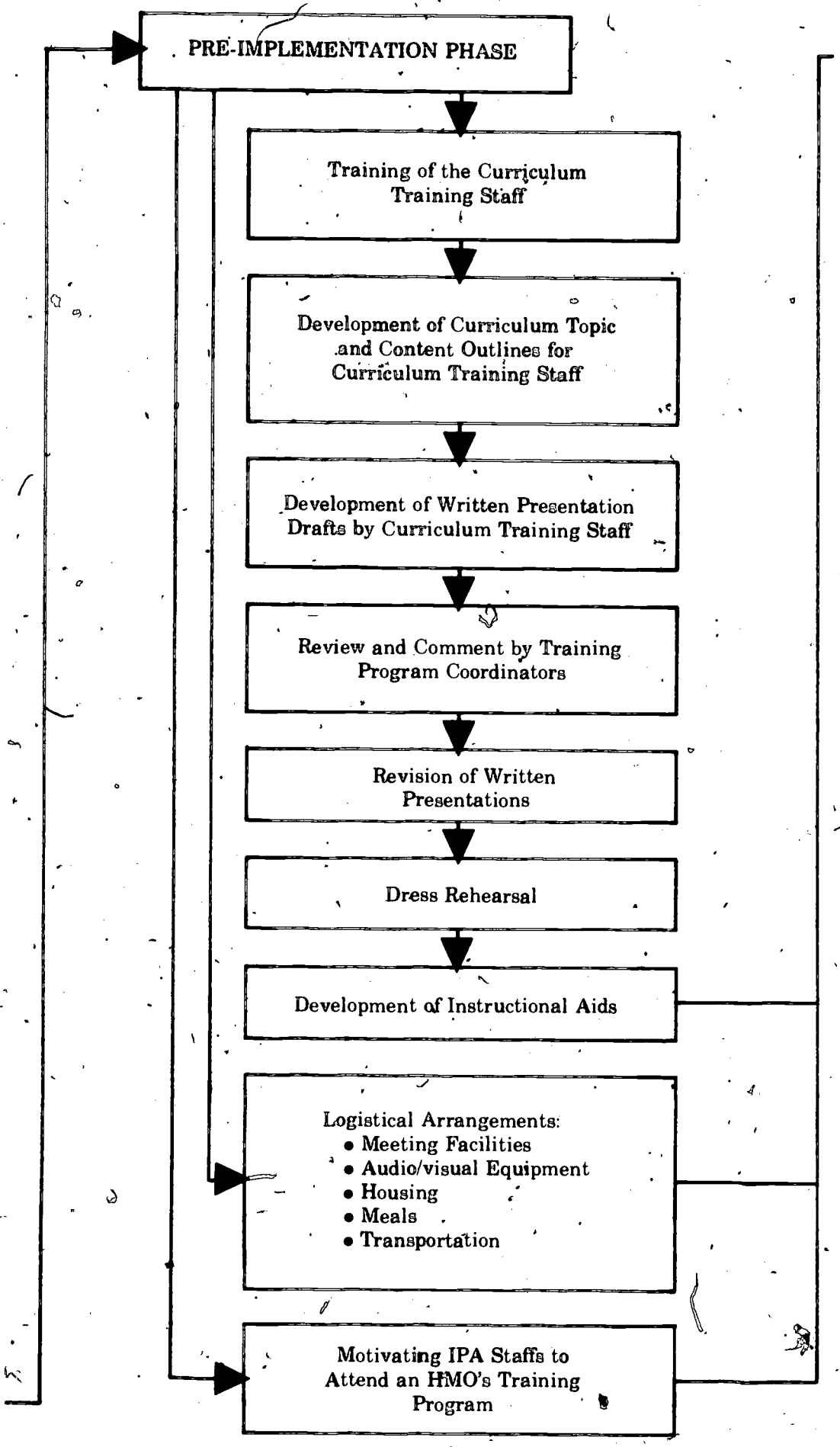
Development of Training Session Agenda

The agenda for the training session should be developed easily from the training curriculum flow chart already described. It should indicate the exact times and meeting rooms for all scheduled activities, including breaks and meals.

If a decision has been made to train both PCU staff physicians and allied health personnel, separate agendas may be necessary, at least for some sessions of the training program. If two separate agendas are designed, color coding is recommended for efficient management of the trainees. It will be easier for each group of trainees to determine where their specific group is supposed to be at any given time.*

A variety of activities may be included as part of a training session. Consideration should be given to scheduling an informal "icebreaker" as a kickoff to a training session. This type of nonstructured gathering gives the trainees, curriculum training staff, and other attendees an opportunity to interact socially with one another before the commencement of formal training activities.

*DMF training session agenda, see Exhibit V.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Training a Curriculum Training Staff

A curriculum training staff should be informed, in writing, of the specific content and topics for which they are responsible. To facilitate this task, it is suggested that topical outlines be prepared for each person on the training staff. The outline should include an indication of the training methodology to be used as well as an indication of the amount of time allotted for each topical area.

The curriculum training staff should be asked to submit drafts of their lectures, discussion questions, and other presentations for review and comment by the coordinators of the training program. Since the quality of these presentations is important to the success of the training program, the drafts should be critically reviewed and returned to the training staff for revisions and polishing.

A dress rehearsal should be scheduled prior to a training session. All lectures and presentations should be delivered by the curriculum training staff. An assessment of the effectiveness of each person's delivery style should be made by project staff. The assessment should result in suggestions for helpful changes in the oral presentation.

The curriculum training staff responsible for leading special seminars and workshops should be well informed of the roles they are to play. Consideration should be given to having a briefing session, specifically for those responsible for leading seminars and workshops. The content of this training session should focus on leadership styles which encourage participation and facilitate group discussion.

Development of Instructional Aids

While instructional aids may greatly enhance the program curriculum their use must be planned consistent with the environment in which they are to be used, e.g., room size, visibility by participants, accoustics, etc. Although instructional aids may appear to be easily produced, it should be kept in mind that effective aids require the expertise of competent professionals. Such professionals require adequate lead time to prepare informative presentations.

Logistical Arrangements

The initial decision must be the location of the training site concomitant with the relative merits of the accessibility of the training site for the program participants. While a conveniently accessible site may enhance physician participation, the proximity of the physician to his patient may lead to his being called from the conference. Therefore, consideration should be given to planning an out-of-town session to which all participants must make a special commitment.

The number of trainees should be determined at the earliest possible date. Pre-registration forms may be used for this purpose. In the event transportation, housing and meals are required, the appropriate arrangements must be made. Relevant considerations in terms of selection sites are meeting room size and number; setting, aesthetics; and other desired amenities of training program participants.

Size and number of training rooms and audio-visual requirements may be determined by agenda requirements. In the event an optimal training site is unavailable, the training agenda must be structured to fit the training site accomodations.

Motivating PCU Staffs to Attend an HMO Training Program

An HMO training program should be legitimized in the eyes of its training program participants. One way to accomplish this task is to include identifiable program participants in the early planning phases of the project. The needs assessment study previously described is an example of this inclusion.

Training program participants must have the impression that the training effort is a sincere attempt to meet their needs.

Following the initial announcement of the training program plans, contact should be made with all PCU staff expected to participate. This contact should consist of a statement of purpose for the training program and the benefits to be gained by attending. In addition, letters, telephone calls, flyers, etc., should be used as a means of continually reminding PCU staffs of the pending HMO training program.

Some difficulty may be experienced because PCU staff physicians and allied health personnel provide health care services to fee-for-service patients as well as HMO patients. Consequently, attempts should be made to schedule training sessions in a time frame that will cause minimum conflict with regular scheduled clinic hours. However, in the event that conflict-free scheduling is not possible, rescheduling of clinic hours by the program director should be investigated.

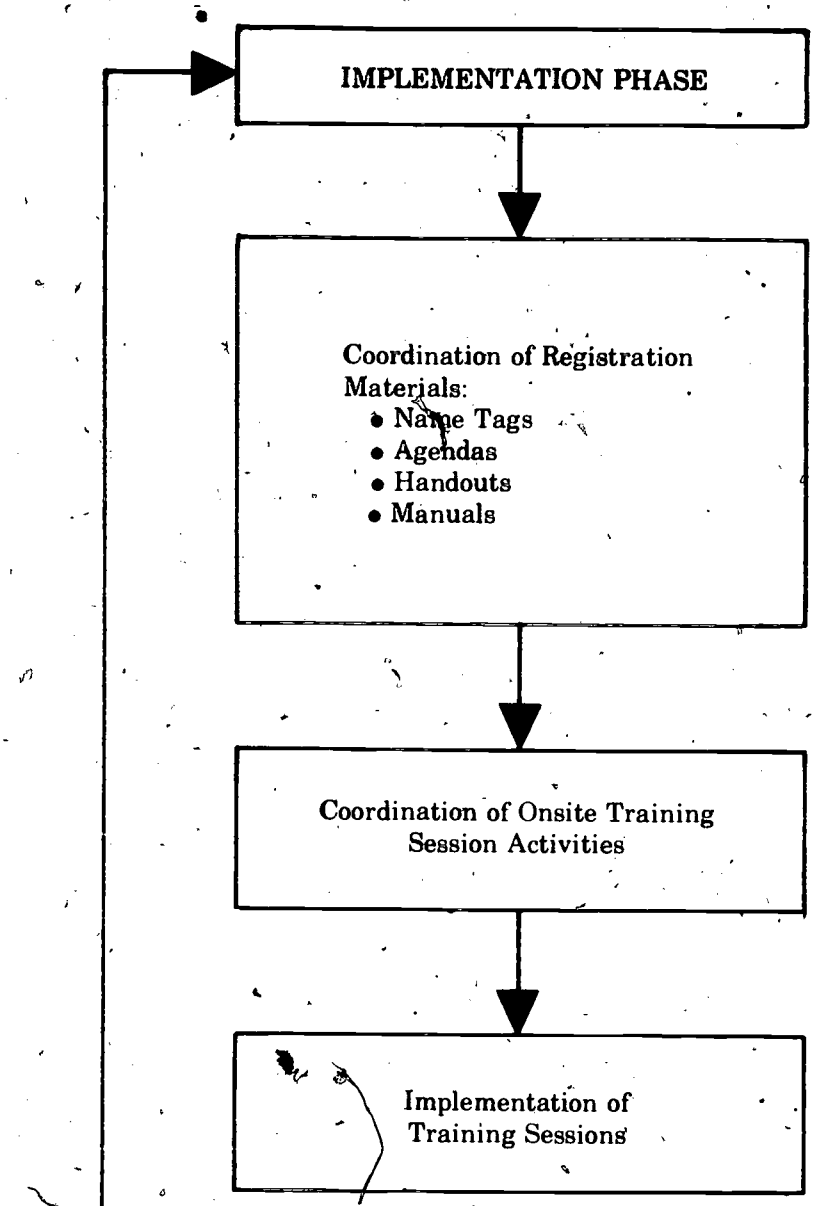
Rescheduling of clinic hours may not occur without some form of peer group persuasion. Peer group persuasion may be initiated by physicians who are members of an HMO's administrative staff and who are also involved in conducting the training program.

A significant issue of clinic rescheduling for PCU staff is potential loss of income which may result from an interruption of usual clinic hours. To compensate for potential loss of income, consideration should be given to paying PCU staffs a stipend for attending an HMO training program.

Other incentives which may motivate PCU staffs to attend an HMO training program are:

- Inclusion of PCU staffs in planning of the training curriculum
- Selection of a convenient meeting time
- Selection of an attractive meeting place
- Selection of a well-known guest speaker
- Provision of continuing education credits for participation in a training program

A great deal of time and effort may be required to motivate potential trainees to attend the training sessions. Hence, the training program must be effectively publicized to potential trainees. Incentives for motivating a high level of attendance must be well planned and implemented far in advance of implementation of a training session.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• Agendas
• Handouts
• Manuals
Coordination of Onsite Training Session Activities
Implementation of Training Sessions

Coordination of Registration Materials

Registration materials should be assembled prior to training sessions. An information packet may be prepared as a means of distributing name tags, training session agendas, handouts, manuals, and all other materials which will be used during a training session. All training materials prepared for trainees should be distributed at one time to avoid interruptions during training session activities.

The handouts should be prenumbered before being inserted into an information packet. The numbers will make it easy for curriculum training staff to refer to the handouts during their presentations.

Coordination of Onsite Training Session Activities

A registration desk should be prepared and staffed throughout the training sessions in case there are late arrivals. A registration desk may also serve as an information booth.

It is very important for physicians in attendance at a training session to be contacted in the event a medical emergency arises with one of their patients. Arrangements should be made to provide a special emergency telephone for physicians. The emergency telephone arrangements should be made in advance, and an emergency telephone number announced to the physicians prior to a training session. A message board should also be placed at the registration desk in case an emergency call is made and a physician cannot be reached.

The training session meetings should move smoothly and on a scheduled basis. To facilitate this, a specific individual should be designated as an onsite conference coordinator. This coordinator *must know* the schedules of the curriculum training staff and the trainees during each phase of a training session. A second individual, a conference monitor, should also be responsible for keeping a training session moving according to a predesignated time schedule. For instance, in each meeting, the speaker should be informed when his alloted time is drawing near so that he may begin to summarize his presentation. This can be effectively handled by the monitor raising a color-coded card indicating "5 minutes", "3 minutes", and "time".

Prior to commencement of a training session, curriculum training staff should be oriented to the meeting facilities. They should know which of the meeting rooms they will be using for presentations or small group workshops. In addition, a curriculum training staff person should know where podiums, microphones, and lights are located in each meeting room and how to operate them.

SUMMARY

This manual describes a sequence of steps for developing and implementing an IPA model HMO training program. To provide a quick overview of this sequential process, the Introduction contains an IPA Model Training Program Flow Chart. The manual is then divided into four sections each of which presents a phase of the training approach in detail as follows:

SECTION I presents the Pre-Planning Phase which describes the necessity of identifying the need for a training program and the training needs of the target population. Goals and objectives are derived from data gathered in a needs assessment study of the trainee population; a baseline information protocol study, and a review of the State-of-the-Art.

SECTION II presents the Planning Phase in which objectives are identified and used to specify a training program curriculum. Possible curriculum topics, a curriculum flow chart, training methodologies, instructional aids and training session agenda are described. Selection of training staff is considered.

SECTION III presents the Pre-Implementation Phase in which a curriculum staff training program and the development of instructional aids for that staff are implemented. Other considerations include logistical arrangements and motivational strategies to ensure trainee participation.

SECTION IV presents the Implementation Phase in which the coordination of activities relevant to trainee registration, onsite training activities, and specific training meetings are reviewed.

While no manual or guide is ever complete, it is hoped that this manual will serve as valuable assistance to others who are attempting to conduct training programs in an IPA model HMO.

EXHIBIT I

"Special Needs Assessment Form"

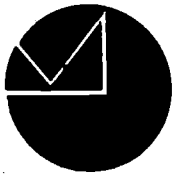

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EXHIBIT I — "Special Needs Assessment Form"

PLEASE USE BRIEF ACTION STATEMENTS

1. What would you like to have included in a training activity that would be beneficial to you in working in this center?

2. What would you like to have included in a training activity that would be beneficial to you in working with HMO Central?

3. What kinds of changes would you like to see happen as a result of training?

EXHIBIT II

"Baseline Information Protocol"

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EXHIBIT II — "Baseline Information Protocol"

I. MHMOP Central Office has a number of departments which are listed below. For each department, please check off TWO answers:

Column A: "YES" you knew it existed, or "NO" you did not know.

Column B. REGARDLESS of your answer for Column A, check the box which most nearly expresses your opinion about such a department.

Department	Column A		Column B				
	YES knew	NO did not know	Necessary to run ANY large operation	Necessary to run this kind of operation	Required by HMO rules NO CHOICE	NOT necessary but useful	Not necessary should be eliminated
1. Administration							
2. Marketing							
a. Public Relations							
3. Systems							
a. Medical Records							
4. Finance							
5. Operations							
a. Health Services							
b. Health Education							

— Continued —

II. Follow are some terms and for each there are several definitions. Place a check in the box next to the one you think is most nearly correct when used in relation to HMOs.

A. **Capitation** (for HMOs) can be defined as:

☐ 1. An insurance premium, of which the amount depends on who the enrolled person is.

☐ 2. Some fixed amount paid per enrolled person.

☐ 3. Some fixed amount paid per enrolled person for a fixed set (package) of services.

B. **Fee-for-Service** Feature of HMOs is:

☐ 1. A portion of the funds which pays the higher compensation rates of members (doctors) who are classified as consultants or specialists.

☐ 2. A portion of the funds which pays medical services not provided by MHMOP but covered by the service package for the enrollees.

☐ 3. A portion of the funds which pays for physician services rendered to the patient while in hospital.

C. **Risk Sharing** in HMOs:

☐ 1. Is a form of malpractice insurance.

☐ 2. Means that any deficit incurred by your health center will be directly paid by your group and your group alone.

☐ 3. Is a portion of the total capitation set aside into a reserve fund to protect the financial interests of all health centers.

— Continued —

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II. Cont'd.

D. **Benefit Package** in HMOs:

☐ 1. An identical range of health services which are guaranteed by MHMOP, regardless of the medical group in which the individual is enrolled for care.

☐ 2. The range of health services to which an enrollee is entitled and which is defined by the individual medical group contract.

☐ 3. Those health services deemed necessary by the patient's physician.

E. **Referrals to Specialists** who are **not** under a capitation contract with MHMOP are paid for by:

☐ 1. The group to which the doctor making the referral belongs.

☐ 2. Out of capitation with prior approval of the MHMOP.

☐ 3. Out of the risk sharing fund with prior approval of the MHMOP.

☐ 4. Out of the fee-for-service fund with prior approval of the medical group.

☐ 5. None of these. (Please describe your understanding of this payment arrangement.)

— Continued —

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III. Below is a list of services which enrollees may either need or request from your group. For EACH check ONE box.

Health Service	Provided by			Not provided at all	Don't Know
	Your group	Referral from you	Referred from MHMOP Center		
1. Prenatal Care					
2. Eye Glasses					
3. Rhino-plasts (cosmetic)					
4. Outpatient X-Ray Studies					
5. EKG & EEG					
6. Abortions					
7. Dental Care					
8. Psychiactric Outpatient					
9. Contact Lenses					
10. Emergency Room Services					
11. Tubal Ligation					
12. Vasectomy					
13. Inpatient Hospital-ization					

(Continued on next page)

(Cont'd)

Health Service	Provided by			Not provided at all	Don't Know
	Your group	Referral from you	Referred from MHMOP Center		
14. Dermatologists					
15. Allergists					
16. Podiatrist					
17. Nutrition Counseling					
18. Health Care (domestic)					
19. VNA					
20. Psychiatric Inpatient					
21. General Surgery					
22. Family Planning					
23. Health Education					
24. Prescriptions					
25. Ambulance					
26. Transportation (other than ambulance)					

— Continued —

III. (Cont'd)

When you talk to an enrollee about a request for a specific service, do you:

☐ 1. Refer to a written guide, list or set of instructions to help you.

☐ 2. Consult with someone in your office.

☐ 3. Call up the MHMOP Central Office.

☐ 4. Already know the answers because you have been doing this for so long.

IV. Which of the following statements best reflects your experience with MHMOP's Central Office:

A. **In regard to enrollees' service requests:** (CHECK ONE)

☐ 1. People at the MHMOP Central Office are unreasonable and demand special deals whenever a patient calls them up and makes waves.

☐ 2. When the MHMOP Center people call up about a service request, it's usually a situation where they are justified in intervening.

☐ 3. It's hard to say; sometimes the MHMOP Center people are reasonable and other times they are not.

B. **In regard to complaints by patients:** (CHECK ONE)

☐ 1. The MHMOP Central Office always takes the patient's side and doesn't listen to reason.

☐ 2. The MHMOP Central Office seems to make reasonable evaluations of complaints and calls to our attention usually on those where a problem does exist.

☐ 3. It is hard to say; sometimes the MHMOP Central Office seems to take sides, other times it seems to be reasonable.

— Continued —

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V. Now a final question. Please check the one statement that most closely reflects your experience in regard to *Enrollment:*

☐ 1. The people at the MHMOP Central Office who enroll new members either don't know about the services that are covered or else they deliberately exaggerate just to "make a sale", because most new enrollees demand much more than they are entitled to.

☐ 2. Some new enrollees don't seem to know what joining MHMOP means and what they are entitled to, but some new enrollees do know fairly accurately.

☐ 3. Most of the time, new enrollees know what they are entitled to and what enrolling means.

* * * * * * * *

Please indicate your function in your health center by checking the appropriate box:

☐ Patient Care: Physician

☐ Patient Care: RN, LPN, Medical Assistant or Aide, Receptionist

☐ Office: Administrator or Administrative Assistant, Manager, Typist, Clerk, Secretary, Billing, Accounting, Bookkeeping

☐ Other: Medical Records, Laboratory or X-ray Technician, etc.

THANK YOU!

EXHIBIT III

"State-of-Art Review"

Exhibit III was removed at the ERIC Clearinghouse on Career Education because it is duplicated by Appendix 3.

EXHIBIT IV

DMF SAMPLE TRAINING PROGRAM
CURRICULUM FLOW CHART

EXHIBIT IV

DMF SAMPLE TRAINING PROGRAM

TRAINING PROGRAM OBJECTIVES	TRAINING CURRICULUM OBJECTIVES	CONTENT DETAIL
1. To improve the level of knowledge and information about important operational components of the Michigan Health Maintenance Organization Plans, Inc. (MHMOP) among the staff of the Individual Practice Association (IPA) Primary Care Units (PCUs) in attendance at the training sessions.	1a. To improve the level of knowledge about the difference between health maintenance organizations and traditional forms of health care delivery among the PCU staff.	1a. **HMO CONCEPT** (1) Definition of HMOs (2) How HMOs differ from other pre-paid health plans (3) Types of HMOs (4) Patient rights in an HMO setting
	b. To improve the ability of PCU staff, to name the major divisions of MHMOP and the areas of responsibility of each major division.	b. **How MHMOP Operates** (1) Description of all departments and divisions of MHMOP and their area of responsibility (2) Identification of department and division heads (3) Description of health services available via MHMOP central office referral (4) Explanation of fee-for-service payments (5) Description of how the Michigan HMO plan is marketed

CURRICULUM FLOW CHART

EXHIBIT IV

INSTRUCTIONAL METHOD	INSTRUCTIONAL AIDS	CURRICULUM TRAINING STAFF PERSON RESPONSIBLE	TIME SCHEDULE
1a. Lecturettes-question and answer sessions	1a. Slides of supplemental and basic health services	1a. (1)-(3) Senior Executive Vice President	1a. (1)-(3) 1 hour
		(4) Corporate Counsel	(4) 15 minutes
b. Lecturettes, question and answer sessions, small group workshops.	b(1) MHMOP's organizational flow chart	b. (1)-(2) Director of Health Care Administration	b. (1)-(2) 30 minutes
	(2) Health Care Administration flow chart		
		(3) Manager of Health Care Administration	(3) 15 minutes
		(4) Manager of Claims Processing Division	(4) 15 minutes
		(5) Director of Marketing	(5) 15 minutes

EXHIBIT V

SAMPLES OF TRAINING SESSION AGENDA

EXHIBIT V

DETROIT MEDICAL FOUNDATION EDUCATION CONFERENCE ON HMOs

PHYSICIAN GROUP

SATURDAY — July 26, 1975

8:00 - 9:00 a.m.	BREAKFAST *(Rooms — Devonshire, Gad's Hill and Dickens Room)*	
9:00 - 9:10 a.m.	Welcome *(Rooms — Betsey Trotwood and Luke Honeythunder)*	William O. Mays, M.D. *President, DMF* *President, MHMOP*
9:10 - 9:15 a.m.	General Introductions	John L. Loomis, M.D. *Project Director, DMF*
9:15 - 10:15 a.m.	"What is an HMO?"	W. Melvin Smith, M.B.A. *Vice President, DMF* *Senior Executive Vice President, MHMOP*
10:15 - 10:30 a.m.	"Patient Rights"	Richard T. White, Esquire *Corporate Counsel*
10:30 - 10:45 a.m.	Questions and Answers	Moderator John L. Loomis, M.D. *Project Director, DMF*
10:45 - 11:00 a.m.	COFFEE BREAK	
11:00 - 11:30 a.m.	"How Michigan Health Maintenance Organization Plans, Inc. (MHMOP) Operates" *(Rooms — Betsey Trotwood and Luke Honeythunder)*	O. Larkin Isaac, M.B.A. *Director of Operations*
11:30 - 11:45 a.m.	"Health Services Available via MHMOP Central Office Referral"	Sandra Billingslea, M.S.W. *Manager Health Care Administration Division*
11:45 - 12 Noon	"Fee-for-Service Utilization"	Bruce E. Mullican *Manager Claims Processing Division*

SATURDAY — July 26, 1975 (cont'd)

12 Noon - 12:15 p.m.	"How the Michigan HMO Plan is Marketed" ..... Fred Prime *Director of Marketing*
12:15 - 12:30 p.m.	Questions and Answers ..... Moderator John L. Loomis, M.D. *Project Director, DMF*
12:30 - 1:15 p.m.	BREAK
1:15 - 2:15 p.m.	LUNCH *(Rooms — Betsey Trotwood and Luke Honeythunder)*
2:15 - 2:45 p.m.	Luncheon Speaker ..... T. H. Billingslea, M.D. *Executive Vice President* *Health Care Administration*
2:45 - 3:00 p.m.	BREAK
3:00 - 4:30 p.m.	Financial Structure of the Plan *(Room — Tilly Slowboy)* Capitation Payment Mechanism ..... Karl Haiser, M.B.A., C.P.A. *Director of Finance* Fee-for-Service Referrals and the Payment Mechanism ..... Bruce E. Mullican *Manager Claims Processing Division* Additional Comments ..... W. Melvin Smith, M.B.A. *Vice President, DMF* *Senior Executive Vice President, MHMOP*
4:30 - 4:45 p.m.	COFFEE BREAK
4:45 - 6:00 p.m.	"Coblestone Conferences" Informal Small Group Discussions with MHMOP Personnel *(Rooms — Tilly Slowboy, Betsey Trotwood and Luke Honeythunder)* **TOPICS:** **Health Care Services** ..... Sandra Billingslea, M.S.W. *Manager Health Care Administration Divisio*

ATURDAY — July 26, 1975 (cont'd)

4:45 - 6:00 p.m. (cont'd)

Patient Referrals and Billing Technicalities of Referrals ..... Bruce E. Mullican
Manager Claims Processing Division

Capitated Services ..... Karl Haiser, M.B.A., C.P.A.
Director of Finance

Medical Records ..... Alegro J. Godley, M.D.
Corporate Medical Director
Dorothy Douthitt, A.R.T.
Medical Records Librarian

Enrollee Concerns ..... Barbara Sue Brown, Supervisor
Subscriber Services

Enrollee Orientation ..... Andrea Williams, Supervisor
Enrollee Orientation

6:00 - 7:30 p.m. **BREAK**

7:30 - 8:00 p.m. Cash Bar *(Rooms — Tilly Slowboy, Betsey Trotwood and Luke Honeythunder)*

:00 - 9:00 p.m. **BANQUET DINNER**

Introduction of Guest Speaker ..... William O. Mays, M.D.
President, DMF
President, MHMOP

GUEST SPEAKER ..... Paul M. Ellwood, Jr., M.D.
President of InterStudy

Michigan Health Maintenance Organizations Plans, Inc. Award Presentations ..... William O. Mays, M.D.
President, DMF
President, MHMOP
W. Melvin Smith, M.B.A.
Vice President, DMF
Senior Executive Vice President, MHMOP
John L. Loomis, M.D.
Project Director, DMF

SUNDAY — July 27, 1975

9:00 - 10:00 a.m. BREAKFAST *(Rooms — Devonshire, Gad's Hill and Dickens Room)*

10:00 - 10:30 a.m. "Effective Patient Management" ..... Alegro J. Godley, M.D.
(Tilly Slowboy) *Corporate Medical Director*

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SUNDAY — July 27, 1975 (cont'd)

10:30 - 10:45 a.m.	Questions and Answers	
10:45 - 11:10 a.m.	"Corporate Dental Planning For Michigan Health Maintenance Organization Plans, Inc."	Samuel L. Thorpe, D.D.S., Ph.D. *Corporate Dental Director*
		Moderator
11:10 - 11:20 a.m.	Questions and Answers	John L. Loomis, M.D. *Project Director, DMF*
11:20 - 12 Noon	Summary of Conference	John L. Loomis, M.D. *Project Director, DMF*
12 Noon	Adjournment	

EXHIBIT V

DETROIT MEDICAL FOUNDATION
EDUCATION CONFERENCE ON HMOs
ALLIED HEALTH PERSONNEL

SATURDAY — July 26, 1975

8:00 - 9:00 a.m.	BREAKFAST *(Rooms — Devonshire, Gad's Hill and Dickens Room)*	
9:00 - 9:10 a.m.	Welcome *(Rooms — Betsey Trotwood and Luke Honeythunder)*	William O. Mays, M.D. *President, DMF* *President, MHMOP*
9:10 - 9:15 a.m.	General Introductions	John L. Loomis, M.D. *Project Director, DMF*
9:15 - 10:15 a.m.	"What is an HMO?"	W. Melvin Smith, M.B.A. *Vice President, DMF* *Senior Executive Vice President, MHMOP*
10:15 - 10:30 a.m.	"Patient Rights"	Richard T. White, Esquire *Corporate Counsel*
10:30 - 10:45 a.m.	Questions and Answers	Moderator John L. Loomis, M.D. *Project Director, DMF*
10:45 - 11:00 a.m.	COFFEE BREAK	
11:00 - 11:30 a.m.	"How Michigan Health Maintenance Organization Plans, Inc. (MHMOP) Operates" *(Rooms — Betsey Trotwood and Luke Honeythunder)*	O. Larkin Isaac, M.B.A. *Director of Operations*
:30 - 11:45 a.m.	"Health Services Available via MHMOP Central Office Referral"	Sandra Billingslea, M.S.W. *Manager Health Care Administration Division*
11:45 - 12 Noon	"Fee-for-Service Utilization"	Bruce E. Mullican *Manager Claims Processing Division*

SATURDAY — July 26, 1975 (cont'd)

12 Noon - 12:15 p.m.	"How the Michigan Health Maintenance Plan is Marketed" ..... Fred Prime *Director of Marketing*
12:15 - 12:30 p.m.	Questions and Answers ..... Moderator John L. Loomis, M.D. *Project Director, DMF*
12:30 - 1:15 p.m.	BREAK
1:15 - 2:15 p.m.	LUNCH *(Rooms — Betsey Trotwood and Luke Honeythunder)*
2:15 - 2:45 p.m.	Luncheon Speaker ..... T. H. Billingslea, M.D. *Executive Vice President* *Health Care Administration*
2:45 - 3:00 p.m.	BREAK
3:00 - 3:45 p.m.	Slide Film ..... Moderator Cynthia L. M. Johnson, M.P.H. *Deputy Project Director, DMF*
	TOPICS:
	Account Executives ..... Fred Prime *Director of Marketing*
	Enrollee Orientation ..... Andrea Williams *Supervisor Enrollee Orientation*
	MHMOP's Hotline ..... Sandra Billingslea, M.S.W. *Manager Health Care Administration*
	Enrollee Concerns ..... Barbara Sue Brown *Supervisor Subscriber Services*
3:45 - 4:30 p.m.	Small Group Workshops **GROUP I:** Michigan HMO Plans' Enrollment Process *(Room — Betsey Trotwood)* **Presiding:** Fred Prime *Director of Marketing* Amyre A. Porter, M.A. *Public Relations Specialist*
	GROUP II: Michigan HMO Plans' Enrollee Orientation Sessions *(Room — Luke Honeythunder)* **Presiding:** Andrea Williams *Supervisor Enrollee Orientation*

ATURDAY — July 26, 1975 (cont'd)

GROUP III: MHMOP's **"HOTLINE"**
(Room — Devonshire)

Presiding: Sandra Billingslea, M.S.W.
Manager Health Care Administration
Yvonne Ugorcak
Emergency Triage Technician

GROUP IV: Enrollee Concerns
(Room — Gad's Hill)

Presiding: Barbara Sue Brown
Supervisor Subscriber Services

4:30 - 4:45 p.m. COFFEE BREAK

4:45 - 6:00 p.m. "Cobblestone Conferences"
Informal Small Group Discussions with MHMOP Personnel
(Rooms — Tilly Slowboy, Betsey Trotwood and Luke Honeythunder)

TOPICS

Health Care Services ..... Sandra Billingslea, M.S.W.
Manager Health Care Administration Division

Patient Referrals and Billing
Technicalities of Referrals ..... Bruce E. Mullican
Manager Claims Processing Division

Capitated Services ..... Karl Haiser, M.B.A., C.P.A.
Director of Finance

Medical Records ..... Alegro J. Godley, M.D.
Corporate Medical Director
Dorothy Douthitt, A.R.T.
Medical Records Librarian

Enrollee Concerns ..... Barbara Sue Brown
Supervisor Subscriber Services

Enrollee Orientation ..... Andrea Williams
Supervisor Enrollee Orientation

6:00 - 7:30 p.m. **BREAK**

7:30 - 8:00 p.m. Cash Bar *(Rooms — Tilly Slowboy, Betsey Trotwood and Luke Honeythunder)*

SATURDAY — July 26, 1975 (cont'd)

8:00 - 9:00 p.m.	BANQUET DINNER	
	Introduction of Guest Speaker	William O. Mays, M.D. *President, DMF* *President, MHMOP*
	GUEST SPEAKER	Paul M. Ellwood, Jr., M.D. *President of InterStudy*
	Michigan Health Maintenance Organization Plans, Inc. Award Presentations	William O. Mays, M.D. *President, DMF* *President, MHMOP* W. Melvin Smith, M.B.A. *Vice President, DMF* *Senior Executive Vice President, MHMOP* John L. Loomis, M.D. *Project Director, DMF*

SUNDAY — July 27, 1975

9:00 - 10:00 a.m.	BREAKFAST *(Rooms — Devonshire, Gad's Hill and Dickens)*	
10:00 - 10:40 a.m.	Appropriate Utilization of Medical Records *(Rooms — Betsey Trotwood and Luke Honeythunder)*	Dorothy Douthitt, A.R.T. *Medical Records Librarian* Shirley Sumerlin, A.R.T. *Medical Records Technician*
10:40 - 11:10 a.m.	Appropriate Utilization of Michigan HMO Plans' Encounter Form	Jim O'Connor, M.B.A. *Acting Director of Management Information Systems*
11:20 - 12 Noon	Summary of Conference *(Rooms — Tilly Stowboy, Betsey Trotwood Luke Honeythunder)*	John L. Loomis, M.D. *Project Director*
12 Noon	ADJOURNMENT	

PART III

EVALUATION REPORT

EVALUATION OF THE

DETROIT MEDICAL FOUNDATION

DEMONSTRATION TRAINING PROGRAM

September 30, 1975

TARP, Inc.
705 G Street, S.E.
Washington, D.C. 20003

CONTENTS

PART 1: PROCESS EVALUATION

PART 2: IMPACT EVALUATION

PART 3: CONCLUSIONS AND RECOMMENDATIONS

PART 1: PROCESS EVALUATION

I. INTRODUCTION

A. TARP's Responsibilities in the Demonstration Training Program

This evaluation report of the Detroit Medical Foundation Demonstration Training Program (DTP) is presented in fulfillment of contractual obligations undertaken on September 8, 1974 between TARP, Inc. and The Detroit Medical Foundation. In addition to the present evaluational activity, TARP also performed the following services for DMF:

- Produced a comprehensive review of the state-of-the-art of the health care training literature. (See Appendix 3)
- Assisted in the development of the training curriculum. (See Appendix 5)
- Assisted DMF staff in the development of training logistics.
- Assisted DMF staff in organizing and producing the final report of the Demonstration Training Program.

This report will accomplish the following:

- Chronologically overview the DTP developmental process and evaluate key elements of that process.
- Identify levels of success in the accomplishment of explicitly stated objectives and subobjectives.
- Identify areas of accomplishment which emerged as the program developed.
- Assess the concrete (measurable) achievements of the DTP (impact analysis).
- Document problems in the DTP developmental process that require improvement in future efforts.
- Identify problem areas requiring treatment in future training efforts.
- Recommend future directions for DMF training activities.
- Recommend future support activities in the HMO manpower development area that the BHRD might appropriately undertake.

B. Original Evaluative Objectives and Modified Evaluative Objectives

As originally stated, the DTP evaluation was to consist of a *process* evaluation and an *impact* evaluation. While both evaluations have been accomplished, modifications were made consonant with the evolution of the DTP developmental process, and were presented in TARP's Evaluation Design paper (see Appendix 6). The essential change in format relates to (a) use of patient-oriented data drawn from the MHMOP information system and (b) use of intra-group process skill data. Both of these data sets were dropped very early in the DMF-DTP planning phase because it became clear that these data would not be readily forthcoming from the evolving demonstration design. Specifically, as the focus of training sharpened on (a) conveyance of basic HMO knowledge from MHMOP central office to member PCU's; and (b) improvement of intraorganization communications vertically (MHMOP central office — PCUs) and horizontally (inter — PCUs), the evaluation design also emerged as focusing on these main operational, objectives. Patient-oriented data was not monitored and intra-group process skills data was not collected Therefore, the following evaluative instruments were utilized: (1) Direct observations of all planning meetings and conferences; (2) transcriptions and notes of all planning meetings and developmental work; (3) needs assessment data derived from three PCUs utilized during the design phase; (4) results of baseline and follow-up information protocols drawn from MHMOP's management planning section, which periodically assesses levels of information and knowledge among PCU staffs; and (5) an after-assessment of PCU's in attendance at the training conference.

C. Format of Presentation

The remainder of this evaluation report will contain; (1) the process evaluation; (2) the impact evaluation; (3) evaluation results and conclusions; and (4) recommendations for future HMO training activities.

D. Methods

TARP's approach to the conduct of the process evaluation was direct observation. TARP personnel consulted with DMF staff, were present as observers at most planning sessions and observed all session of the training (conference) program and the one-day follow-up session. In addition, TARP has conducted a detailed content analysis of all written documentation accompanying the DTP. Finally, TARP has sought not merely to accurately describe the unfolding saga of the DTP, but to provide a conceptual (developmental) framework of the morphology of MHMOP.

II. NARRATIVE OF EVENTS

The DTP included the following phases of activity:

1. Proposal writing, submittal, and acceptance; contract/sub-contract finalization.
2. Staff recruitment
3. Planning
4. Components development
5. Training and follow-up conferences
6. Final products development and program evaluation.

Highlights of significant events from each phase are described below.

A. Proposal Writing, Submittal, and Acceptance; Contract/Sub-Contract Finalization: February — July, 1974

On January 31, 1974, the Office of Special Programs, Bureau of Health Resources Development announced the availability of funds to help facilitate the development of health manpower in the context of HMO and pre-paid group practice settings. Shortly thereafter, the Detroit Medical Foundation (hereafter, DMF) decided to undertake such a training venture as a service to its primary client, Michigan Health Maintenance Organization Plans (hereafter, MHMOP). At that time, Technical Assistance Research Programs (hereafter, TARP), was asked by DMF to participate in the conceptualization of a proposal and to undertake certain tasks within the project, should the proposal be accepted.

The proposal was submitted on March 11, 1974. Notification of acceptance was received by DMF in early July, 1974. A contract with TARP was entered into on September 8, 1974, and work formally commenced on the Demonstration Training Program (DTP) during the last week in September, 1974. The project formally concluded on November 30, 1975.

B. Staff Recruitment: July — August, 1974

During the months of July and August, 1974, DMF set about to recruit key staff to implement the DTP. There was the need to find a new project director since the individual initially identified in the proposal was unavailable, and a deputy project director. Finalization of these recruiting efforts delayed actual commencement of the DTP's operational phase until the latter part of September, 1974 when a new project director came on board.

C. Planning: September, 1974 — February, 1975

The DTP planning process was a group effort involving: DMF staff assigned to the DTP, consultants, and selected MHMOP staff, who were drawn in periodically, on an "as needed" basis. The period for planning extended from late September, 1974 to early February, 1975. By early February, the course of the DTP was largely set and a briefing meeting was held with the federal project officers to indicate the directions the project would take. A detailed review of planning activities follows.

1. **September 27 — October 10, 1974:** This period saw the start of the project. Responsibilities of the staff were delineated. Prime contractor and sub-contractor relationships were established. The original DTP proposal was reviewed and up-dates and modifications were begun.
2. **October 11 — October 29, 1974:** The state-of-the-art literature review was begun by TARP. A detailed work plan, specifying all project elements was developed.
3. **October 30 — November 14, 1974:** The structure of the DTP, in terms of an experimental design, was firmed up in specific terms. Selection criteria for the six PCU training cohort were designed. Information requirements for curriculum design were determined and data collection strategies were discussed.
4. **November 15 — November 25, 1974:** Final decisions on the revised project methodology were made, including a time-phased work plan for completion of all remaining project requirements. Six PCUs which would serve as the training cohort were selected. The first draft of the state-of-the-art literature review was presented by TARP.
5. **November 26 — December 18, 1974:** Discussions with MHMOP commenced on the utilization of data from their management information system (MIS). Areas of priority for the training curriculum were determined.
6. **December 19 — January 10, 1975:** Information inputs and the training program role of MHMOP staff were determined. Final decisions on the utilization of the MHMOP MIS were made and

a needs assessment protocol was devised. These items constituted baseline information inputs to the curriculum, training format, and evaluation.

7. **January 11 — February 6, 1975:** The MHMOP MIS was utilized to determine levels of PCU staff knowledge. The needs assessment protocol was finalized. A briefing session with the federal project officers was held.

Note: From February 7 through March 15, 1975, the DTP experienced staffing difficulties. The deputy project director was transferred and a new deputy project director was hired. No substantive work on the DTP was accomplished during this period.

D. **Components Development: March — July, 1975**

During this phase of the DTP, all components necessary for the conduct of the three-day July training conference and follow-up (one-day) conference were designed. The activities undertaken were:

— Curriculum design and

— Training program format.

1. **March 15 — April 14, 1975:** MHMOP MIS data on levels of knowledge and information present at the PCU level was analyzed. Also, inquiries were made to MHMOP staff about the kinds of information required by the PCUs and how such information should be prioritized in the training conferences.

2. **April 15 — May 3, 1975:** The needs assessment procedure was implemented at three of the PCUs included in the training cohort. This exercise elicited specific information about the kinds of issues, questions, and topics that PCUs felt should be covered in the training conferences. The consumer panel was convened and then input was solicited as to topics that should be covered in training.

3. **May 4 — May 8, 1975:** The basic curriculum for the training conference was drafted. It covered the five topic areas originally described in the proposal.

4. **May 9 — May 29, 1975:** The basic curriculum was detailed out as to specific content. The curriculum content was reviewed, revised, and finalized. TARP submitted the final state-of-the-art literature review paper.

5. **June 1 — June 2, 1975:** Meetings were held in Washington, D.C. with TARP personnel to coordinate plans for their observation of the training conferences and to identify the specific pieces of DTP data that were to be employed in both the process and impact evaluations. A briefing session was held with the federal project officers.

6. **June 3 — June 25, 1975:** Logistics for implementing the training phase of the DTP were finalized including training strategies for the DTP training staff, insuring that each trainer's presentation reflected guidance received from DTP project staff. A specific guidance format designed to aid presenters in structuring their presentations was developed. Final arrangements were made with media consultants for use of slides and the "hot-line" presentation. A second meeting with the consumer panel was held and further issues of consumer concern were presented. Vigorus recruitment efforts were undertaken to ensure high levels of attendance at the July 25-27 conference in Ann Arbor, Michigan.

7. **June 26 — July 8, 1975:** Final decisions on DTP curriculum, training formats, and logistical arrangements were made. All MHMOP staff trainers were tasked according to the guidance format on how to structure their presentations and which topics to cover and emphasize. Modifications in pre-conference data collection formats were made in order to streamline administration at the follow-up training conference session.

8. **July 9 — July 24, 1975:** MHMOP staff trainers worked with DTP project staff on their presentations. A one-day "dress rehearsal" was held on July 21. DTP staff worked with each presenter on an individual basis. Final logistical arrangements were made, including the structuring of the conference and coordination of audio-visual utilization.

E. **Training Conferences: July — August, 1975**

1. **July 25 — July 27, 1975:** The first part of the training conference was held in Ann Arbor, Michigan. Approximately 150 people attended the day and one-half conference. During the conference, a short meeting with the federal project officer was held, and final product presentation formats were confirmed.

2. **July 28 — August 6, 1975:** Final preparations were made for the second part of the conference, a session in Detroit, Michigan, held on August 6.

F. **Final Products Development and Program Evaluation: August — October, 1975**

1. **August 7 — October 15, 1975:** Deliverable products were produced. All data from the conference was evaluated. The training manual was revised on the basis of experience.

2. **October 26 — November 30, 1975:** Review and comment was provided by the Bureau of Health Manpower and requested revisions were discussed and accomplished.

III. THE ORGANIZATIONAL CONTEXT

In this section of the evaluation TARP presents an analysis of each component of the DTP. The purpose is to identify areas of success as well as problems requiring resolution in future training efforts.

A. General Observations

In most complex organizations, training of staff is not placed high on the list of priorities. By its very nature, training stands beside other tools of modern management as potentially threatening to the organizational status quo. The trend in most organizations is to look to others outside the immediate unit or division to point out as being the source of what is wrong in the organizational system.

But organizations do suffer from problems of internal management. And, more often than not, these internal problems are structural in nature, and rob even moderately well functioning organizations of their capacity to function even better.

Another point that needs to be stressed is that organizational survival ultimately depends on the capacities of organizations to learn. Learning is the ability to reflect self-consciously on the need to adapt to changing environmental pressures, and to make those periodic adjustments necessary for organizational survival.

For these reasons, the self-consciously reflective organization recognizes the utility of training as an important component of organizational development and adaptation. The decision to train is often made by top management because they recognize the ultimate need for such efforts. This perspective is often not shared by lesser units in the organization, however. Thus, the trainers are sent forward to do battle, in an environment of mixed interest and varying feelings about the training enterprise.

These observations are by way of an appropriate introduction to an analysis of the Demonstration Training Program.

B. MHMOP's Organization: A Developmental Perspective

MHMQP is an independent practice association (hereafter, IPA) HMO. This fact is not only an organizational reality of MHMOP's present and future, but a legacy of its past. An IPA-HMO is a modest innovation in the structure of a solo practice, fee-for-service delivery system. When an IPA model of HMO organization is selected, it is because HMO planners intend to utilize much of the medical capital already in place in the health care delivery system.

The reality confronting DMF planners in 1971 was the following. Large numbers of physicians in the Detroit Metropolitan area were seeing patients through the Medicaid system. As a result, they were experiencing the usual administrative problems associated with payment derivative from third party vendors, rather than immediate cash transaction. A number of clinic operations (professional corporations) began to spring up so that physicians could pool their administrative overhead, and, by centralizing billing and record keeping, free themselves for their primary tasks of providing medical care. The DMF plan to establish MHMOP, then, was the next logical step in an evolving developmental process. Significantly, therefore, the nucleus of clinics which joined to become the core of MHMOP's PCUs, predated MHMOP's existence, as independent professional corporations. As the Plan grew, physicians in solo practice were urged to join together to form new PCUs. The independence of each PCU was guaranteed through contracts, whereby the PCUs agreed to serve MHMOP patients but could continue to maintain their individual practices.

The fundamental independence of provider groups in the IPA-HMO model is that model's most important reality. It is the case with MHMOP, as well, and this independence of PCUs defines the Plan's intrinsic organizational character, and identifies many of its organizational problems. TARP will not dwell on the positive aspects of the IPA approach here. It has been written about extensively elsewhere. Rather, the organizational problems of the IPA model are of greater interest to us, because these problems both constrain and challenge the best efforts of training in the IPA setting.

The chief problem facing MHMOP is the lack of control available to the Plan over its member PCUs. Their contractual obligations to the Plan are limited, i.e., physicians are only obligated to partial practice commitments to the HMO, reserving the balance of their time to private practice.

Another problem facing MHMOP is that the Plan has grown rapidly by undertaking service obligations to an ever increasing number of patients, requiring continuous expansion of the number of PCUs participating in the Plan. The central administration of MHMOP is, therefore, faced with the ongoing managerial problem of socializing an ever-widening cohort of PCUs to the HMO process, in an environment that contractually maintains a maximum amount of local PCU independence.

The need for socialization may be termed the "vertical" organizational development dimension. The PCUs, by entering into contract with MHMOP, promise to perform within the HMO setting. But, the reality is that they are novices to the HMO process and require guidance and technical assistance, if they are to perform as well-functioning members of the "HMO team."

And, the HMO concept which the PCUs are being called upon to operationalize, runs directly counter to many of the established patterns of medical care practice that have been operative in the pre-HMO, fee-for-service environment:

- HMOs place great emphasis on the 'team' concept of health care, requiring greater involvement of allied health personnel than in traditional fee-for-service settings.
- HMOs emphasize primary prevention, early diagnosis and early treatment, requiring physicians and allied health personnel to see their patients much earlier in the "wellness-illness" continuum, thereby decreasing, over time, the need for costly curative procedures.
- HMOs must maintain comprehensive reporting systems which require more complex and elaborate records systems than fee-for-service practices usually require.
- HMOs operate under a set of economic principles that run directly counter to the incentives provided by fee-for-service payment. Specifically, prepayment puts physicians at risk for costs that exceed actuarially determined prepaid premiums.

  In the context of MHMOP, this means that the percentage of payments held back by the Plan to meet excess costs, will not be available for distribution to the PCUs, if they must be utilized to meet unanticipated medical care and operating costs.

These are only some of the conceptual differences between HMO and fee-for-service practices that must be understood by PCU personnel. MHMOP's problem, then, is classic: How to alter the behavior of the PCU cohort, when the very nature of the IPA model reinforces both the contractual and the structural (vertical) independence of the PCUs from the MHMOP's central administration?

The DTP was viewed by MHMOP's central administration as a vehicle for facilitating the socialization process. But, to accomplish this goal, the basic isolation of the PCUs from the central administration (vertical) and from each other (horizontal) had to be overcome.

To MHMOP's central administration, the underlying implicit objective of the DTP was to create a vehicle for socialization of the PCUs to be IPA-HMO model by reducing both the vertical and horizontal isolation present in MHMOP's administration system. If these gaps could even be partially closed through the implementation of the DTP, then important knowledge and information could be exchanged and attitudes fostering isolation could be (at least somewhat) overcome.

* * * * *

With these contextual observations, TARP has portrayed the environment within which the DTP undertook its work. What follows in a component-by-component review of DTP activities in order to highlight areas of success and areas in need of further effort during subsequent phases of training.

IV. PROCESS ANALYSIS OF THE DEMONSTRATION TRAINING PROGRAM

A. Proposal Writing Submittal and Acceptance; Contract/Sub-Contract Finalization: February — July, 1974

The DTP proposal was written in response to a solicitation from the Division of Associated Health Professions, Bureau of Health Manpower/Health Resources Administration. As presented, it attempted to balance two fundamental interests: the federal interest for generalizability of experience from one HMO setting to others; and the local interest to utilize training to solve some perceived organizational management problems. The federal interest, of necessity, was on products; the local interest was primarily on process. These two objectives have not always been compatible.

Product-oriented objectives perceive the local program as a laboratory out of which can be developed identifiable products which can be applied in other organizational settings. By its very nature, a product-oriented objective tends to give a lower priority to the intrinsic behavioral needs of the specific organization serving as the laboratory.

Process-oriented objectives, on the other hand, tend to be parochial in nature. They are geared to meeting the perceived needs of a specific organization at a specific point in time. Thus, process-oriented objectives focus on the immediate results of a beneficial nature that will accrue to an organization undergoing a training experience.

From its inception, DMF and its client MHMOP, wished to implement a training program that would produce observable results — the conveyance of specific information about the nature of the MHMOP sytem to MHMOP's operating (PCU) units. Products of such an effort would be sufficient if they proved useful in the facilitation of this impact-oriented objective. The accomplishment of the federal objective, it was felt, should be satisfied, but not at the expense of meeting the fundamental objective of improving MHMOP's system efficiency.

The DTP, then, focused primarily on the resolution of immediate MHMOP systems problems. Products would be generalized from this experience, but the project would not begin with generalized objectives and impose them a priori on the MHMOP system. This point of view was consistently maintained throughout the DTP.

B. Staff Recruitment: July — August, 1974

This component of the DTP took longer to complete than originally projected because a search for an appropriate project director and deputy project director had to be undertaken. The originally designated project director was unavailable to DMF because she had to assume major management responsibilities within MHMOP. Similarly, a deputy project director had to be recruited.

When these problems were solved, others quickly developed. The project director selected was an accepted member of the DMF-MHMOP physician community. The decision to select a physician with close ties to the principal subjects of training proved to be a wise judgment. However, many times throughout the project the director found himself under severe time and scheduling constraints. While sufficient time was allocated to the DTP, his first commitment was to his patients, which meant that the DTP was of a lower priority than this primary commitment. It was not an insurmountable obstacle, however.

The deputy project director proved more difficult. This individual was to be the focal point of DTP developmental efforts. A person was recruited with (apparently) appropriate credentials. That individual was not up to the rigors of the DTP, and was transferred to another assignment in February, 1975. A new deputy project director was recruited and the DTP moved smoothly forward.

The lesson from these staffing problems is that greater efforts should have been exerted by DMF to screen and recruit appropriate personnel early in the project. As the project unfolded, however, staffing problems tended to be resolved, but at some cost to planning efficiency.

C. Planning: September, 1974 — February, 1975

The planning phase of the project, while successful in the aggregate, took longer to complete than had been expected. There were two reasons for this: (a) the staffing problems alluded to in B. above; and (b) the need for DTP staff to orient MHMOP staff to the specifics of the objects of training. This latter problem deserves further elaboration.

While MHMOP top management perceptively understood that there was a great need to better communicate information from the Central Office to the PCUs, they did not fully realize the need for developing a structural mechanism to facilitate that communication. Nor did they perceive the true levels of ignorance of the MHMOP system and the lack of a feedback mechanism from the PCU level to MHMOP Central Administration.

These dimensions of the process-oriented elements of organizational management came to light during the unfolding of the DTP planning and components development stages. They were not, however, fully anticipated as issues by either the DTP staff or MHMOP Central Administration. While it was extremely useful to the MHMOP system that these issues came to the fore, their emergence greatly complicated the overall implementation of the DTP.

D. Components Development: March — July, 1975

The five information categories (i.e., finance, marketing, health services, operations, and information systems) were the focal point of curriculum design. That these five categories were the correct areas of focus was clearly verified through needs assessments interviews held with the PCUs, and through examination of information levels present in the PCUs. Both inquiries indicated much ignorance about MHMOP at the PCU level. The task of the curriculum, therefore, was firmly directed toward designing a training format that would overcome this ignorance.

It also became clear during this phase of the DTP that MHMOP central office staff would greatly benefit from direct contact with the PCUs. As the data reviewed in the impact analysis section of this report reveals, MHMOP staff were quite ignorant of precise levels of information present at the PCU level. In short, the DTP uncovered a wide gulf between Central Office and PCUs that had to be bridged.

E. Training Conferences: July — August, 1975

The training conference may be evaluated on two levels: (a) as a means for improving the MHMOP communications process and (b) as a vehicle for conveying specific information. TARP's conclusion is that the former objective was more successfully achieved than the latter objective. This point will be elaborated more fully in the impact analysis section of this report.

F. Final Products Development and Program Evaluation: August — October, 1975

The DTP did achieve the federal objective of demonstration products development. The utility of these products for other HMOs will require further testing in those contexts. the TARP evaluation, while accurate and objective, labored under the exigencies of poor evaluative data, owing essentailly to the inability of MHMOP staff, both Central Office and PCU, to handle written materials.

The explicit objective of the DTP was to train PCU staff in workings of MHMOP. Underlying the perception by MHMOP's central administration that basic information about the MHMOP operation was not being effectively communicated to the PCUs, was the reality that no structured channel for such communication was present in the MHMOP organizational system.

Only recently a newsletter, produced by the Central Office, has become available to the PCUs. Beyond this vehicle, periodic meetings of the Board of Trustees discuss top management issues. These meetings usually do not go into "micro"-level discussion of day-to-day operating problems. Moreover, information provided to PCU presidents does not routinely filter down to PCU rank and file staff, either physician or allied health.

The primary direct contact between PCU rank and file staff and MHMOP Central Office, then, has been routine (indirect) contacts: patients who have been enrolled appear at clinics to seek care; referrals are made by MHMOP from one clinic to another; a complex and often bewildering array of records are required of PCU staff by MHMOP with no clear understanding on the PCUs part as to why such records are necessary; after hours emergencies are referred via MHMOP's hot line. These contacts are invariably initiated by MHMOP and impose responsibilities and burdens on PCUs, without adequate opportunity (given the lack of two-way communication) for them to ask questions and indicate the sources of their confusion and frustration.

A further area of contact occurs when MHMOP staff alert PCU staff to problems with particular patients who have either complained or have disenrolled. This type of contact is, by its very nature, negative: the Central Office is calling to tell the PCU something decidedly unpleasant — that they have, in the eyes of the patient, either mistreated him or lost him through disenrollment.

The vertical fragmentation of the IPA-HMO model builds in isolation between central management and practitioner units. If the only routine direct contacts between these two organizational components are negative in tone, then the result can only be (a) the belief by central staff in a general lack of concern and/or competence on the part of PCU staffs; and (b) the belief by PCU staffs that they are being somehow manipulated by the central administration and, because they have not been provided with adequate knowledge and information about what their responsibilities are within the MHMOP setting, the feeling that they are being unfairly criticized for

doing things they did not know should have been done in the first place. Estrangement and hostility between both groups will increase, as the HMO system grows more complex and the incidence of problems increases. This estrangement can only be resolved through mutual communication and accommodation which must be routinely structured into the HMO's organizational system.

Prior to and during the duration of the DTP, no such structured communications process was present in MHMOP. The DTP, however, came to fill that void, albeit tentatively, and in a limited and, perhaps, only temporary way. For, by establishing a framework to design a training program, the basis of two-way communication was established for the simple reason that the DTP required feedback from PCUs about what *they* thought ought to be in a training curriculum, i.e., needs assessment and baseline protocol. Conversely, Central Office staff were, for the first time, placed in a setting where they directly heard from PCUs regarding their levels of knowledge, misunderstandings, lack of information, etc. This contact enabled MHMOP staff to adjust their own attitudes about the PCU staffs to whom they would convey information through the DTP training conference.

In sum, MHMOP has long suffered from the vertical fragmentation intrinsic to the IPA-HMO model. Isolation and hostility at the PCU level have increased as the system has grown more complex. The Central Administration has also found itself isolated as its own work has become more complicated. Open communication between PCUs and Central Administration has become increasingly necessary over time both to reduce the growing sense of mutual estrangement and hostility and to convey routinely needed information, in both directions between Central Office and PCUs. Rapid functional growth and diversity, however, has led to organizational lag, whereby the permanent structure for communication has not been constructed. The DTP has been the first step in this organizational development process. Hopefully, it will not be the last.

PART 2: IMPACT EVALUATION

V. METHODS

This aspect of the evaluation report presents TARP's analysis of the impact of the entire DTP effort. The classic research model to assess the occurrence of desired change is the "controlled before and after" experimental design. This design calls for selecting two groups, the "experimental group" which is exposed to the training effort and the "control group" which is not so exposed. Measurements of levels of information and attitudes for both groups are made before the training effort and afterwards. Findings from the comparison of "before and after" data are analyzed to establish (1) if any significant change in level of information and attitudes has occurred; (2) if such changes are in the desired direction; and (3) if the observed changes may be attributed to the training effort or must be attributed to other factors. A detailed description of this research design's logic may be found in Appendix 6, *Evaluation Component Design for the Detroit Medical Foundation Demonstration Training Program*, particularly pages 5-11.

A. The Proposed Research Design

The specific design adopted called for the selection of entire PCU staffs as population units. The alternative possibility of pooling all personnel from all PCUs, stratifying this pool by job classification (e.g., MD., R.N., receptionists, etc.) and pulling an experimental and a control group from this pool was rejected. The factor considered most significant in this choice was the problem of contamination between individuals from the experimental and control groups if they happened to be in daily contact in the same PCU. A second factor given weight in this decision to consider PCUs the basic population unit was that MHMOP structure is such that PCUs and not individual staff members of the PCUs are the units with whom the relationships exist. The PCU staff is employed by the PCU not MHMOP; the PCU nurses do not relate to MHMOP as nurses but as staff of the PCU.

The early recognition that MHMOP Central Office staff, though involved in the training as "teachers," also could be expected to be influenced by participation in the training effort led to the decision that there should be some form of "before and after" measurement for this group also.

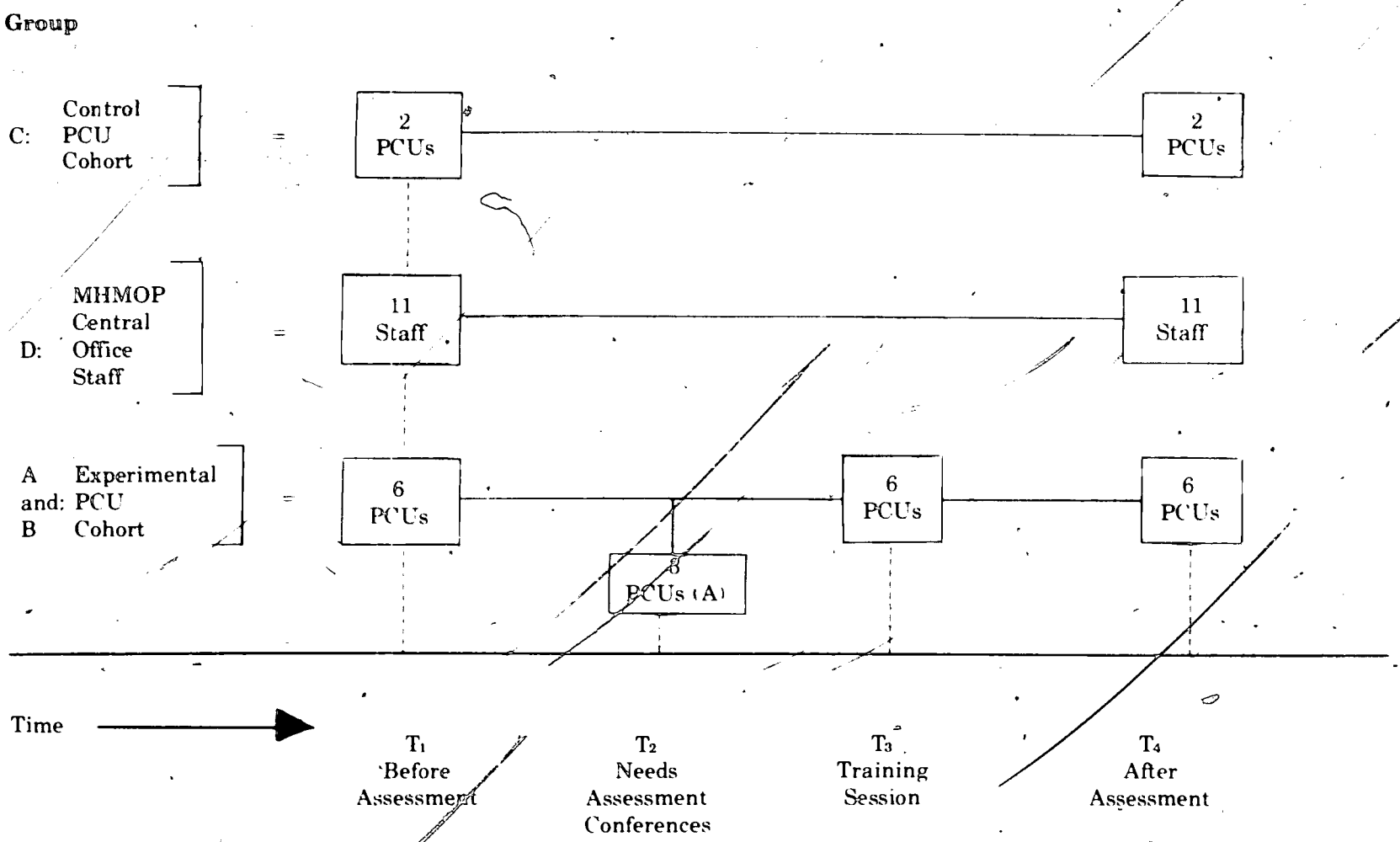
The decision to involve the PCUs in the development of the curriculum by means of needs assessment meetings permitted a further refinement of the basic design. The possibility presented itself to evaluate the impact of involvement in the planning process on learning. Consequently, the design called for the further selection of PCUs within the experimental group to establish a "control" group which would not participate in planning by means of involvement in needs assessment, and an experimental group which would participate.

The basic design,* as planned is shown in Figure 1.

*For greater detail, see Appendix 6, pages 12-15

Figure 1

BASIC DESIGN FOR IMPACT EVALUATION



The four (4) analytic groups were:
A + B:

A + B: Experimental PCU cohort of 6 PCUs
A = 3 PCUs involved in Needs Assessment
B = 3 PCUs not involved in Needs Assessment
C: Control PCU cohort of 2 PCUs
D: Cohort of MHMOP Central Office Staff of 11 persons.

B. Implementation and Modification of the Basic Design

The execution of the impact evaluation phase met with all the problems usually encountered when an ideal design is applied in the real world. The modifications which had to be instituted, as well as the resulting implications for the analytic scheme were significant.

1. Selection of PCUs for Experimental and Control Groups

The 18 PCUs participating in MHMOP at the beginning of the DTP varied considerably in terms of size of staff, type of care provided, length of membership and degree of conflict within PCU and between PCU and MHMOP, as well as degree of commitment to the principles of the HMO modality of providing medical care. While many of these differences among PCUs were not documented, they were nevertheless perceived to be real by MHMOP, both by the central office staff and the Board. As a consequence, the selection of eight PCUs to participate, either as experimental or control cohorts, was not random in any sense of the statistical meaning of this word. Instead, the Board approved eight PCUs for inclusion in the DTP, leaving allocation as experimental or control group cohorts to the DTP staff. As a result, the PCUs selected are not a representative sample of all PCUs in MHMOP.

As is usually the case, the judgments of the Board and MHMOP appeared quite justified: The degree of commitment of individual PCUs to HMO concepts and, consequently, the individual PCU's degree of co-operation with the DTP varied as predicted.

2. Development of Instruments and Data Collection

a. "Before" Assessment

TARP agreed to utilize a questionnaire used by MHMOP's MIS to assess PCU staff members' level of information and attitudes for baseline "before" assessment. This instrument (Appendix 2) was administered under MIS auspices. The individual PCUs were provided with enough copies for all staff and asked to complete the questionnaires and return them by a certain time. The questionnaries were processed at the Central Office, and TARP was provided with the tabulations.

TARP asked that the Central Office staff, constituting analytic group D, fill out the same questionnaire by predicting the distribution of responses for four categoreis of PCU staff: (1) Physicians, (2) Nurses and other personnel in contact with patients, (3) managerial, administrative or office personnel, and (4) technical other personnel such as lab technicians, medical records clerks, etc.

The attempt by MHMOP to collect this information from PCUs revealed that a large number of PCU staff of all levels refused to participate. Intense effort was required to obtain the amount of participation finally achieved. For the eight PCUs of interest, the return rates were as follows:

Table 1

RESPONSE TO "BEFORE" QUESTIONNAIRE

PCU	Number of Staff	Questionnaires Returned	
		Number	Percent
A	10	2	20%
B	4	3	75
C	12	2 + 3 "Don't Know	42
D	14	3 + 1 "Don't Know"	29
E	15	2	13
F	10	7	70
G	9	9	100
H	10	3	30
Total	74	31 + 4 = 35	47%

The response from the Central Office staff resulted in eight useable sets of predictions.

The difficulties encountered by the Central Office in obtaining co-operation with the questionnaires proved to be valid indication of the chasm that appeared to exist between the PCUs and the Central Office. There were hostile comments with the refusals as well as expressions of frustration. Comments ranged from a polite "too busy" to "this is another phoney smokescreen" and unrelated comments which expressed chronic despair with perceived policy positions and bureaucratic deafness.

The questionnaire itself asked about knowledge and attitudes about the MHMOP organizational structure, knowledge about HMO features, knowledge about the provision of individual services for enrollees, information seeking behavior, and finally attitudes about the Central Office.

The data obtained was so sparse that the planned analyses by four categories of PCU personnel was abandoned, and usually only the distinction between physicans and all other personnel could be maintained. The data will be presented below. At the time, findings were used by DTP staff for the Needs Assessment Meetings.

b. **"After" Assessment**

The preferred choice of the "after" assessment instrument is the original one devised for the "before" assessment. This usually is based on the assumption that the curriculum content is known, and that testing before and after will focus on the areas which are addressed by the curriculum. In the DTP instance, the curriculum content was not at all specific at the time the "before" assessments needed to be done. It was felt that the curriculum development required the needs assessments conferences to obtain PCU input, and these conferences were originally scheduled much earlier than the time at which they finally were held. In order to obtain comparable data for the A group, the baseline data were collected with an instrument which was not tailored specifically for the curriculum. It was, consequently, not entirely suitable for the "after" testing. In addition, the format of the MIS questionnaire had proven to be difficult for respondents. It was therefore decided that a revision of the original instrument would have to be produced. MHMOP's MIS needed such a revision in any case, and TARP assisted in this task. They developed the adaptation for MIS use and, at the same time, to serve as an "after" test.

This questionnaire was distributed at the August 6th session, which was not attended by all the individuals who had participated in the first phase of the training sessions. At the banquet dinner during the first training conference in July, 68 persons had completed a brief questionnaire titled: "Your Opinion Please." Of these, 10 were physicians. At the second phase, 55 persons completed the "after" questionnaires, 7 of these were physicians. However, on analysis it developed that some of the persons participating in the training sessions originated from a PCU which was not one of the six selected as experimental cohort PCUs. To confound the analytic problem, it was discovered that this particular PCU had not been approached in the initial attempt to obtain information since this PCU

is not a "clinic" but provides psychotherapeutic services. It proved, hence, impossible to add the PCU's data to the "before" data. However, a comparison of that group's responses to the other non-physician staff responses revealed no clustering of responses that would produce a bias, and it was decided to retain these responses.

The Central Office staff, once again, was asked to use the questionnaries given to the PCU's and to indicate their prediction of the distribution of responses. They filled out two sets of questionnaries each: one for physicians and the second for all other allied health personnel. Thirteen sets of questionnaires were completed.

Finally, MHMOP attempted to obtain completed questionnaires from the two PCUs constituting the control group (c). So few responses were obtained that no findings will be presented. In addition, through errors in logistical arrangements, staff from the two control PCUs attended the Ann Arbor Conference, thereby invalidating any data collected from this source. However, in order to provide a quasicontrol group, data will be presented from persons who attended the August 6th session and filled out the questionnaire despite the fact that they had not attended the Ann Arbor session. Clearly, this group is not an altogether acceptable substitute since they are self-selected and, also, interested and motivated enough to attend part of the training procedure.

All the data that was obtained will now be presented.

VI. FINDINGS

The tabulation of the data for all instruments revealed a rather interesting degree of inability to follow instructions. There were no complex directions nor anything unusual in the questionnaires to indicate that it was the questionnaire that provided the stumbling block. In any case, so many individuals coped incorrectly with some of the items that not all data was complete enough to warrant presentation.

A. "Before" Assessment of PCUs

The first question provided a list of the nine (9) departments and sub-departments in the MHMOP Central Office and asked if the respondent knew or did not know of the existence of each. Table 2 shows the distribution of the responses for physicians and all other staff labeled Allied Health Personnel (AHP). "No responses" (NA) were grouped with "no, did not know" answers for simplicity of presentation. Overall, *Administration* was known by most with 84 percent, while *Systems* and *Operations* were known to only about 60 percent. The physicians as a group knew equally frequently about *Administration* and *Health Services* with about 99 percent for each, while the remaining answers were in the "did not know" category for these two items.

The Allied Health Personnel (AHP) also reported *Administration* as known to exist most frequently with 83 percent. However, this group reported knowledge about *Medical Records* and *Finance* next most frequently with about 78 percent for each. This undoubtedly reflects realistically the nature of the routine contacts between PCU personnel and the Central Office: the various PCU employees, by the nature of their specific tasks, will deal with *Medical Records* or *Finance;* physicians will deal with *Health services*, i.e., referrals and patient recourse to the Hot Line in off hours.

Table 2

KNOWLEDGE ABOUT DEPARTMENTS IN MHMOP CENTRAL OFFICE BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)*

Department	Total (N=32) Percent[1]			M.D.s (N=9) Percent[1]			AHP (N=23) Percent[1]		
	Knew	Did Not Know	N.A.[2]	Knew	Did Not Know	N.A.[2]	Knew	Did Not Know	N.A.[2]
Administration	84	3	12	89	11	—	83	—	17
Marketing	66	19	16	67	22	11	65	17	17
Public Relations	66	22	12	67	33	—	65	17	17
Systems	59	22	19	56	33	11	61	17	22
Medical Records	75	9	16	67	22	11	78	4	17
Finance	72	16	12	56	44	—	78	4	17
Operations	59	22	19	56	22	22	61	22	17
Health Services	69	9	22	89	11	—	61	9	30
Health Education	63	25	12	67	33	—	61	22	17

[1]Rounded, may add to 99% or 101%
[2]N.A. = Not Answered

*See Appendix 2 for text of Q.1

The surprising findings consisted of the reported low level of knowledge about *Marketing* and *Health Education*. The former was interesting since, as will be shown later, much of the basic disagreement between PCUs and Central Office centers around the question of enrollee expectations about services to be provided them by the PCUs. It would appear that PCU personnel frequently blamed the unspecified "they" for overselling HMO services, but did not question how this "overselling" was coming about. The relative inawareness of Health Education, particularly in the case of the physicians, appears to indicate that one of the operating principles of HMOs, namely prevention and education, has not been conveyed effectively. The Health Education department is, in fact, relatively recent, and may not have had a chance as yet to have made its presence felt.

A group of five questions were concerned with knowledge about HMO teams and operating principles. The format was a multiple choice one. Table 3 presents the distributions of answers for physicians and AHP. Percentages are shown for correct answers. The five aspects selected were:

Capitation in HMOs
Fee-for-service
Risk Sharing in HMOs
Benefit Package in HMOs
Referrals to Specialists outside capitation contracts with MHMOP

Table 3

KNOWLEDGE ABOUT HMO FEATURES, BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)*

HMO Feature	Total (N = 32) Percent[1]				M.D.s (N = 9) Percent[1]				AHP (N = 23) Percent[1]			
	Right	Wrong	Don't Know	N.A.[2]	Right	Wrong	Don't Know	N.A.[2]	Right	Wrong	Don't Know	N.A.[2]
Capitation	28	56	9	6	44	56	—	—	22	56	13	9
Fee-for-Service	38	44	9	9	44	56	—	—	35	39	13	13
Risk Sharing	66	19	9	6	67	33	—	—	65	13	13	9
Benefit Package	38	41	6	16	44	56	—	—	35	35	9	22
Specialist Referral	47	41	9	3	56	44	—	—	43	39	13	4

[1]Rounded, may add up to 99% or 101%
[2]N.A. Not Answered

*See Appendix 2 for Text of Q. IIA E

The overall level of correct information was very low, indeed only the *Risk Sharing* question received a majority of correct answers from both physicians and AHPs. The AHPs' level of information was low, but since, in a sense, none of this is of direct significance to them in their work, this is not too surprising. However, the physicians appeared not much better informed.

A word of caution appears in order here. The number of physicians (9) is of course extremely small and the results are to be interpreted with great caution. However, to anticipate, attention is called to Table 18 showing the distribution of correct answers to these same five items for physicians "Before" and "After" as well as for the "Not at Ann Arbor" group. Grouping the "Before" and "Not at Ann Arbor" responses (before training and without training), the percent correct for 14 physicians were as follows:

Capitation	64%
Fee-for-Service	64%
Risk Sharing	79%
Benefit Package	50%
Specialist Referral	64%

Inescapably, we must conclude that physicians are not as well informed as might be desired.

The PCU staffs' knowledge about the availabilty of an array of specific services was also tested. Table 4 presents the distribution of correct and incorrect answers for all respondents. Physicians and AHP are not reported separately since the differences for individual items did not reveal any significantly different patterns. Uniformly, the level of information is low. Correct information was shown most frequently for *Prenatal Care:* 76 percent answered correctly. Seven further items were correctly answered by between roughly a half to three quarters of the respondents. These were *Tubal Ligation* 73 percent, *Inpatient Hospitalization* 73 percent, *Nutrition Counselling* 70 percent, *EKG and EEG* 67 percent *General Surgery* 65 percent, *Outpatient X-ray Studies* 61 percent, and *Family Planning* 57 percent. Perhaps the most interesting finding is the relative low proportion of individuals who stated that they *did not know* as compared to the proportion who possess wrong information.

Table 4

KNOWLEDGE ABOUT THE PROVISIONS OF SERVICES, BY PCU PERSONNEL*

Service	PCU PERSONNEL (N=32) Percent[1]		
	Right	Wrong	Don't[2] Know
Prenatal Care	76	—	12
Eye Glasses	10	70	10
Rhino-Plasts-Cosmetic	10	60	17
Outpatient X-Ray Studies	61	26	—
EKG and EEG	67	23	—
Abortions	47	37	3
Dental Care	29	58	—
Psychiatric Care-Outpatient	3	77	10
Contact Lenses	3	72	14
E-R Services	5	81	—
Tubal Ligation	73	13	3
Vasectomy	37	37	13
Inpatient Hospitalization	73	13	—
Dermatologists	45	38	7
Allergists	40	43	7
Podiatrists	47	—	43
Nutrition Counseling	70	11	11
Health Care-Domestic	10	57	23
VNA	10	48	29
Psychiatric Care-Inpatient	14	66	10
General Surgery	64	23	3
Family Planning	57	30	3
Health Education	39	39	12
Prescriptions	6	74	—
Ambulance	32	45	13
Transportation	45	32	13

[1]Rounded, may add to 99% or 101%
[2]No Answers not shown in Table

*See Appendix 2 for text of Q. III

One question dealt with the way PCU personnel handle giving information about specific service requests. Table 5 shows the distributions of answers. Physicians and AHP differ in the proportions who *consult someone in their office*, 46 and 6 percent respectively, and those who *call up MHMOP*, with 15 percent of physicians but 35 percent of AHPs resorting to this way of obtaining information. Interesting is the low reported use of written materials.

Table 5

HANDLING REQUESTS FOR SERVICES BY ENROLLEE,
BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)

Q.III "When you talk to an enrollee about a specific service, do you:"*

Response	Total (N = 32) Percent [1]	M.D.s (N = 9) Percent [1]	AHP (N = 23) Percent [1]
Refer to written materials	7	—	12
Consult with someone in your office	23	46	6
Call up the MHMOP Central Office	27	15	35
Already know answers because been doing this for so long	23	15	29
No Answers, More than 1	20	23	18
Total	100	99	100

[1] Rounded, may add to 99% or 101%

*See Appendix 2 for text of Q. III

Two questions were asked to elicit attitudes towards the Central Office's handling of problems relating to enrollees' service requests and complaints. Table 6 shows the distributions of responses. Physicians are more critical than AHP. No AHP felt that the Central Office is unreasonable, but some proportion, eight percent, of the physicians did. Further, physicians more frequently felt that the Central Office was sometimes reasonable but not at other times than did AHPs, 61 and 29 percent respectively. The largest proportion, 59 percent of AHP, felt that the Central Office service requests are usually justified. It is indeed interesting to note that extreme attitudes were reported relatively infrequently.

Table 6

ATTITUDES TOWARDS MHMOP CENTRAL OFFICE'S HANDLING OF ENROLLEES' SERVICE REQUESTS BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)

Q. IVA: "In regard to enrollees' service requests: (CHECK ONE)"*

Responses	Total (N=32) Percent[1]	M.D.s (N=9) Percent[1]	AHP (N=23) Percent[1]
"People at the MHMOP Central Office are unreasonable and demand special deals whenever a patient calls them up and makes waves."	3	8	—
"When the MHMOP Center people call up about a service request, it's usually a situation where they are justified in intervening."	43	23	59
"It's hard to say: sometimes the MHMOP Center people are reasonable and other times they are not."	43	61	29
No Answer, More than 1 answer	10	8	12
Total	99	100	100

[1]Rounded, may add up to 99%

*See Appendix 2 for text of Q IVA

Table 7 shows the responses about Central Office handling of complaints. Physicians and AHP differ in their attitudes towards the Central Offices with the AHPs seeing the Central Office generally being reasonable (65 percent) while physicians more often (61 percent) see the Central Office sometimes taking sides and other times being reasonable. Again, the extreme view of the Central Office is not held for this question by any individual.

The final question related to enrollees' knowledge about the services to which they are entitled, and the Central Office's culpabilty in misconceptions. Table 8 shows the results. No AHP individual thought most enrollees well informed, but 23 percent of the physicians did so. Both groups most frequently took the middle position with two-third of the AHPs and about 40 percent of the physicians doing so. Again, the extremely critical response was not overwhelmingly endorsed, but about a quarter of the physicians and a fifth of the AHPs did so.

B. **"Before" Assessment of MHMOP Central Office Staff**

The MHMOP Central Office staff was asked for its attitudes by requesting their prediction of response distributions. This would reflect their assessment of PCU staffs' knowledge and attitudes, in short their image of PCU personnel.

Table 7

ATTITUDES TOWARDS MHMOP CENTRAL OFFICE'S HANDLING OF ENROLLEES' COMPLAINTS, BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)

Q. IVB: "In regard to complaints by patients: (CHECK ONE)"*

Response	Total (N=32) Percent[1]	M.D.s (N=9) Percent[1]	AHP (N=23) Percent[1]
The MHMOP Central Office always takes the patient's side, doesn't listen to reason.	—	—	—
The MHMOP Central Office seems to make reasonable evaluations of complaints and calls to our attention usually only those where a problem does exist.	47	23	65
It is hard to say: sometimes the MHMOP Central Office seems to take sides, other times it seems to be reasonable.	37	61	18
No Answer, More than 1 answer.	16	15	18
Total	100	99	101

[1]Rounded, may add to 99% or 101%

*See Appendix 2 for text of Q. IVB.

Table 8

ATTITUDES TOWARDS MHMOP CENTRAL OFFICE'S MARKETING PRACTICES AND EXPLANATIONS ABOUT BENEFIT PACKAGE, BY PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP)

Q V: "Please check the one statement that most closely reflects your experience in regard to *Enrollment*:"*

Response	Total (N=32) Percent [1]	M.D.s (N=9) Percent [1]	AHP (N=23) Percent [1]
The people at the MHMOP Central Office who enroll new members either don't know about the services that are covered or else they deliberately exaggerate just to "make a sale," because most new enrollees demand much more than they are entitled to.	20	23	18
Some new enrollees don't seem to know what joining MHMOP means and what they are entitled to, but some new enrollees do know fairly accurately.	53	38	65
Most of the time, new enrollees know what they are entitled to and what enrolling means.	10	23	—
No answer, More than 1 answer.	17	16	18
Total	100	100	101

[1] Rounded, may add to 99% and 101%

* See Appendix 2 for text of Q V

These projections are presented in relation to the actual distributions obtained from the PCU questionnaires. The Central Office staff were asked to predict for four groups of PCU staff: (1) physicians; (2) personnel with patient contact; (3) administrative and clerical personnel; and (4) technical staff.

Table 9 shows the data for these projections. The grouping for the percentages mentioned by the Central Office staff are very large, but they are designed to point out 100%, 50% and 0% answers. The eight Central Office respondents all felt that all (100%) the physicians would know that the *administration* department exists. For the three groups of AHP shown, fewer felt that all (100%) knew of this department, namely 6, 7 and 6 for the three groups respectively. In fact, 89% of the physicians and 83% of the AHP were correctly informed.

On the whole, Central Staff overestimated the knowledge of the PCU physicians. This is particularly striking for *marketing* and *finance*. Not shown in Table 9 is the finding that for *systems*, one Central Office respondent came within 10% of the actual percentage of informed physicians and two came within 10% for Health Education. In all other cases, no one from Central Office came within 10% of the observed percentage.

The picture for the AHPs is not much different, insofar as accuracy of prediction is concerned. It is interesting to note that the Central Office staff sees physicians as better informed than AHP with two exceptions: 3 Central Office staff believed that 100% of the office personnel knew of the *Systems* department, while only two thought all physicians knew of it. The *Medical Records* department was believed to be universally known by office and technical personnel, by four and three Central Office members while only two each thought so of physicians and nurses. Five Central Office staff believed 100% of patients contact personnel knew about the *Operations* department, while only two believed this of physicians. Finally, and perhaps most astonishingly, is the Central Office staff's perception of AHP's acquaintance with *Health Services*, in particular with regard to the patient contact personnel: six Central Office staff envisage below 50 percent awareness of this department and two of these feel none are aware of its existence.

Table 9

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTIONS OF PCU PERSONNEL WHO KNOW THAT SPECIFIC DEPARTMENT EXISTS.*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knows About Department. (N=8).**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
ADMINISTRATION								
	8	100%	6	100%	7	100%	6	100%
	—	95-55%	—	95-55%	1	95-55%	1	95-55%
	—	50%	2	50%	—	50%	1	50%
	—	45-5%	—	45-5%	—	45-5%	—	45-5%
	—	0%	—	0%	—	0%	—	0%
Actual % who knew		89%				83%[4]		
MARKETING								
	6	100%	2	100%	2	100%	2	100%
	—	95-55%	2	95-55%	4	95-55%	1	95-55%
	1	50%	2	50%	—	50%	2	50%
	—	45-5%	1	45-5%	1	45-5%	2	45-5%
	1	0%	1	0%	—	0%	1	0%
Actual % who knew		67%				65%[4]		
PUBLIC RELATIONS								
	2	100%	—	100%	—	100%	—	100%
	3	95-55%	2	95-55%	3	95-55%	1	95-55%
	1	50%	1	50%	2	50%	—	50%
	2	45-5%	3	45-5%	2	45-5%	4	45-5%
	—	0%	2	0%	1	0%	3	0%
Actual % who knew		67%				65%[4]		
SYSTEMS								
	2	100%	—	100%	3	100%	1	100%
	3	95-55%	1	95-55%	2	95-55%	—	95-55%
	1	50%	1	50%	—	50%	—	50%
	2	45-5%	4	45-5%	3	45-5%	5	45-5%
	—	0%	—	0%	—	0%	2	0%
Actual % who knew		56%				61%[4]		

[1]PCP = Patient Contact Personnel = RN, LPN, Medical Assist. or Aids, Receptionist.

[2]OP = Office Personnel = Administrator, Admin Asst & other office and clerical.

[3]TP = Technical Personnel = Medical Records, Laboratory.

[4]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

* See Appendix 2 for text of Q.I.

**Some columns do not sum to 8 because of missing responses.

Table 9 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knows About Department. (N=8).**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
MEDICAL RECORDS								
	2	100%	2	100%	4	100%	3	100%
	6	95-55%	5	95-55%	3	95-55%	3	95-55%
	—	50%	—	50%	—	50%	—	50%
	—	45-5%	1	45-5%	1	45-5%	1	45-5%
	—	0%	—	0%	—	0%	1	0%
Actual % who knew		67%				78%[4]		
FINANCE								
	8	100%	2	100%	7	100%	3	100%
	—	95-55%	5	95-55%	1	95-55%	4	95-55%
	—	50%	—	50%	—	50%	—	50%
	—	45-5%	1	45-5%	—	45-5%	1	45-5%
	—	0%	—	0%	—	0%	—	0%
Actual % who knew		56%				78%[4]		
OPERATIONS								
	2	100%	5	100%	2	100%	—	100%
	4	95-55%	2	95-55%	3	95-55%	1	95-55%
	1	50%	1	50%	—	50%	3	50%
	1	45-5%	—	45-5%	2	45-5%	3	45-5%
	—	0%	—	0%	—	0%	1	0%
Actual % who knew		56%				61%[4]		
HEALTH SERVICES								
	4	100%	—	100%	1	100%	1	100%
	2	95-55%	1	95-55%	4	95-55%	2	95-55%
	1	50%	1	50%	1	50%	1	50%
	—	45-5%	4	45-5%	2	45-5%	2	45-5%
	—	0%	2	0%	—	0%	1	0%
Actual % who knew		89%				61%[4]		

[1] PCP = Patient Contact Personnel - RN, LPN, Medical Assist or Aide, Receptionists.
[2] OP = Office Personnel - Administrator, Admin. Asst. & other office and clerical.
[3] TP = Technical Personnel - Medical Records, Laboratory.
[4] This percent is for all AHP combined -- breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.
**Some columns do not sum to 8 because of missing responses.

TABLE 9 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knows About Department. (N=8).**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
				HEALTH EDUCATION				
	2	100%	—	100%	—	100%	—	100%
	2	95-55%	1	95-55%	4	95-55%	1	95-55%
	—	50%	—	50%	—	50%	1	50%
	3	45-5%	5	45-5%	4	45-5%	5	45-5%
	—	0%	1	0%	—	0%	1	0%
Actual % who knew		67%				61%[4]		

[1]PCP Patient Contact Personnel - RN, LPN, Medical Assist or Aids, Receptionist
[2]OP Office Personnel Administrator, Admin Asst & other office and clerical
[3]TP Technical Personnel Medical Records, Laboratory
[4]This percent is for all AHP combined - breakdown into 3 groups not possible since too many respondents failed to indicate their job classification
**Some columns do not sum to 8 because of missing responses

Perception of PCU physicians knowledge about HMO terms and operating principles (Question II A-E) will be presented in terms of the number of Central Office predicting the proportions of correct answers given by the physicians. It will be recalled from Table 3 that knowledge was found to be quite limited. The staff's perception of physician knowledge was much larger than the actual findings. Only six respondents completed Question II. Table 10 shows the data for Physicians. Only for one item, *Fee-for-Service*, did one Central Office member predict accurately within 10% for physician knowledge.

Table 10 shows comparable data for the predictions for AHPs knowledge about HMOs. Office Personnel (OP) are perceived as knowledgeable as physicians. Patient Care Personnel (PCP) and Technical Personnel (TP) are preceived as less knowledgeable. Consequently, OP was overrated and the other two AHP groups were perceived more realistically.

It was not possible to compare projections by Central Office staff for Questions III, the provision of specific services. The correct answers by PCU personnel depended on the nature of the PCU in which they work and the type of contract that the PCU has with MHMOP. The single projections by the staff do not take this into consideration, and comparisons are invalid.

The comparisons of Central Office staff predictions for Questions III (second part), the ways of obtaining information about service requests, show none of them approaching the actual distribution found and shown in Table 5. The only congruence observed is that Central Office staff does not, on the whole, visualize PCU staffs using written materials for obtaining information. Table 11 shows the data for this comparison.

Central Office staff, on the whole, also believe that most PCU staff perceive MHMOP as reasonable sometimes and not reasonable other times in approaching PCUs with enrollee service requests. About 61 percent of the PCU physicians did select this response. The AHPs, 59 percent, reported a more benign attitude and selected the response indicating that MHMOP usually is justified when it intervenes with such requests. Table 12 presents this data.

Central Office staff sees PCU physicians as more understanding in regard to handling patient complaints than distribution of physician answers indicate. Half the Central Office staff see AHPs as understanding, half see them as less understanding of the Central Office. Table 13 shows this data for Questions IVB.

Table 10

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO KNOW THE CORRECT ANSWERS TO HMO FEATURES*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knows HMO Feature Correctly. (N=6.)**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
CAPITATION								
	3	100%	1	50%	2	100%	1	100%
	1	25%	1	30%	1	90%	2	30%
	2	0%	1	20%	1	20%	1	10%
			1	10%	2	0%	2	0%
			2	0%				
Actual % who knew		44%				22%[4]		
FEE-FOR-SERVICE								
	2	100%	1	70%	1	100%	1	90%
	1	90%	1	60%	2	90%	1	60%
	1	80%	1	33%	3	80%	1	33%
	1	50%	2	20%			1	20%
	1	20%	1	0%			2	0%
Actual % who knew		44%				35%[4]		
RISK SHARING								
	3	100%	1	60%	1	100%	1	33%
	1	80%	1	33%	2	90%	1	30%
	1	50%	1	30%	2	80%	1	10%
	1	20%	3	0%	1	29%	3	0%
Actual % who knew		67%				65%[4]		
BENEFIT PACKAGE								
	1	100%	1	80%	1	100%	1	50%
	1	90%	1	60%	2	90%	1	33%
	2	80%	1	33%	3	80%	1	30%
	2	20%	1	30%			1	20%
			1	20%			1	10%
			1	0%				
Actual % who knew		44%				35%[4]		

[1]PCP = Patient Contact Personnel = RN, LPN, Medical Assist. or Aide, Receptionist.
[2]OP = Office Personnel = Administrator, Admin. Asst. & other office and clerical.
[3]TP = Technical Personnel = Medical Records, Laboratory.
[4]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

*See Appendix 2 for text of Q. IIA-E.
**Some columns do not sum to 6 because of missing responses.

Table 10 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knows HMO Feature Correctly. (N=6).**

PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDITIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
SPECIALISTS REFERRAL							
1	100%	1	40%	1	100%	1	30%
2	80%	2	20%	1	90%	2	20%
1	30%	3	0%	2	80%	3	0%
1	20%			1	50%		
1	0%			1	0%		
Actual % who knew	56%				43%[4]		

[1]PCP Patient Contact Personnel RN, LPN, Medical Assist or Aide, Receptionist
[2]OP Office Personnel Administrator, Admin Assist & other office and clerical
[3]TP Technical Personnel Medical Records, Laboratory
[4]This percent is for all AHP combined breakdown into 3 groups not possible since too many respondents failed to indicate their job classification
**Some columns do not sum to 6 because of missing responses

Table 11

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO SELECTED A GIVEN RESPONSE - CATEGORY FOR Q. III*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer (N=7)**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
Response: "Refer to Written Material"								
	1	20%	1	50%	1	30%[4]	1	90%
			1	30%			1	50%
			1	10%			2	20%
Actual % who gave this response		0%				12%[5]		
Response: "Consult With Someone In Office"								
	1	100%	1	100%	1	100%[4]	2	100%
	1	50%	1	80%	1	60%	1	70%
			1	50%	1	50%	1	60%
			1	25%			1	40%
			1	20%			1	10%
Actual % who gave this response		46%				6%[5]		
Response: "Call Up MHMOP Central Office"								
	1	90%	1	100%	1	100%[4]	1	100%
	1	60%	1	60%	1	95%	1	10%
	1	30%	1	25%	1	40%		
			1	20%	1	20%		
Actual % who gave this response		15%				35%[5]		
Response: "Already Know Answer Because I Have Been Doing This So Long"								
	21	100%	3	50%	1	80%[4]	1	60%
	1	70%	1	40%	1	20%	1	40%
	1	50%	1	10%			1	10%
	1	20%						
Actual % who gave this response		15%				29%[5]		

[1]PCP = Patient Contact Personnel = RN, LPN, Medical Assist, or Aide, Receptionist.
[2]OP = Office Personnel = Administrator, Admin. Asst. & other office and clerical.
[3]TP = Technical Personnel = Medical Records, Laboratory.
[4]For OP's only 5 Respondents.
[5]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

*See Appendix 2 for text Q III.
**Some columns do not sum to 7 because of missing responses.

Table 12

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO SELECTED A GIVEN RESPONSE CATEGORY FOR Q. IVA*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer. (N=7).**

	PREDICTIONS FOR M.D.s	PREDICTIONS FOR PCP[1]	PREDICTIONS FOR OP[2]	PREDICTIONS FOR TP[3]
Response: "MHMOP COS Unreasonable, Makes Waves"				
	1 20%	2 20%	1 20%[4]	3 20%
		1 5%		
Actual % who gave this response	8%		0%[5]	
Response: "MHMOP COS Usually Reasonable"				
	1 100%	2 100%	2 100%[4]	3 100%
	2 50%	2 40%	1 90%	1 50%
	1 40%	1 20%	1 50%	2 20%
			1 20%	
Actual % who gave this response	23%		59%	
Response: "MHMOP COS Sometimes Reasonable, Sometimes Not"				
	3 100%	2 100%	1 95%	1 100%
	2 50%	1 60%	1 50%	1 90%
	1 40%	1 55%	1 60%	1 60%
		2 40%	1 10%	1 40%
				1 30%
Actual % who gave this response	61%		29%	

[1]PCP = Patient Contact Personnel = RN, LPN, Medical Assist. or Aide, Receptionist.
[2]OP = Office Personnel = Administrator, Admin. Asst. & other office and clerical.
[3]TP = Technical Personnel = Medical Records, Laboratory.
[4]For OP's only 5 Respondents.
[5]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

*See Appendix 2 for text of Q. IVA
**Some columns do not sum to 7 because of missing responses.

Table 13

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO SELECTED A GIVEN RESPONSE CATEGORY FOR Q. IVB*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer. (N=7).**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
Response: "MHMOP Always Takes Patient's Side"								
	1	20%	2	20%	1	20%[4]	3	20%
			1	10%				
Actual % who gave this response		0%				0%[5]		
Response: "MHMOP Makes Reasonable Evaluations"								
	3	100%	3	100%	2	100%[4]	3	100%
	1	80%	1	60%	1	90%	1	50%
	1	50%	1	40%	1	50%	1	30%
	1	20%	1	30%	1	20%	1	20%
Actual % who gave this response		23%				65%[5]		
Response: "MHMOP COS Sometimes Takes Sides," Sometimes Reasonable								
	1	90%	1	100%	1	95%[4]	1	100%
	1	80%	1	60%	1	60%	1	90%
	1	50%	1	50%	1	20%	1	60%
	1	20%	1	40%	1	10%	1	50%
			1	30%			1	30%
Actual % who gave this response		61%				18%[5]		

[1]PCP - Patient Contact Personnel = RN, LPN, Medical Assist. or Aide, Receptionist.
[2]OP - Office Personnel = Administrator, Admin. Asst. & other office and clerical.
[3]TP - Technical Personnel = Medical Records, Laboratory.
[4]For OP's only 5 Respondents.
[5]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

* Appendix 2 for text of Q. IVB.
**Some columns do not sum to 7 because of missing responses.

The final comparison, the perception of PCU staff assessment of the problems with the *Benefit Package* is presented in Table 14. More hostility towards the marketing personnel was expected by Central Office staff than was actually found for either the physicians or the AHP. Central Office staff, however, did not expect many PCU staff to feel that enrollees on the whole are well informed. Table 14 shows the comparisons for Question V.

C. "Your Opinion Please"

This brief questionnaire, reproduced in Appendix 7, was completed by persons attending the Ann Arbor session of the training. Question I asked for evaluation of the information presented during the training session along four dimensions. Critical responses such as: too much, not enough, not helpful at all, confusing, boring in every instance, represented a minority opinion. Table 15 contains the data for this question.

Participants were asked to select the one presentation they liked best and the one liked least. Question 2 provided a total listing of the 15 presentations. However, physicians attended only 9 of these, while AHP attended 12. The rankings of presentations has been presented in two versions. One, Table 16A shows the rankings of the six presentations shared by all participants. The second, Table 16B, shows rankings of nine sessions by physicians and twelve sessions by AHP. The best liked was *Patients Rights*. the *Marketing* presentation (item f) was the least liked by physicians and nurses, while the remaining AHP agreed on *What is an HMO?* (item a). Perhaps as significant as the identification of best and least liked presentations, is the finding that many fewer persons indicated a "least" liked choice than a "best liked" choice. Twenty-three made no adverse selections, while six failed to identify a "best liked" presentation. The relationship between "best" and "least" liked speeches does not appear to be direct. Overall, it would seem that presentations about subjects like *Forms* (items k^1 and k^2) are the least popular for AHP, while physicians liked *Medical Topics* but did not care much one way or another about *Future Plans Relating to Dental Care*. It is impossible to attribute the reasons for these likes and dislikes since no information about them was collected, but undoubtedly the content of the presentations was not the only factor considered when making choices.

The comments made were generally brief and limited to naming areas of concern for MHMOP development. Some comments were critical and some complementary. Generally there was diversity of opinion: one respondent would eliminate discussion of encounter forms, another wished to hear more on that topic. (Table 17).

D. "After" Assessment of PCUs.

The questionnaire used for the data collection after the training session was, as mentioned previously, an adaptation of the initial MIS instrument. The adaptations consisted of the following:

1. A physician and AHP version were devised. The physician questionnaire contained previous questions on HMO terms and organizational principles in identical format. The AHP version omitted this group of items; it was felt, by MHMOP, that AHP do not require a knowledge of these aspect and had not been present at some of the presentations delving into such topics.
2. The former Question III, relating to provision of services, was redesigned in view of its format and coding complexity. The frame of reference was shifted to inclusion of items in the basic Benefit Package, i.e., availability if ordered by a physician or absolute exclusion. A few items were dropped.
3. Reworking of previous Question V, enrollee expectations, into a new Question IIB.
4. New questions stemming from material covered by the training session but of basic concern or strong current concern as observed during the needs assessment. Questions III, IV and V of new version.

The revised instruments are shown in Appendices 7 and 8.

The questions relating to knowledge about HMO characteristics, Question I for physicians, will be presented first. Table 18 shows the results of the "Before" questionnaire (administered prior to the Ann Arbor conference) and those for the August conference held in Detroit. It will be recalled that some persons attended this meeting even though they had not participated in the Ann Arbor session. As previously discussed, the significance of the observed improvement for the pure "Before" group and the "After Ann Arbor" group rests on very few cases. A comparison with the few cases in the "Not at Ann Arbor" group illustrated the softness of the data.

Table 14

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO SELECTED A GIVEN RESPONSE CATEGORY FOR Q. V*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer. (N=7).**

	PREDICTIONS FOR M.D.s		PREDICTIONS FOR PCP[1]		PREDICTIONS FOR OP[2]		PREDICTIONS FOR TP[3]	
Response: "MHMOP Don't Know or Exaggerate "To Make Sale"								
	1	100%	1	80%	1	90%[4]	2	40%
	1	40%	2	40%	1	40%	1	10%
			1	30%	1	10%		
Actual % who gave this response		23%				18%[5]		
Response: "Some New Enrollees Don't Know What Joining Means, Some Know Fairly Accurately"								
	3	100%	4	100%	2	100%[4]	3	100%
	1	90%	1	70%	2	90%	1	50%
	2	50%	1	50%	1	40%	1	30%
			1	40%			1	20%
Actual % who gave this response		38%				65%[5]		
Response: "Most of the Time, New Enrollees Know What They Are Entitled To"								
	1	50%	1	20%	1	20%[4]	2	20%
	1	10%	1	10%	1	10%	1	10%
Actual % who gave this response		23%				0%[5]		

[1]PCP - Patient Contact Personnel - RN, LPN, Medical Assist. or Aide, Receptionist.
[2]OP - Office Personnel - Administrator, Admin. Asst. & other office and clerical.
[3]TP - Technical Personnel - Medical Records, Laboratory.
[4]For Op's Only 5 Respondents.
[5]This percent is for all AHP combined — breakdown into 3 groups not possible since too many respondents failed to indicate their job classification.

*See appendix 2 for text of Q V.
**Some columns do not sum to 7 because of missing responses.

Table 15

PARTICIPANTS' EVALUATION OF INFORMATION PRESENTED AT TRAINING SESSION

Q. I.: "The information given during the conference was: "*

	Responses	Total (N=68) Percent [3]	M.D.s (N=10) Percent[3]	PCP[1] (N=21) Percent[3]	Other AHP[2] (N=37) Percent[3]
a.	Too much	9	—	9	11
	Just Right	56	70	52	54
	Not Enough	19	30	9	22
	No Answer	16	—	29	13
	Total	100	100	99	100
b.	Very Helpful	59	70	48	62
	Somewhat Helpful	26	20	38	22
	Not Helpful At All	9	10	5	11
	No Answer	6	—	9	5
	Total	100	100	100	100
c.	Very Clear	35	20	33	40
	Okay	34	60	14	38
	Confusing	12	—	19	11
	No Answer	19	20	33	11
	Total	100	100	99	100
d.	Interesting	71	70	67	73
	Alright	13	20	5	16
	Boring	7	—	9	8
	No Answer	9	10	19	3
	Total	100	100	100	100

[1]PCP Patient Care Personnel : RN, LPN, Medical Assistant or Aide, Receptionist.
[2]AHP Allied Health Personnel
[3]Rounded, may add to 99% or 101%.

*See Appendix 7 for text of Q. I.58

Table 16A

RANKING OF PRESENTATION AS *BEST LIKED* AND *LEAST LIKED* FOR 6 TOPICS ATTENDED BY ALL PARTICIPANTS

Q. 2.: "Put a check mark by the *one* presentation you liked best in Column A and a check mark by the *one* presentation you liked least in Column B."*

Presentation	Rankings of Presentations					
	Best Liked by			Least Liked By		
	M.D.s (N=10)	PCP[1] (N=21)	Other AHP[2] (N=37)	M.D.s (N=10)	PCP[1] (N=21)	Other AHP[2] (N=37)
a. "What is an HMO?"	2	3	2	3	4	1
b. "Patient Rights"	1	1	1	5	2	5
c. "How Michigan HMO Plans, Inc. Operates"	4	2	6	5	6	3.5
d. "Health Services Available via MHMOP Central Office Referral"	5	4	5	5	5	3.5
e. "Fee-for-Service Utilization"	3	6	4	2	3	2
f. How Michigan HMO Plan is Marketed"	6	5	3	1	1	6
Number Not Answering	(1)	(-)	(5)	(4)	(5)	(14)

[1] PCP - Patient Care Personnel RN, LPN, Medical Assistant or Aide, Receptionist.
[2] AHP - Allied Health Personnel

*See Appendix 7, for text of Q. 2.

Table 16B

RANKING OF PRESENTATIONS AS *BEST LIKED* AND *LEAST LIKED* FOR 9 ATTENDED BY PHYSICIANS AND 12 ATTENDED BY ALLIED HEALTH PERSONNEL (AHP)*

	Ranking of Presentations					
	By M.D.s		By PCP[1]		By Other AHP	
	(N=10)		(N=21)		(N=37)	
	Best	Least	Best	Least	Best	Least
a. "What is an HMO?"	2	3	3	2	5	1
b. "Patient Rights"	1	5	1	1	2	5
c. "How Michigan HMO Plans, Inc. Operates"	6	5	2	6.5	11	3.5
d. "Health Services Available via MHMOP Central Office Referral"	7	5	5	5	10	3.5
e. "Fee-for-Service Utilization"	5	2	9	4	4	2
f. "How Michigan HMO Plan is Marketed"	8	1	6	3	1	6
g. "Financial structure of the Plan"	4	7	—	—	—	—
h. Effective Patient Management"	3	—	—	—	—	—
i. "Corporate Dental Planning for MHMOP"	9	8	—	—	—	—
j_1 "Account Executives"	—	—	11	11.5	7.5	9
j_2 "Enrollee Orientation"	—	—	8	9	6	8
j_3 "MHMOP's HOTLINE"	—	—	4	11.5	7.5	11
j_4 "Enrollee Concerns"	—	—	10	6.5	9	7
k_1 "Medical Records"	—	—	7	8	12	10
k_2 "MHMOP's Encounter Form"	—	—	12	10	3	12
Number Not Answering	(1)	(4)	(-)	(5)	(5)	(14)

[1]PCP Patient Care Personnel: RN, LPN, Medical Assistant or Aide, Receptionist.

*See Appendix 7

Table 17

PARTICIPANTS' OPINIONS ABOUT INCLUSIONS AND EXCLUSIONS OF TOPICS

Q. 3.: "Is there any topic or subject that was not covered that you think should have been covered? If YES, describe TOPIC."*

Q. 4.: "Is there any topic or subject that was covered which could have been left out? If YES, describe TOPIC."*

	Total (N=68) Percent [3]	M.D.s (N=10) Percent [3]	PCP[1] (N=21) Percent [3]	Other AHP[2] (N=37) Percent [3]
Could have included additional topic(s)				
Yes	21	30	19	19
No	48	60	57	40
No Answer	31	10	24	40
Total	100	100	100	99
Could have omitted some topics(s)				
Yes	12	10	14	11
No	57	60	67	51
No Answer	31	30	19	38
Total	100	100	100	100

[1]PCP Patient Contact Personnel RN, LPN, Medical Assistant or Aide, Receptionist
[2]AHP Allied Health Personnel
[3]Rounded, may add to 99% or 101%

Suggestions for inclusion: Outreach, Pharmacy, Hospital Care; "Marketing" procedures, Physician and Personnel rights, Encounter Forms, Financial burden of hospital over-utilization, HMO, Patient Rights, Enrollee Orientation: Acceptance of Provider Group
Suggestions for ommissions: Marketing, "most of it", Medical Records, The Whole Thing, Encounter Forms, Referral Details
General Comments: (Q 6) Consumer, Outreach, several compliments; should be repeated every four months"

*See Appendix 7

Table 18

PCU PHYSICIANS ANSWERING QUESTIONS ON HMO FEATURES CORRECTLY* BEFORE AND AFTER TRAINING SESSION, Q.I.**

HMO Feature	PCU Physicians Answering Correctly*			
	Before Training (A) (N=9) Percent	After Training (B) (N=7) Percent	Not Trained (C) (N=5) Percent	A and C (N=14) Percent
Capitation	44	100	100	64
Fee-for-Service	44	71	100	64
Risk Sharing	67	100	100	79
Benefit Package	44	57	60	50
Specialist Referrals	56	71	80	64

A = Data from questionnaire administered before Needs Assessment.
B = Data from Physicians attending Ann Arbor Training Session.
C = Data from Physicians NOT attending Ann Arbor Training Session but attending August 6th Session.

*Correct Responses: QIA., QIB2., QIC3., QID1., QIE4.

**See Appendix 8 for text of QIA-E (Physician Version).

Nevertheless, since the data all go in one direction, some impact appears to have been made by the training sessions.

Questions IIA assesses PCU staffs' knowledge about the availability of an array of services. The question was scored for each individual respondent, possible scores ranging up to 23. After some scoring had been done, it became clear that some respondents frequently checked more than one answer per service, and it became necessary to score by deducting "wrong" answers. This, in turn, created the possibility of obtaining scores of less than 0, and such scores have been labelled 99 to distinguish them from 0.

It was then attempted to score the "Before" question so that scores could be compared, but the lack of proper identification for relevant items made this impossible. Therefore, Table 19 presents "After" data only. The overall level of knowledge is not very high: 10 of the 55 from the "At Ann Arbor" group, or 18 percent, scored below 0, while the second group contained 37.5 percent of negative scorers. Since all negative scorers came from AHP and none from among the PCU physicians. This may be interpreted to show that AHP benefited from the training session in this area. The case for the physicians' profiting equally cannot however be made since the distribution of Physician scores for "trained" and "untrained" respondents shows an essentially similar pattern. The score distributions for the two AHP groups appear to differ with the untrained respondents clustering apparently around lower scores.

The final questions in the revised instrument are, as pointed out previously, not comparable to questions in the original questionnaire used for the "before" assessment. However, since both "trained" and "untrained" respondents can be identified, comparison between these groups will be examined. Table 20 shows Questions IB and Question II*, while Table 21 shows Questions III and IV.*

Question IB asks about the reason for refusals of enrollees' requests for services. Two answers were most frequently chosen: the enrollee's failure to understand and that no one reason predominates. Usually the first reason carries the larger percentage of answers. The "hostile" response that MHMOP oversells enrollees occurs more frequently among the "untrained" than the trained. Again, it is dubious that one may ascribe this small difference to participating in the training session.

The second question is a True-False one, asking whether the primary relationship of the enrollee is to either MHMOP or a PCU. The correct response, relationship between MHMOP and the enrollee, was selected slightly more frequently by the trained group. Support for this may exist in the finding that none of the seven "untrained" selected the correct response. However, the small numbers make interpretation precarious.

Table 21 presents the distribution of attitudes towards the Hot Line and about paperwork. Question III appears to show more positive opinions that the Hot Line is a proper Central Office function. Among the "trained," interestingly enough, the proportion who do not accept the location of the Hot Line in the Central Office is about the same in both trained and untrained groups. The number of persons who have "no opinion" is quite different between the two groups with those having received training showing fewer in this category, with the difference essentially going to the supportive position. If this shift is indeed real, training exposure seems to have had some impact. Opinions about paperwork and its reasonableness perhaps also have undergone a slight modification towards acceptance among the trained group. Again, the tenuous character of the data should counsel caution in interpretation.

*Questions IB, II, III, and IV in the AHP questionnaire are Questions IIB, III, IV and V in the Physician questionnaire.

Table 19A

DISTRUBUTION OF SCORES* FOR KNOWLEDGE ABOUT THE AVAILABILITY OF SERVICES, BY PCU PERSONNEL AFTER TRAINING** AND WITHOUT TRAINING.*** Q.IIA****

Score* (Optimal=23)	After Training Session**				Not At Training Session***			
	Total	M.D.s	PCP[1]	Other AHP[2]	Total	M.D.s	PCP[1]	Other AHP[2]
Less than 0	10	—	3	7	6	—	2	4
1	3	—	—	3	—	—	—	—
2	2	—	1	1	2	—	1	1
3	7	—	5	2	1	—	1	—
4	5	—	—	5	—	—	—	—
5	7	—	1	6	—	—	—	—
6	—	—	—	—	1	—	—	1
7	4	—	—	4	—	—	—	—
8	2	1	1	—	2	1	—	1
10	2	—	1	1	—	—	—	—
11	4	1	3	—	1	1	—	—
12	1	—	—	1	—	—	—	—
13	1	1	—	—	—	—	—	—
14	3	1	—	2	1	1	—	—
15	3	2	1	—	—	—	—	—
16	—	—	—	—	1	1	—	—
18	1	1	—	—	—	—	—	—
19	—	—	—	—	1	1	—	—
Total	55	7	16	32	16	5	4	7

[1]PCP - Patient Care Personnel = RN, LPN, Medical Assist. or Aide, Receptionist.
[2]AHP = Allied Health Personnel.

*See text for scoring method.
**"After Training" denotes PCU personnel who attended Ann Arbor Training Session.
***"Not At Training Session," or "Without Training" denotes PCU Personnel who did NOT attend Ann Arbor Session but attended August 6th Session.
****See Appendix 8 for text of Q.IIA (Physician Version).

Table 19B

KNOWLEDGE ABOUT AVAILABILITY OF SERVICES "AFTER TRAINING"* AND "WITHOUT TRAINING"** FOR PCU PHYSICIANS AND ALLIED HEALTH PERSONNEL (AHP). Q. IIA***

Health Services	Percent Answering Correctly					
	M.D.s			AHP		
	Total (N=11)	After Training* (N=6)	Without Training** (N=5)	Total (N=59)	After Training* (N=48)	Without Training** (N=11)
1. Prenatal Care	91	83	100	90	92	82
2. Eye Glasses	54	50	60	49	54	27
3. Plastic Surgery (Cosmetic)	18	17	20	29	31	18
4. Outpatient X-ray Studies	91	83	100	58	60	45
5. EKG & EEG	91	83	100	85	87	73
6. Abortions	27	33	20	37	42	18
7. Dental Care	45	50	40	25	29	9
8. Psychiatric Care Outpatient	64	50	80	52	56	36
9. Contact Lenses	27	33	20	34	35	27
10. Emergency Room Services	91	100	80	61	81	64
11. Tubal Ligation	27	17	40	34	37	18
12. Inpatient Hospitalization	82	100	60	78	81	64
13. Dermatologists	45	67	20	42	42	45
14. Allergists	54	67	40	44	46	36
15. Podiatrist	45	50	40	36	40	18
16. Health Care (domestic)	36	33	40	27	25	36
17. VNA	45	50	40	32	37	9
18. Psychiatric Care Inpatient	45	50	40	52	58	27
19. General Surgery	82	67	100	78	83	54
20. Health Education	54	67	40	51	56	27
21. Prescriptions	82	67	100	86	90	73
22. Ambluance	36	33	40	24	23	27
23. Transportation (other than ambulance)	27	—	60	12	10	18

*"After Training" – Participants at Ann Arbor Session
**"Without training" – Participants only at August 6th Session
***See appendix 8 for text of Q. IIA.

Table 20

RESPONSES TO ATTITUDINAL AND FACTUAL QUESTIONS, BY PCU PERSONNEL "AFTER TRAINING"* AND "WITHOUT TRAINING."** Q. IB AND II

Q. IB: "When you think about enrollee service requests which are not granted, this most often happend because: (CHECK ONLY)"***

Responses	After Training Session				Not At Training Session**			
	Total (N=55) Percent[3]	M.D.s (N=7) Percent[3]	PCP[1] (N=16) Percent[3]	Other AHP[2] (N=32) Percent[3]	Total (N=16) Percent[3]	M.D.s (N=5) Percent[3]	PCP[1] (N=4) Percent[3]	Other AHP[2] (N=7) Percent[3]
1. "The enrollee hasn't understood what the Plan in fact provides."	49	14	44	59	50	20	50	71
2. "PCU Staff is not correctly and completely informed as to the range of services to which the enrollee is entitled."	4	—	—	6	—	—	—	—
3. "MHMOP CO has not explained the provisions to the PCU."	2	—	—	3	—	—	—	—
4. "MHMOP CO has always oversold the enrollee."	5	29	6	—	6	—	25	—

[1]PCP Patient Care Personnel - RN, LPN, Medical Assist. or Aide, Receptionist.
[2]AHP Allied Health Personnel
[3]Rounded, may add to 99% or 101%.
*"After Training" denotes PCU personnel who attended Ann Arbor Training Session.
**"Not at Training Session" or "Without Training denotes PCU Personnel who did NOT attend Ann Arbor Session but attended August 6th Session
***See Appendix 9 for text of Q. IB.

Table 20 (Continued)

Responses	After Training Session*				Not At Training Session**			
	Total (N = 55) Percent[3]	M.D.s (N = 7) Percent[3]	PCP[1] (N = 16) Percent[3]	Other AHP[2] (N = 32) Percent[3]	Total (N = 16) Percent[3]	M.D.s (N = 5) Percent[3]	PCP[1] (N = 4) Percent[3]	Other AHP[2] (N = 7) Percent[3]
5. "Some instances of each of the above reasons, no one in particular."	27	57	31	19	31	80	—	14
No Answers	13	—	19	12	12	—	25	14
Total	100	100	100	99	99	100	100	99

Q. II: "Which of the following statements is TRUE? (CHECK ONE OF THE 3 BOXES)

A. "The primary contractual relationship is between the PCU and the enrollee assigned to it." (FALSE)	22	14	37	16	25	20	—	43
B. "The primary contractual relationship is between MHMOP's Central Office and the enrollee." (TRUE)	49	71	25	56	31	60	50	—

[1]PCP Patient Care Personnel RN, LPN, Medical Assist or Aide Receptionist.
[2]AHP Allied Health Personnel
[3]Rounded, may add to 99% or 101%.
*"After Training" denotes PCU personnel who attended Ann Arbor Training Session.
**Not At Training Session" or "Without Training" denotes PCU personnel who did NOT attend Ann Arbor Session but attended August 6th Session.

Table 20 (Continued)

Responses	After Training Session*				Not At Training Session**			
	Total (N=55) Percent[3]	M.D.s (N=7) Percent[3]	PCP[1] (N=16) Percent[3]	Other AHP[2] (N=32) Percent[3]	Total (N=16) Percent[3]	M.D.s (N=5) Percent[3]	PCP[1] (N=4) Percent[3]	Other AHP[2] (N=7) Percent[3]
C. Don't Know	20	14	25	19	31	20	50	29
No Answer	9	—	12	9	12	—	—	29
Total	100	99	99	100	99	100	100	101

[1]PCP Patient Care Personnel – RN, LPN, Medical Assist. or Aide, Receptionists.
[2]AHP Allied Health Personnel.
[3]Rounded, may add to 99% or 101%.

*"After Training" denotes PCU personnel who attended Ann Arbor Training Session.
**"Not At Training Session" or "Without Training" denotes PCU Personnel who did NOT attend Ann Arbor Session but attended August 6th Session

Table 21

RESPONSES TO ATTITUDINAL QUESTIONS, BY PCU PERSONNEL "AFTER TRAINING"* AND "WITHOUT TRAINING."**

Q. III: "By placing the Emergency Care "HOTLINE" in MHMOP's Central Office, the Central Office is: (CHECK *ONE* OF THE FOLLOWING 3 STATEMENTS)"***

Response	After Training Session*				Not At Training Session**			
	Total (N=55) Percent[3]	M.D.s (N=7) Percent[3]	PCP[1] (N=16) Percent[3]	Other AHP[2] (N=32) Percent[3]	Total (N=16) Percent[3]	M.D.s (N=5) Percent[3]	PCP[1] (N=4) Percent[3]	Other AHP[2] (N=7) Percent[3]
A. "Performing a reasonable necessary part of patient care efficiently."	76	86	81	72	44	80	50	14
B. "Is intruding in patient care under the guise of providing an efficent service."	5	—	12	3	12	20	25	—
C. No Opinion	11	—	6	16	37	—	25	71
No Answer	5	—	—	9	6	—	—	14
Total	97[4]	86[4]	99	100	99	100	100	99

[1]PCP = Patient Care Personnel = RN, LPN, Medical Assist or Aide, Receptionist.
[2]AHP = Allied Health Personnel.
[3]Rounded, may add to 99% or 101%.
[4]One "other answer not shown in table.

*"After Training" denotes PCU personnel who attended Ann Arbor Training Session.
**"Not At Training Session" or "Without Training" denotes PCU personnel who did NOT attend Ann Arbor Session but attended August 6th Session.

***See Appendix 8 for text of Q. III.

Table 21 (Continued)

Q. IV: "Considering the paper work required of the PCU by Central Office: (CHECK *ONE* OF THE FOLLOWING STATEMENTS)"

Responses	After Training Session*				Not At Training Session**			
	Total (N=55) Percent[3]	M.D.s (N=7) Percent[3]	PCP[1] (N=16) Percent[3]	Other AHP[2] (N=32) Percent[3]	Total (N=16) Percent[3]	M.D.s (N=5) Percent[3]	PCP[1] (N=4) Percent[3]	Other AHP[2] (N=7) Percent[3]
A. "All of it seems reasonable and there seems to be justification for all of it!"	29	14	31	31	6	—	—	14
B. "Some of it seems reasonable and is justified but some is not."	60	86	56	56	75	100	100	43
C. "Very little seems reasonable and very little seems justified."	2	—	6	—	12	—	—	29
No Answer	9	—	6	12	6	—	—	14
Total	100	100	99	99	99	100	100	100

[1]PCP Patient Care Personnel RN, LPN, Medical Assist. or Aide, Receptionist.
[2]AHP Allied Health Personnel
[3]Rounded, may add to 99% or 101%.

* "After Training" denotes PCU personnel who attended Ann Arbor Training Session.
** "Not At Training Session" or "Without Training" denotes PCU personnel who did NOT attend Ann Arbor Session but attended August 6th Session.

E. The "After" Assessment of MHMOP Central Office Staff

The staff was given one each of the two "After" questionnaires and asked to estimate the distribution of responses for physicians and separately for AHP. The instructions did not ask them to take into account the training impact on PCU personnel, but avoided the notion of training and impact completely. The purpose of the before and after comparison here is to explore if their image of PCU personnel has changed, and if so, in what direction.

Table 22 shows the Central Office staff's projections for physicians' knowledge about HMO features (Question IA-E, Physician Questionnaire.). There appears to have been change in perception: In some areas of knowledge the perceived image of PCU physicians has improved: *Capitation* showed a dichotomy before training, i.e., half saw all physicians knowledgeable, half saw them quite, if not totally, ignorant, "After" perception is much less dichotomus, and only a quarter perceive these physicians as extremely ignorant. The perception about correct *Benefit Package* information which PCU physicians have also changed, with about 70 percent reporting that all (100%) of the PCU physicians have correct information. The previous perception had 17 percent holding that all PCU physicians had correct information. The remaining items do not appear to show any significant changes in any direction. The spread for the "after" data is probably due to the increase in number of Central Office staff who responded.

The questionnaire for AHP does not contain this set of questions and therefore no "after" data is available for analysis of change.

The projection of degree of knowledge about provision of services cannot be analyzed in terms of impact because no data exists from the "before" questionnaire. Instead, Table 23 was constructed simply to report Central Office staff perceptions in this area: Question IA (Question IIA). The two sets of figures show the number of Central Office staff who believed 100 to 90 percent of PCU physicians and AHP would have correct information. The second column for the PCU physicians and AHP shows the number of Central Office staff who felt no one would have accurate information. Clearly, Central Office staff perceive physicians as better informed, for every service listed: there are more Central Office staff who believe physicians to be correctly informed than they believe of AHP.

Question IB, II, III, and IV* (Appendix 9) which test attitudes and knowledge, as stated before, have no previously asked equivalents. Table 24 shows the item for each of the questions which received the largest response, when both "trained" and "not trained" groups' data were merged for PCU physicians and AHP. The predictions for the frequency with which physicians and AHP would select the indicated response are shown also. Most of the AHP predictions appear neither of extremely good fit nor very far off. The one item which shows extreme difference between actual response distribution and prediction is for alternative 5 in Question IB. Only three members of the Central Office staff apportioned any response for this one, and of these one was for 100 percent of responses, one for 80 percent and the third for 10 percent.

F. Discussion

Before going into any details about the findings of this impact evaluation, it must once again be stressed that the numbers involved are quite small and that therefore the percentages should not be taken as other than gross indications of distributions: a shift of a single response often would change percentages quite drastically.

The knowledge the PCU personnel have about the Central Office organization (Table 1) does not seem extraordinary when one takes into account (1) that not all physicians working in PCUs are in contractual relationships with MHMOP but are employed by PCUs; and (2) that the different Allied Health Personnel either deal with only one or two departments and perhaps with none depending on their particular job. The departments which by their very nature require contact with personnel from PCUs, for example Medical Records, proportionately are also better known by appropriate groups.

*Or, Physician Questionnaire Question IIB, III, IV and V. (Appendix 8.)

Table 22

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PHYSICIANS WHO KNOW THE CORRECT ANSWERS TO HMO FEATURES* FOR "BEFORE"** AND "AFTER TRAINING"*** COS RESPONSES.

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Physicians Know HMO Features "Before" and "After Training."

	PREDICTION "BEFORE" (N=6)		PREDICTION "AFTER TRAINING" (N=13)	
CAPITATION				
	3	100%	3	100%
	1	25%	1	90%
	2	0%	1	80%
			1	70%
			1	60%
			2	50%
			1	40%
			1	30%
			1	20%
			1	0%
Actual % who knew		44%		64%[1]
FEE-FOR-SERVICE				
	2	100%	3	100%
	1	90%	3	90%
	1	80%	1	80%
	1	50%	1	70%
	1	20%	1	50%
			1	35%
			1	20%
			1	10%
Actual % who knew		44%		64%[1]
RISK SHARING				
	3	100%	7	100%
	1	80%	2	95%
	1	50%	1	80%
	1	20%	1	70%
			1	40%
			1	33%
Actual % who knew		67%		79%[1]

[1]Combined for group A and C, Table 18.

*See Appendix 8 for text of Q. IIA-E

**Responses obtained before Training Session.

***Responses obtained after Ann Arbor Training Session.

Table 22 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Physicians Knows HMO Features "Before" and "After Training."

	PREDICTION "BEFORE" (N = 6)		PREDICTION "AFTER TRAINING" (N = 13)	
BENEFIT PACKAGE				
	1	100%	9	100%
	1	90%	1	90%
	2	80%	1	0%
	2	20%	2	NA[2]
Actual % who knew		44%		50%[1]
SPECIALIST REFERRALS				
	1	100%	4	100%
	2	80%	1	80%
	1	30%	2	50%
	1	20%	1	30%
	1	0%	1	25%
			2	20%
			1	0%
Actual % who knew		56%		64%[1]

[1]Combined for Group A and C, Table 18
[2]Not Answered

Table 23

CENTRAL OFFICE STAFF (COS) PREDICTIONS, AFTER TRAINING SESSION,* OF PROPORTION OF PCU PERSONNEL ANSWERING CORRECTLY ABOUT THE AVAILABILITY OF SERVICES. — SELECTED SERVICES SHOWN WITH FIVE MOST FAVORABLE** AND FIVE LEAST FAVORABLE*** COS PREDICTIONS FOR Q. IIA****

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knew Correct Answer. (N = 12).

	PREDICTIONS FOR M.D.s		PREDICTION FOR AHP[1]	
5. EKG and EEG				
	11	100%	7	100%
	1	90%	2	90%
	1	80%	2	50%
			1	40%
Actual % who gave correct answer:		91%		85%
1. PRENATAL CARE				
	10	100%	5	100%
	2	90%	1	90%
	1	70%	2	80%
			1	60%
			3	50%
Actual % who gave correct answer:		91%		90%
2. EYE GLASSES				
	9	100%	2	100%
	1	90%	1	80%
	1	60%	1	60%
	1	30%	3	50%
	1	0%	2	40%
			1	30%
			2	0%
Actual % who gave correct answer:		54%		49%

[1]AHP — Allied Health Personnel
*After Training Session at Ann Arbor.
**Most Favorable as shown by frequency of predicting 100%
***Least favorable as shown by frequency of predicting 0%.
****See Appendix 8 for text of Q. IIA.

Table 23 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knew Correct Answer. (N=12).

	PREDICTIONS FOR M.D.s		PREDICTION FOR AHP[1]	
12. INPATIENT HOSPITALIZATION				
	9	100%	9	100%
	1	80%	1	80%
	1	35%	1	60%
	1	0%	1	0%
Actual % who gave correct answer:		82%		78%
21. PRESCRIPTIONS				
	9	100%	6	100%
	2	90%	1	80%
	1	30%	1	70%
	1	0%	1	60%
			1	50%
			1	20%
			1	0%
Actual % who gave correct answer:		82%		86%
22. AMBULANCE				
	2	100%	1	100%
	1	25%	1	60%
	1	10%	3	50%
	9	0%	1	20%
			1	10%
			4	0%
Actual % who gave correct answer:		36%		24%
23. TRANSPORTATION OTHER THAN AMBULANCE				
	2	100%	1	100%
	1	95%	2	60%
	1	95%	2	50%
	1	20%		
	1	10%	1	40%
	8	0%	1	20%
			1	10%
			4	0%
Actual % who gave correct answer:		27%		12%

*AHP - Allied Health Personnel.

*After Training Session at Ann Arbor.

**Most Favorable as shown by frequency of predicting 100%; Least Favorable as shown by frequency of predicting 0%.

Table 23 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Knew Correct Answer. (N=12).

	PREDICTIONS FOR M.D.s		PREDICTION FOR AHP[1]	
3. PLASTIC SURGERY-COSMETIC				
	3	100%	1	90%
	1	40%	1	70%
	1	20%	1	50%
	1	10%	1	40%
	7	0%	1	30%
			1	10%
			6	0%
Actual % who gave correct answer:		18%		29%
9. CONTACT LENSES				
	2	100%	1	40%
	1	90%	1	25%
	1	45%	1	20%
	1	30%	9	0%
	7	0%		
Actual % who gave correct answer:		27%		34%
11. TUBAL LIGATION				
	3	100%	2	100%
	1	95%	1	80%
	1	90%	1	60%
	2	50%	2	50%
	6	0%	1	40%
			2	20%
			3	0%
Actual % who gave correct answer:		27%		34%

[1]AHP = Allied Health Personnel.

*After Training Session at Ann Arbor.
**Most Favorable as shown by frequency of predicting 100%; Least Favorable as shown by frequency of predicting 0%.

Table 24

CENTRAL OFFICE STAFF (COS) PREDICTIONS OF PROPORTION OF PCU PERSONNEL WHO SELECTED A GIVEN RESPONSE CATEGORY FOR Q. IB, II, III AND IV*

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer.

	PREDICTIONS FOR M.D.s (N=13)[2]		PREDICTION FOR AHP[1] (N=12)[2]	
Q. IB, Response: Enrollee has not understood what Plan provides				
	4	80%	1	100%
	1	60%	1	90%
	3	50%	1	70%
	2	40%	1	60%
	1	NA	2	50%
			1	33%
			1	25%
			1	20%
			1	10%
Actual % who gave this response:		17%		56%
Q. IB, Response: PCU Staff not correctly and completely informed				
	1	20%	1	100%
	1	10%	1	33%
	1	NA	1	30%
			2	10%
			1	5%
Actual % who gave this response:		0%		3%
Q. IB, Response: MHMOP COS has not explained Plan to PCU				
	1	50%	1	40%
	1	30%	1	30%
	1	20%	1	20%
	4	10%	1	10%
	1	NA		
Actual % who gave this response:		0%		2%

[1]AHP = Allied Health Personnel.
[2]Number of Central Office Staff Responding on Physician Questionnaire (13) and Allied Health Personnel Questionnaire (12).

*See Appendix 9 for text of Q. IB, II, III and IV.

Table 24 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer.

	PREDICTIONS FOR M.D.s (N=13)[2]		PREDICTION FOR AHP[1] (N=12)[2]	
Q. IB, Response: MHMOP COS has always oversold the enrollee				
	2	50%	1	80%
	2	30%	1	70%
	1	20%	1	30%
	4	10%	2	25%
			1	20%
			1	10%
Actual % who gave this response:		17%		3%
Q. IB, Response: Some instances of each of above, none in particular				
	1	100%	1	33%
	1	80%	2	30%
	1	10%	2	20%
			1	10%
Actual % who gave this response:		67%		20%

[1]AHP Allied Health Personnel.
[2]Number of Central Office Staff Responding on Physician Questionnaire (13) and Allied Health Personnel Questionnaire (12).

Table 24 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer.

	PREDICTIONS FOR M.D.s (N=13)[2]		PREDICTION FOR AHP[1] (N=12)[2]	
Q. II, Response; Primary relationship is between PCU and enrollee				
	1	100%	1	90%
	1	80%	1	80%
	2	60%	1	60%
	1	50%	2	50%
	2	20%	1	40%
	2	10%	1	35%
			1	20%
			1	10%
Actual % who gave this response:		17%		24%
Q. II, Response: Primary Relationship is between MHMOP and enrollee				
	3	100%	1	90%
	2	90%	1	80%
	2	80%	1	75%
	1	50%	1	50%
	1	40%	3	40%
	1	20%	1	35%
	2	10%	1	30%
			1	20%
			1	10%
Actual % who gave this response:		67%		41%
Q. II, Response: Don't Know				
	1	80%	1	100%
	1	20%	1	60%
	2	10%	1	30%
			3	20%
			1	5%
Actual % who gave this response:		17%		24%

[1]AHP - Allied Health Personnel
[2]Number of Central Office Staff Responding on Physician Questionnaire (13) and Allied Health Personnel Questionnaire (12).

Table 24 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer.

	PREDICTIONS FOR M.D.s (N=13)[2]		PREDICTION FOR AHP[1] (N=12)[2]	
Q. III, Response: HOTLINE in Central Office reasonable part done efficiently				
	3	100%	2	100%
	1	90%	1	90%
	4	80%	1	80%
	2	70%	1	70%
	1	50%	2	60%
	1	33%	3	50%
	1	25%	1	20%
			1	10%
Actual % who gave this response:		83%		66%
Q. III, Response: HOTLINE in Central Office intrudes in patient care				
	1	75%	1	60%
	1	50%	3	50%
	1	33%	1	40%
	2	30%	1	20%
	1	10%	1	10%
Actual % who gave this response:		8%		7%
Q. III, Response: No Opinion				
	1	33%	1	90%
	4	20%	1	30%
			2	20%
			2	10%
Actual % who gave this response:		0%		20%

[1]AHP - Allied Health Personnel.
[2]Number of Central Office Staff Responding on Physician Questionnaire (13) and Allied Health Personnel Questionnaire (12).

Table 24 (Continued)

Number of COS Predicting Specific Percentage to Indicate What Proportion of PCU Personnel Gave a Specific Answer.

	PREDICTIONS FOR M.D.s (N=13)[2]		PREDICTION FOR AHP[1] (N=12)[2]	
Q. IV, Response: Paperwork required all seems reasonable and justified				
	2	100%	2	50%
	1	80%	1	40%
	2	50%	2	30%
	2	30%	1	20%
	1	15%	2	10%
	2	10%		
Actual % who gave this response:		8%		27%
Q. IV, Response: Some of paperwork seems reasonable and justified, some is not				
	1	100%	3	100%
	2	70%	4	70%
	1	60%	4	50%
	3	50%	1	20%
	1	40%		
	1	25%		
	2	20%		
Actual % who gave this response:		92%		58%
Q. IV, Response: Very little of paperwork seems reasonable and justified				
	1	80%	1	80%
	1	65%	1	30%
	1	50%	2	20%
	2	20%	1	10%
	1	15%		
	2	10%		
Actual % who gave this response:		0%		10%

[1]AHP = Allied Health Personnel.
[2]Number of Central Office Staff Responding on Physician Questionnaire (13) and Allied Health Personnel Questionnaire (12).

The Central Office staff's perception of the PCU personnel tends to overrate physician knowledge on the whole and seems to contain some extreme images, as shown by responses of 100% or 0% which occur fairly regularly. Not evident from the data presented in the tables (Tables 9-13 and 21-23) is the fact that these extremes were not held by particular individuals for each question but by different persons for different items.

The lack of understanding of HMO features (Table 2) is substantiation of MHMOP's feeling that basic concepts need to be called to PCU physicians' attention, even if Allied Health Personnel (AHP) perhaps do not need to be familiar with all these concepts. Certainly some of the Central Office staff, despite their awareness of the need for training, still perceived the PCU physicians as better informed than they indeed proved to be (Table 10). Interestingly enough, office personnel were perceived as well informed by half the Central Office staff though in fact they differed but little from their allied health colleagues. The feeling expressed in comments on questionnaires that AHP do not need to know operating, and particularly financial aspects of HMOs, raises an interesting question. Namely, would the PCUs function more efficiently if all personnel understood the hazards of prepaid group practices?

This consideration particularly comes to mind when information about specific services and their availability to patients is considered. Essentially, as long as PCU personnel do not know what services are and are not available under what conditions, it might be expected that ongoing confusion results in continuous tense interaction between Central Office staff and the PCUs as referrals are either challenged, billed, or refused, to the consternation of the PCU. That the confusion is not occasional but relatively deepseated, may perhaps be substantiated by the findings shown in Table 6. PCU physicians, more than half, feel that Central Office decisions about service requests are sometimes reasonable and sometimes not. This would argue either ignorance about the rules by which request are handled or perhaps a feeling that there are no rules, requiring frequent reliance on negotiation and arbitration. This interpretation is somewhat reinforced by data from Table 7, where, again, more than half the physicians are expressing the feeling that the Central Office handles patient complaints not by rules but by other mechanisms. Interestingly enough, the AHP reported greater confidence in the way in which Central Office staff go about requests for services and complaints. It would be interesting to explore the reasons for these different attitudes. Unfortunately, the data available do not cover this area.

A further area of misperception exists between Central Office staff and PCU staffs, namely the utilization of written materials when handling requests for services (Table 5). At the training sessions, the participants expressed their conviction that either no written materials exist, or that they are inadequate. At this juncture it seems relevant to mention that very simple instructions in the various questionnaires used in this evaluation were very badly handled by a large number of individuals. The unusual number of "No Answers" were not produced by several individuals but by a large number. It seems to call for an assessment of two things: the level at which personnel can handle written materials and also the materials themselves.

The true "bone of contention" which emerged at the training session was the question of enrollee expectations and why they were unrealistically too high. Table 8, which presents data about this area understates the attitudes as expressed at the training sessions. Perhaps a more valid picture would have been obtained if the individuals who refused to fill out the questionnaire because they were sure it was "window dressing" and so on, had stated their opinions.

The participants' evaluation of the Training Session was favorable as seen by Tables 14 and 15. The rankings are difficult to interpret without further information as to the reasons for the choices: was it the subject matter, the quality of the presentation, the time at which it was presented — all these questions must go unanswered.

The impact of the training session appears to have been in the desired direction. Evidence may be derived from data in several tables. Table 17 shows an increase of correct information about HMO features for physicians. This finding is based on small numbers and is not as "hard" as could be wished for, but each item shows improvement. Table 18 shows, again on an inadequate basis, that AHP profited from the training. The proportion of those trained who had a score of less than 0 is 21%; for those not attending the session it is over half. Physicians seem to have remained stationary in this respect: there is no discernable difference between those attending and not attending the training. Interestingly enough, both physicians and AHP rated the relevant session ("d" in Table 16A) very similarly — it was not a favorite nor disliked vehemently except perhaps by the AHP who have no direct patient care responsibility. Still, some of them absorbed some of the information.

Table 19 speaks, once again, to the problem of lack of information and to the more serious issue of not realizing one's lack. The scores (Table 18) show only 16% with 12 or over for the attenders,

while about the same proportion (18%) reached such scores among those not attending, and physicians account for most of these higher scores. Yet there is nothing in Table 19 to indicate that PCU staffs are aware of any need for more information. The ratio of wrong to "don't know" answers is revealing (Tables 4 and 22).

The Training Session seems to have brought about favorable attitudes towards the Hot Line if there was indeed a shift from "No Opinion" to thinking of it as a reasonable and efficient method of patient care. Equally, headway seems to have been made in gaining better acceptance of paperwork required by the Central Office.

A most interesting change seems to have occurred in the Central Office staff. Examining Tables 21-23 will show that there is very little evidence of "paranoia," even when the opportunity presents itself. See for example response 3 for Question IB, response 2 for Question III and finally response 3 for Question IV (all in Table 23).

It would seem that some learning has indeed taken place; but it is, of course, impossible to say how much there should have been. And it seems also evident that stereotypes were weakened when its bearers came in contact with each other and met persons who had problems and were willing to learn to solve them.

In short, the net impact of training has been to open channels of communciation where none previously existed and to point, in a very limited way, towards the closing of critical information gaps among members of the MHMOP team.

PART 3: CONCLUSIONS AND RECOMMENDATIONS

VII. CONCLUSIONS

A. Regarding the DTP Process

1. Proposal Writing, Submittal, and Acceptance

   a. The original program solicitation requested proposals that would demonstrate methods, techniques, etc. for improving health manpower in HMO settings. The DTP has successfully accomplished this objective.

   b. The DTP had to balance the federal requirement for generalizability of experiences against the local (MHMOP) desire to undertake activities of an immediately useful and localized nature. The DTP project staff was, for the most part, sympathetic to local concerns and willingly modified its broader objectives to accommodate local perspectives.

   c. The original proposal was modified and simplified during the planning phase of the DTP. In hindsight, it should have been less complex to begin with. A simple "before-after" design without regard to control groups, appears more practical and appropriate to the capacities of developing HMOs.

2. Staff Recruitment

   DMF experienced recurrent staffing problems throughout the first phases of the DTP. This problem should have been anticipated and compensated for by building staff recruitment, orientation, and training into the original proposal.

3. Planning

   The planning phase successfully operationalized the original proposal, but took too long owing to the staffing problems alluded to above.

4. Components Development

   a. The needs assessment was not as useful as it should have been due to various problems relating to scheduling and administration. The needs assessment did contribute to the curriculum development. However, it was not well integrated into the evaluation design.

   b. The MHMOP MIS baseline and follow-up "knowledge level" surveys served DMF needs reasonably well. However, adequate pre-testing by MHMOP could have better served DMF training needs by allowing for modifications in the instruments prior to training.

   c. Training program logistics were, on the whole, well co-ordinated. A notable exception was the use of audiovisual materials which for the most part was not well integrated in the structure of the conference formats.

   d. MHMOP staff were, on the whole, responsive to DTP guidance regarding the structure and content of training lectures and discussions. However, insufficient time was made available by MHMOP staff to the preparation and formatting of their presentations.

5. Training Conferences

   a. The conferences were well received by the PCUs.

   b. The informational content of the lectures and discussions covered topics of concern to PCU staff.

   c. The tone and content of PCU staff comments strongly indicated a feeling of isolation and ignorance about the MHMOP system and the HMO process.

   d. Coupled with PCU staffs' lack of information was the clear indication of little communication, outside routine encounters, between MHMOP and PCU staffs.

   e. From a purely process point of view, the main success of the DTP conferences was to provide an initial framework for discussion and dialogue between MHMOP and the PCUs and among the PCU staffs.

B. **Regarding the DTP Impact**

1. The State of Knowledge and Perceptions Prior to the Training Conferences:
   a. PCU physicians and AHP did not demonstrate extensive knowledge about the MHMOP system.
   b. MHMOP Central Office staff tended to somewhat overrate physicians' knowledge about the Plan, while somewhat underrating AHP knowledge.
   c. A significant number of PCU personnel (both physicians and AHP) refused to participate in the MHMOP baseline MIS survey indicating suspicion of MHMOP Central Office motives.
2. The State of Knowledge and Perceptions After Training:
   a. The general direction of the training program's impact was positive.
   b. Physicians and AHP information levels somewhat increased.
   c. Levels of frustration and suspicion of MHMOP's motives appear to have been significantly reduced.
   d. MHMOP staff tended to display greater sophistication in their views of PCU levels of knowledge and capacities. In particular, there was less of a tendency to rely on stereotypes of "physicians," "nurses," etc., but to perceive the PCUs more accurately.

VIII. RECOMMENDATIONS

A. To the Bureau of Health Manpower

1. The DTP accomplished its basic objectives and therefore warrants continued interest by DMF, MHMOP, and the Bureau of Health Manpower.
2. TARP is particularly concerned that the progress in communications and knowledge development clearly indicated during the DTP contract period, not be lost because of lack of support from the Bureau of Health Manpower. We therefore urge the Bureau to consider ways to continue the DTP and to expand and modify it based on the just concluded experience. Much was learned. Useful products were produced. MHMOP must continue to pay attention to staff development requirements. Otherwise the limited gains of the DTP will be quickly lost.

B. To the Detroit Medical Foundation and MHMOP

1. DMF and MHMOP should recognize the importance of staff development activities such as the DTP. MHMOP, in particular, should place the DTP high on its agenda of activities in need of on-going consideration.
2. Future DTP efforts should concentrate on permanent training staff development, and ways to ultimately subsidize such efforts through MHMOP income, rather than through continuous reliance on outside support. In the short run, however, the Bureau of Health Manpower should recognize the need for additional federal support.

PART IV

APPENDICES

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APPENDIX 1 — "Special Needs Assessment Form"

PLEASE USE BRIEF ACTION STATEMENTS

1. What would you like to have included in a training activity that would be beneficial to you in working in this center?

2. What would you like to have included in a training activity that would be beneficial to you in working with HMO Central?

3. What kinds of changes would you like to see happen as a result of training?

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APPENDIX 2 — "Baseline Information Protocol"

I. MHMOP Central Office has a number of departments which are listed below. For each department, please check off TWO answers:

Column A, "YES" you knew it existed, or "NO" you did not know.

Column B, REGARDLESS of your answer for Column A, check the box which most nearly expresses your opinion about such a department.

Department	Column A		Column B				
	YES knew	NO did not know	Necessary to run ANY large operation	Necessary to run this kind of operation	Required by HMO rules NO CHOICE	NOT necessary but useful	Not necessary should be eliminated
1. Administration							
2. Marketing							
a. Public Relations							
3. Systems							
a. Medical Records							
4. Finance							
5. Operations							
a. Health Services							
b. Health Education							

— Continued —

II. Follow are some terms and for each there are several definitions. Place a check in the box next to the one you think is most nearly correct when used in relation to HMOs.

A. **Capitation** (for HMOs) can be defined as:

☐ 1. An insurance premium, of which the amount depends on who the enrolled person is.

☐ 2. Some fixed amount paid per enrolled person.

☐ 3. Some fixed amount paid per enrolled person for a fixed set (package) of services.

B. **Fee-for-Service** Feature of HMOs is:

☐ 1. A portion of the funds which pays the higher compensation rates of members (doctors) who are classified as consultants or specialists.

☐ 2. A portion of the funds which pays medical services not provided by MHMOP but covered by the service package for the enrollees.

☐ 3. A portion of the funds which pays for physician services rendered to the patient while in hospital.

C. **Risk Sharing** in HMOs:

☐ 1. Is a form of malpractice insurance.

☐ 2. Means that any deficit incurred by your health center will be directly paid by your group and your group alone.

☐ 3. Is a portion of the total capitation set aside into a reserve fund to protect the financial interests of all health centers.

— Continued —

II. Cont'd.

D. **Benefit Package** in HMOs:

☐ 1. An identical range of health services which are guaranteed by MHMOP, regardless of the medical group in which the individual is enrolled for care.

☐ 2. The range of health services to which an enrollee is entitled and which is defined by the individual medical group contract.

☐ 3. Those health services deemed necessary by the patient's physician.

E. **Referrals to Specialists** who are **not** under a capitation contract with MHMOP are paid for by:

☐ 1. The group to which the doctor making the referral belongs.

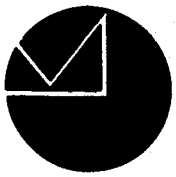
☐ 2. Out of capitation with prior approval of the MHMOP.

☐ 3. Out of the risk sharing fund with prior approval of the MHMOP.

☐ 4. Out of the fee-for-service fund with prior approval of the medical group.

☐ 5. None of these. (Please describe your understanding of this payment arrangement.)

— Continued —



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III. Below is a list of services which enrollees may either need or request from your group. For EACH check ONE box.

Health Service	Provided by			Not provided at all	Don't Know
	Your group	Referral from you	Referred from MHMOP Center		
1. Prenatal Care					
2. Eye Glasses					
3. Rhino-plasts (cosmetic)					
4. Outpatient X-Ray Studies					
5. EKG & EEG					
6. Abortions					
7. Dental Care					
8. Psychiactric Outpatient					
9. Contact Lenses					
10. Emergency Room Services					
11. Tubal Ligation					
12. Vasectomy					
13. Inpatient Hospital-ization					

(Continued on next page)

(Cont'd)

Health Service	Provided by			Not provided at all	Don't Know
	Your group	Referral from you	Referred from MHMOP Center		
14. Dermatologists					
15. Allergists					
16. Podiatrist					
17. Nutrition Counseling					
18. Health Care (domestic)					
19. VNA					
20. Psychiatric Inpatient					
21. General Surgery					
22. Family Planning					
23. Health Education					
24. Prescriptions					
25. Ambulance					
26. Transportation (other than ambulance)					

— Continued —

III. (Cont'd)

When you talk to an enrollee about a request for a specific service, do you:

- ☐ 1. Refer to a written guide, list or set of instructions to help you.
- ☐ 2. Consult with someone in your office.
- ☐ 3. Call up the MHMOP Central Office.
- ☐ 4. Already know the answers because you have been doing this for so long.

IV. Which of the following statements best reflects your experience with MHMOP's Central Office:

A. **In regard to enrollees' service requests:** (CHECK ONE)

- ☐ 1. People at the MHMOP Central Office are unreasonable and demand special deals whenever a patient calls them up and makes waves.
- ☐ 2. When the MHMOP Center people call up about a service request, it's usually a situation where they are justified in intervening.
- ☐ 3. It's hard to say; sometimes the MHMOP Center people are reasonable and other times they are not.

B. **In regard to complaints by patients:** (CHECK ONE)

- ☐ 1. The MHMOP Central Office always takes the patient's side and doesn't listen to reason.
- ☐ 2. The MHMOP Central Office seems to make reasonable evaluations of complaints and calls to our attention usually on those where a problem does exist.
- ☐ 3. It is hard to say; sometimes the MHMOP Central Office seems to take sides, other times it seems to be reasonable.

— Continued —

V. Now a final question. Please check the one statement that most closely reflects your experience in regard to *Enrollment:*

☐ 1. The people at the MHMOP Central Office who enroll new members either don't know about the services that are covered or else they deliberately exaggerate just to "make a sale", because most new enrollees demand much more than they are entitled to.

☐ 2. Some new enrollees don't seem to know what joining MHMOP means and what they are entitled to, but some new enrollees do know fairly accurately.

☐ 3. Most of the time, new enrollees know what they are entitled to and what enrolling means.

* * * * * * * *

Please indicate your function in your health center by checking the appropriate box:

☐ Patient Care: Physician

☐ Patient Care: RN, LPN, Medical Assistant or Aide, Receptionist

☐ Office: Administrator or Administrative Assistant, Manager, Typist, Clerk, Secretary, Billing, Accounting, Bookkeeping

☒ Other: Medical Records, Laboratory or X-ray Technician, etc.

THANK YOU!

APPENDIX 3 — "State-of-Art Review"

A STATE OF THE ART REVIEW OF THE LITERATURE ON TRAINING PROGRAMS WITH RELEVANCE TO HEALTH MAINTENANCE ORGANIZATIONS

June, 1975

Submitted to the Detroit Medical Foundation
in Performance of Sub-Contract Obligations
under US DHEW Contract No. 1-MB-44196,
"Demonstration Training Program."

TARP, Inc.
705 G Street, SE
Washington, DC 20003
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1. OVERVIEW

The following "State-of-the-Art" review was undertaken for the Detroit Medical Foundation's Demonstration Training Program. The purpose of this program is to improve the capacity of primary care unit staffs to function within the Health Maintenance Organization setting. The objectives of the training program are to:

- Design an appropriate curriculum for staff of primary care units to gain important knowledge and information about the operational components of their HMO plan.
- Develop training methodology appropriate to the implementation of the curriculum.
- Evaluate all aspects of the training demonstration.
- Produce a model training manual outlining the training procedure that should be followed by other HMO's.

The specific task of this review, based on the preceding objectives, is to review the literature, government reports, and all training manuals which are presently available. The purpose of the review is to provide useful material for various aspects of the developing curriculum. The review is specifically focused on the nature of the group to be trained.

The format for the "State-of-the-Art" paper is as follows:

- A presentation and discussion of the data review methodology.
- Presentation of the State-of-the-Art.
- The significance of the review and its implications for the training program.

2. METHODOLOGY

An extensive review of the literature has been undertaken, beginning with the exploration of citations in the following bibliographies:

(1) Comprehensive Bibliography on Health Maintenance Organizations: 1970-1973, compiled by Patricia N. Pinel, Director, Library Reference Service, Medical Group Management Association.

(2) Selected Annotated Bibliography on "Health Maintenance Organizations and Organized Health Care Systems" compiled by Alan Bloom and Paul Kosko, Health Maintenance Organization Program Office, U.S. Public Health Service, August 1973 and Special Supplement to HMO Bibliography, April 1974.

(3) Planning, Organizing and Evaluating Training Programs, Personnel Bibliography Series No. 41, U.S. Civil Service Commission Library, Washington, D.C., 1971.

Next, a list of technical assistance projects and reports was obtained from the Federal Health Maintenance Organization Program Office. Contact and repeated follow-up was made with those projects having reports which were considered relevant to the review. This determination was based upon the brief description on the list. The poor response for the various projects precludes this source's inclusion in the review.

Contact was also made with the National Medical Libraries Audio-Visual Center. The center is currently compiling a national survey of instructional materials related to the health field. Their final product will be a data base which includes; type of health training materials; an assessment of its instructional value; evaluation of the training materials and classification by audience type. This resource will be available by mid-summer, 1975. A site visit would provide sources for the development of specific training materials, methodologies and evaluation designs for the DMF project.*

In addition to these specific source catalogues, indexes and abstracts were searched at Countway Medical Library in Boston, Massachusetts, and the School of Public Health, University of Michigan to identify publications not cited in the compilations previously mentioned. The headings used to search the various catalogues, indices and abstracts were:

- Public Health
- Prepaid group practices
- Group practices
- Neighborhood health centers
- Health maintenance organizations
- Team training
- Health team training
- Health manpower training
- Health training
- Health education
- Education
- Health organizations training
- Training methodologies experiences and-or evaluation

Of the headings researched, the following have no pertinent information: prepaid group practices; neighborhood health centers; public health; and health team training.

The following list identifies the most useful of the indexes and journal abstracts examined:

Index Medicus
American Journal of Public Health
Medical Care
Medical Care Review
Health Service Reports
Hospitals
Training & Development Journal (and other American Society of Training and Development Officials materials)

*From a discussion with the assistant Director for Audio-visual Education development, it was concluded that such a visit would be most useful in developing specific instructional media. Therefore, the training program coordinator should visit the center to discuss and develop the specific audio-visual components of the curriculum.

Milbank Memorial Fund Quarterly
Journal of the American Medical Association
World Health Organization Technical Reports
Journal of Medical Education
Education Index

At this stage, articles were excluded from the review based on length (i.e., one page or less). Those editorials which did not indicate sufficient information were also excluded.

The literature was classified into the following areas prior to the review of materials. The classification processes consisted of:

(1) **Grouping by training studies and non-studies.** Training studies were examined to identify the type of audience methodology and evaluation designs. Non-studies are included based on relevancy of experience to team training in health settings. Both studies and non-studies were considered based on their potential usefulness to the prospective training program.

(2) **Grouping by HMO content areas.** The areas of concern delineated were: HMO philosophy and concepts; provider orientation and concerns; quality of care in prepaid groups; HMO health delivery systems; HMO marketing, HMO information systems; and HMO financing.

The plan of analysis entailed cataloguing data according to the preceding classification scheme. To further meet the review objectives, the data was then applied to the various components of HMO operations with implication for team development; and to training methodologies and evaluation which are not substantively related to HMOs but which might have implications for team building in innovative settings. The underlying criteria of inclusion for each publication and training instrument is its contribution to the successful dissemination of information and its potential in adding to the knowledge of trainees regarding increasing team efficiency and plan management.

3. STATE-OF-THE-ART LITERATURE REVIEW

3.1 Training Studies and Non-Studies

3.1.1 Criteria for Review

Criteria for inclusion of articles in the training section of the state-of-the-art review are the following:

1. Is the described training inter-disciplinary in nature?
2. Does the literature discuss training for those who have limited exposure to team training?
3. Is the training example focused on changing attitudes, knowledge and behavior?
4. Does the literature describe a training methodology in detail?
5. Does the literature discuss and-or provide model evaluation instruments for training?
6. Articles less than four pages and purely descriptive were usually excluded. An article, book or study was included if its analysis resulted in *a positive* response to any one of the preceding five questions.

3.1.2 Review

1. U.S. Civil Service Commission Bureau of Training, *Visual Materials: Guidelines for Selection and Use in Training Situations*, Training Systems and Technology Series, No. VI, U.S. Civil Service Commission Office of Training Assistance, December 1971.

   The paper discusses the characteristics, advantages, limitations and uses of the most commonly encountered instructional media. In addition, it offers guidelines that a training specialist can use when selecting visual materials for group instructions. Indicators of need for visual training materials are identified. The design characteristics of visual use are explained. Techniques and functions are described as well as the various types of soft and hardware used in visual presentations. A follow-up evaluation is also presented. The evaluation form for instructional materials includes a rating of the materials based on clarity of objectives; clarity of organization; appropriateness for course; sufficient emphasis on important points; ability to hold the attention of the audience; and clarity of detail. Of secondary importance was: treatment appropriate for subject matter; rate of introduction of concepts; integration of verbal and pictorial content; and number of concepts.

2. Baird, Leonard, "Common and Uncommon Models for Evaluation Teaching," *New Directions for Higher Education*, No. 4, 1973.

   Four approaches to the evaluation of teachers ranged from: (a) the highly detailed to the global; (b) specific goal attainment to the environment that helps determine goals; (c) a formal model to the process of teaching; to, (d) a broad assessment of the environmental field of forces on the teacher. The standard model of evaluation deals with goal determination. The design of relevant materials, and measurement of progress in attaining objectives. Consideration is given to the attainment of objectives and the costs associated with differential attainment of objectives. Consideration is also given to various teaching approaches and roles. General theories of human cognition applicable to teaching within the standard model are: (a) the anchoring of broad philisophies of life and/or ideologies in the student's structure of ideas; (b) vertical transfer of learning from one behavior or cognition level to a higher one; and (c) discovery of learning where students, by inductive reasoning, infer a concept or principle.

3. Carlaw, R.W. and Callan, L.B., "Team Training — An Experiment with Promise," *Health Sciences Report*, Vol. 88, No. 4, April 1973, pp. 328-336.

   The article examines team training as a concept and its importance for public health practitioners. The learning constructs identified were tested in a team training experiment among county health teams in Georgia. A training program was designed using PERT as the primary planning model to be undertaken by the teams. The training goal was to promote the widest use of skills in multidisciplinary approaches by careful definition, planning, and program implementation. A pre-training program was designed to involve team members in the identification of projects on which they would work. An evaluation and follow-up intervention strategy was also used. The methodological emphasis was on working in dyads and triads on consultation for teams and individuals. Most of the training situations were based on real situations. Role playing was used effectively at appropriate times. Participant responses were highly positive. The only difficulty in preforming an adequate evaluation was the inability to perform objective field measurement from the instructor's perspective.

4. Havelock, Ronald, and Havelock, Mary C., *Training for Change Agents – A Guide to the Design of Training Programs in Education and Other Fields*, Center for Research on Utilization of Scientific Knowledge, Institute for Social Research, The University of Michigan, Ann Arbor, Michigan, 1973.

This book is intended for use by change agents and change agent trainees in all levels of education and in other human science areas where specialized resource helping and linking roles are being developed. Part One provides a framework for the design of programs to train change agents in the skills of facilitating change and of resource utilization. Part One includes the theory, goals and structure essential to program design. The first chapter focuses on the major perspectives on the change process. They are grouped under the following headings: change as a problem-solving process; change as a research-development and diffusion process; change as a process of social interaction; change as a linkage process; and, conflict theory of change. Chapter Two focuses on the issues around goal setting. Chapter Three identifies some principles of goal training design. These principles include: relevance; specifity; generality; reinforcement; in-process evaluation and feedback; openness and flexibility; linkage; involvement; cost effectiveness; redundancy; synergy; training for psychological wholeness of learning; training for transferability; and compatibility. Chapter Four focuses on a framework for training designs. Eight elements are analyzed which are primary to whole-role training. They are:

a. definition and rationale for the role;
b. criteria for trainee selection,
c. outcomes expected of trainees (attitude and values; knowledge; skills),
d. ways to provide training to achieve these outcomes,
e. ways to set the role in an institutional context,
f. criteria for program success,
g. evaluation processes for a training program, and
h. utilization of evaluation.

Part Two considers five training program models: 1) programs to train school systems to develop a self-renewal capacity; 2) programs for change agent linkage of school systems to resources; 3) programs to effect political and structural changes in school systems; 4) programs to improve the effectiveness of other educational agencies; and, 5) a sample model of a fully developed training design.

5. U.S. Civil Service Commission, Bureau of Training, *Training Evaluation: A Guide to Its Planning, Development, and Use in Agency Training Courses*, Training Systems and Technology Series, No. 10, U.S. Civil Service Commission, May 1971.

This paper describes an approach which can be used by the agency training specialist to assess the effectiveness of many internally developed and conducted training courses. The paper offers a conceptual framework for evaluation; the essential steps in developing training objectives; an in-course training evaluation process; and, a description of the steps involved in developing and using data gathering instruments. The paper concludes with a discussion of the factors to be considered when implementing the kind of evaluation program described in this paper. They are: 1) course content which is influential and the amount of measurement which can be applied; 2) the learning level of the course (what is its purpose); and 3) course costs (per unit (trainee) costs and frequency of courses given). Overriding factors are the degree of control exercised by the agency over course delivery and the resources available to the agency. The development of direct measurement instruments entails the following steps:

a. Decisions as to what is to be measured,
b. The development of measurement matrix,
c. The development of the elements of the measurement instruments,
d. Assembling the measurement instrument,
e. Preparation of directions for administering the instrument,
f. A pretest of the instrument,
g. Establishment of the critical point,
h. Administration of the instrument,
i. Analysis and evaluation of results of the instrument, and
j. Revisions of the instrument based on the above analysis,

Two kinds of indirect measurement instruments are discussed: those designed to gather trainee opinion, and those for collecting the opinions of qualified classroom observers. The same steps described earlier are applied with the two exceptions: there is no need to develop a measurement matrix, and no need to establish critical achievement points.

6. Nagi, S., "Teamwork in Health Care in the U.S. — A Sociological Perspective", *Milbank Memorial Fund Quarterly*, Winter 1975.

   This paper reviews current studies, important findings, and points out research dimensions. Themes prominent in the literature relate to the following concepts: a) status, power, authority, and influence, b) roles and professional domains, and c) decision-making and communication. A number of important dimensions seem to be neglected such as the effectiveness of teams as an approach to the delivery of services, the modes of organization and the dilemma of gate-keeping decisions, and the relations of team approaches to manpower problems. In the main, the task in this paper has been one of conceptual development, systemization of literature, and identification of neglected topics. The vast majority of the literature on teamwork is descriptive and prescriptive rather than analytical. The following points were made: a) a common characteristic shared by health teams is the direct face-to-face interaction among members in the course of performing services; b) ambiguity of roles in certain professions and the overlap among them can be a source of difficulty in organizing teamwork; and c) the structure of decision-making relates closely to the structure of roles and authority.

7. Baum, Bernard R., Sorenson, Peter F., and Place, William S., "The Effect of Managerial Training on Organizational Control: An Experimental Study", *Organizational Behavior and Human Performance* Vol. 5, 1970.

   The utilization of organization theory in the evaluation of managerial training is explored. Participants in a management training program involving the concepts and techniques of "power equalization" and the "interaction-influence" model comprised the experimental group. The group was compared on a before and three-months-after training basis with a control group. Tannenbaum's control questionnaire was employed to determine the effect of such training on the organizational control structure. Change in the direction of a more egalitarian control structure was found in the experimental group.

8. Eliason, Alan, "A Study of the Effects of Quantitative Training," *Academy of Management Journal*, June, 1972.

   Two groups of subjects, one with advanced quantitative training, and the other with little or no quantitative training, were exposed to an interactive-decision simulation gaming model to experimentally test possible effects of quantitative training. The findings show that the quantitative group achieved a higher level of game performance, but were unable to justify why gaming decisions were necessary. Other conclusions identify possible areas of weakness in quantitative training methodology.

9. Fordyce, Wesley, *Managing With People*, Addison-Wesley Publications, Maple Park, Cal., — 1971.

   A model is presented which is designed to improve organizational functioning. The model addresses perceptions of work groups and staff as to their roles and responsibilities. These varied perceptions provide input to determine what interventions are required.

10. Hall, Jay, and Williams, Martha C., "Group Dynamics Training and Improved Decision-Making", *Journal of Applied Behavioral Science*, Vol. 6, No. 1, 1970.

    The efficacy of laboratory training in group dynamics as a technique for modifying group processes in the direction of theoretically more effective practices was explored. Thirty groups trained in group dynamics were compared with thirty untrained groups with respect to their performance on the 12 Angry Men Decision Making Task. Several differences among co-varying performance and process variables were identified in trained versus untrained groups.

11. Petty, M.M., "Relative Effectiveness of Four Combinations of Oral and Written Presentation of Job Related Information to Disadvantaged Trainees", *Journal of Applied Psychology*, Vol. 59, No. 1, pp. 105-6 1974.

    Relative effectiveness of four different combinations of oral and written presentations of information was investigated. It was hypothesized that the treatments which began with

an oral presentation would be more effective in disseminating information than the treatments which began with written presentation. The criterion of effectiveness was a multiple choice test designed to measure the subject's knowledge of the disseminated information. All eight *a priori* comparisons made on the basis of the research hypothesis were in the expected direction, but only three were statistically significant.

12. World Health Organization, Technical Report Series No. 521, "Training and Preparation of Teachers for Schools of Medicine and of Allied Health Sciences", Report of a WHO Study Group, Geneva, 1973.

    This report focuses on the preparation of teachers. The process and methods of education are reviewed. It includes a description and evaluation of various teaching methods and instruments such as: the lecture, group discussion, tutorials, clinical laboratory and field teachings, research and project teaching, testing, team teaching, and simulation. While the primary theme of the article is on developing teachers' ability as instructors, the article is useful in its assessment of teaching customs.

    The following is the assessment of the teaching methods and instruments as identified:

    1. The lecture is neither the most efficient nor the most effective method of imparting knowledge. It should be used sparingly in order to maximize its effectiveness.
    2. Group discussion has been adopted as an important instructional devise in many curricula for the health professions. Effective group leadership requires that the leader listens more than talks to avoid the trap of lecturing to a small group.
    3. Tutorials are frequently used as drill or quiz sessions rather than opportunities for student expression, exploration of ideas, and guidance from a sensitive monitor.
    4. Clinical laboratory and field teaching should be designed to allow the student to explore and complete a project.
    5. Research and project teaching though costly are invaluable methods that allow students to gain experience in problem identification, problems pursuit, data analysis and synthesis.
    6. Testing can be used as an instructional device.
    7. Team teaching has great advantages; however, it has not become of common usage.
    8. Simulation is an easily available and readily adaptable supplement to reality.

13. McTeenan, Edmund and Hawkins, Robert O., eds., *Educating Personnel for the Allied Health Professions and Services*, St. Louis, Mosler, 1972.

    Two chapters which focus on developing the educational program would be highly useful in developing training and methodology. They are: Chapter 6, Planning the Curriculum, pp. 57-65; and Chapter 8, Instructional Technology, pp. 85-110. Chapter 6 covers how to establish educational objectives in light of student needs; the basic organization of learning opportunities; and evaluation and updating of learning objectives. Chapter 8 continues with a discussion of choosing teaching strategies and various modalities of instructional technology.

14. Odiorne, George S., *Training by Objectives*, New York, MacMillan Company, 1970.

    This book focuses on the design of training based upon stated objectives. It reviews the process of identification of training needs and alerts the trainer to problems which must be addressed. A point especially identified is the need to incorporate the effect of messages being received by the trainee outside of training.

15. Pierleoni, Robert G., "Teaching Health Care Professionals", *Journal of the Kansas Medical Society*, March 1973, pp. 1-8, 68-71.

    An instructional design model is discussed. The model contains four components, each representing a product or series of products. They are: pre-assessment of the learner; instructional objectives; instructional procedures; and evaluation procedures. The emphasis is placed on teaching the learner, not on teaching the subject matter.

    The pre-assessment of the learner is a series of statements regarding the learning achievements. The instructional objectives should be stated in terms of learner behavioral outcomes and should be observable and measurable by the instructor; and, minimum performance standards should include the design of appropriate procedures and the selection or preparation of measuring devices.

    They should be based on the behavioral requirements of the objectives and on the abilities of the target learners.

16. Van der Embse, Thomas, "Choosing a Management Development Program: A Decision Model", *Personnel Journal*, October 1973, pp. 907-12.

The article discusses, in depth, an experiment in team training. The goal was to train a multidisciplinary group in various approaches to the resolution of public health problems. A description of the training process and workshop evaluations are included. The methodological emphasis was on working in dyads and triads. Role playing was also used. The evaluation procedure, while limited to participant responses, could be useful for any training effort.

17. Rubin, Irvin and Beckhard, Richard, "Factors Influencing the Effectiveness of Health Teams," *Milbank Memorial Fund Quarterly*, July 1972, Part 1, Vol. 50, No. 3, pp. 317-335.

The central focus of the paper was upon the internal dynamics involved when a collection of individuals attempts to function as a group. The objective was to provide a framework that will facilitate consideration of several important issues involved in the more effective utilization of groups in delivering health care. Several key variables known to be of prime importance to any group situation are discussed in light of their relevance to group medical practice. They are: goals or mission; role expectations (internal and external); decision-making; communication patterns; leadership and norms.

Implications were:

1. Some conscious program that helps team members look at preceding variables is essential for team effectiveness.
2. Behavioral science knowledge and techniques developed in a variety of non-medical settings are relevant and appear to be transferable to organizations involved in the delivery of health care.
3. Capability for helping teams look at their own workings should be built into the training of team leaders.
4. The organization needs to develop an internal capability to help groups manage their own process.
5. Programs should also include a focus on the problems of helping people cope with cultural discrepancies.
6. The development of team leadership and membership skills should occur.
7. The team should be trained as a unit.
8. Socialization of new team members should be examined.

18. Buchanan, Paul C., "Laboratory Training and Organizational Development", *Administrative Science Quarterly*, Vol. 14, No. 3, 1969, pp. 466-480.

The purpose of this paper was to update an earlier review of the literature on the effectiveness of laboratory training in industry and other organizations. The findings as to the value of laboratory training are:

1. It facilitates personal growth and development and, thus, can be of value to the individual who participates.
2. It accomplishes changes in individuals which, according to several theories, are important in effecting change in organizations and in effectively managing organizations.
3. One study, in which an instrumental laboratory approach was compared with sensitivity training, provides some indication that more organizational change resulted from the instrumental approach.
4. The findings from this literature search are compatible with the conclusion reached in a similar review made four years ago.

19. Balman, Lee, "Laboratory Versus Lecture in Training Executives", *Journal of Applied Behavioral Science*, Vol. 6, No. 3, 1970, pp. 323-335.

Four different sessions of an educational program for business executives were studied to compare the differential effects of laboratory human relations (T-Group) training versus a lecture-discussion approach to interpersonal relations in organizations. Both types of programs produced equal change in participants' stated beliefs about effective interpersonal behavior. Laboratory training showed greater effects on participants' perceptions of themselves and on their behavior as analyzed from tape recordings of case discussion meetings. However, there was evidence that the participants had difficulty transferring learning from the T-Group to other parts of the program and that there was considerable fade-out of the effects of training.

20. Golembiewsik, Robert T., and Carrigan, Stokes B., "The Persistence of Laboratory-Induced Changes in Organization Styles", *Administrative Science Quarterly*, Vol. 18, No. 3, 1970, pp. 330-340.

Changes in interpersonal and intergroup styles in a small managerial population were observed following exposure to a learning design based on the laboratory approach. Managerial self reports on the Likert profile of organizational characteristics were used to gauge change. This report establishes the basic persistence of the initial changes over a period of some 18 months. Despite various inelegancies of the design and methods of this field study, the persisting changes strongly imply that the training design induced the changes. This report also suggests the value of a design element to help reinforce change in programs of organization development. In this case, a mild reinforcement session was held about one year after the initial training. The research design underlying the report is described as O_1, X, O_2, O_3, O_4 which is a modified time-series design with an experimental treatment preceded by a single pre-test and followed by multiple post-tests. While various inadequacies of the research design were identified, the results indicated that the training design helped induce and sustain major changes in a large number of measures of the interpersonal and intergroup styles of a small organization unit.

21. Maier, Norman R.F., Salem, Allen R., and Maier, A., *Supervisory and Executive Development – A Manual for Role Playing*, New York, John Wiley and Sons, 1957.

This book provides two aspects of skills practice. The first aspect permits role-playing which is a method that furnishes an opportunity to practice a human relations incident in a life-like setting. The second aspect is that of being a casebook. The cases provided incorporate conflicts, differences in power and responsibility, and practical considerations. This approach invites practice in discussing and analyzing crucial issues. The case-study approach assumes group discussion and the cases are sufficiently involved and detailed to produce a wide range in opinion concerning: (a) who was to blame; (b) what caused a person's behavior; and (c) what is the best corrective action to take. Role-playing allows the person to give insight into some of his relationships with others by having him play the role of those other persons. The specific values of the case-study approach and role playing are identified.

22. Byars, Lloyd, and Crane, Donald P., "Training by Objectives — A Comprehensive System for Evaluating Training Programs," *Training and Development Journal*, Vol. 23, No. 6, June 1969, pp. 38-41.

The article presents some techniques for defining objectives and a simple model for evaluating the effectiveness of training. The following criteria is considered as a guidepost in defining objectives:

1. Training objectives and corporate goals must be compatible.
2. Objectives must be realistic.
3. Objectives should be clearly stated in writing.
4. Results should be measurable and verifiable.

Two basic areas of training must be distinguished in writing training objectives. The first area deals with the development of skills. The second is the development of knowledge, understanding and attitudes. Various levels of learning are identified in each area. The levels of evaluation are:

1. Internal evaluation which occurs while the course is still in progress.
2. Immediate evaluation or end-of-course evaluation.
3. Intermediate evaluation which takes place sometime after the course is completed and attempts to determine the course's effect on attitudes, behavior and skills.
4. Final evaluation measures changes in performance.

Various techniques are examined with respect to each level of evaluation.

23. Bradford, L.P., and Lippitt, H., "Role-Playing in Supervisory Training," *Personnel*, Vol. 22, No. 6, May 1946.

The role-playing method, adapted from the psyschodrama and socio-drama techniques enables participants to act out spontaneously the problems facing them. New insight is gained into employee motives and attitudes, and opportunity is provided for constructive practice in typical situations. The article provides a case study of the role-playing training program and discusses fundamental aspects of the method. Those aspects are:

1. Getting top management involved in the training process.
2. The involvement of all levels of the organization hierarchy in the training process.
3. Organizing three-or-four-level training to facilitate communication.
4. Taking a problem census to involve group members in identifying major areas of concern.
5. Classifying problems into major areas.
6. Role-playing to clearly identify problems.
7. Diagnostic discussion of role playing situations.
8. Role-playing as solution-making to test new ways of handling the problem.

Skill in using role-playing lies in four areas: (a) the selection of scenes to be played and the setting up of these scenes to dramatize important points; (b) cutting off the scenes after major points have been played; (c) focusing the discussion on the major points; and (d) setting up other scenes growing out of the original diagnostic sets. Other uses of role-playing include: role reversal; exploration of a variety of roles; and anticipatory role-playing.

24. Green, Thad B., and Cotlar, Morton, "A New Dimension in Management Training: A Video-Audio-Participative System", *Training and Development Journal*, Vol. 24, No. 10, October 1970, pp. 22-27.

This article first describes an approach for achieving better management. The video-audio-participative (VAP) system is a combination of several video and audio teaching methods and learning resources including participative elements which promote active participation in the learning process by every learner. The aim of the VAP system is to improve the quality of the learning experience. Management theories and concepts are chosen which are most applicable to the needs of the learner. The system is designed to reinforce the student's understanding of principles and concepts. This is accomplished in two ways. Students engage in simulated experiences, and, students continually respond to a variety of stimuli including filmed incidents and objective questions, with the aim of generating thinking and probing analysis. The VAP technique is a systems approach for learning relevant material in a relevant format and is designed for intense participant involvement in the learning process.

25. Underwood, William J., "Evaluation of Laboratory-Method Training", *Training Directors*, Vol. 19, No. 5, May 1965, pp. 35-40.

This is a report on an exploratory study to determine:

1. Whether a sensitivity training course conducted by the T-Group Method would produce a change in the job behavior of its participants;
2. What kind of change would be produced; and
3. Whether change could be measured by the use of untrained observers; job associates of the participants.

The report concludes that it is feasible to measure job behavior effects of T-Group training by the use of work associates as untrained observers. When assessed in this manner, it can be hypothesized that T-Group training will:

1. Produce behavior change perceptible to others;
2. Produce greatest changes in interpersonal interactive situations; and
3. Produce change, the incidence of which will be cumulative with progress of the course and will diminish after termination of the course.

26. Robinson, Joseph A., "Videotape in Training — Some Limitations and Criteria to Help Select Its Best Application," *Training and Development Journal*, Vol. 22 No. 11, November 1968, pp. 15-17.

The article attempts to address the question of how a training director can choose and use videotape to make it a solid, permanent part of his professional resources. It indicates source limitations, strengths, and guidelines for use. Its limitations relate to mis-application, quality of the end product, and equipment incompatibility. Under misapplication. videotape cannot make judgements regarding right, wrong, good, etc. If quality is noticeably inferior in content, staging or reproduction, the viewer may be bored by, or prejudiced against the message. Its strengths are: relating observable behavior and providing a setting for objectivity. Playback can allow an analysis of complex situations, allow a large audience to view the experience, and allow for personal involvement to facilitate change among participants.

27. Roser, John A., *Simulation and Society: An Exploration of Scientific Gaming*, Boston: Allyn and Bacon, Inc., 1969.

This book is designed to introduce social scientists to simulation and gaming. It examines the history of simulation, discusses their theoretical and philosophical underpinnings of simulation and gaming. The book also analyzes some of the strong and weak points of simulation and gaming, deals with questions of validity and usefulness within a variety of contexts, and tries to project some further directions for the field.

The nature of simulations and games in general is considered. The author examines the philosophical and epistemological foundations of social science games, and traces their intellectual and historical roots. It was emphasized that whereas several intellectual streams, including small group experimentation, decision theory, and systems analysis, all have fed into the mainstream of simulation work, the use of games and simulations has grown from its genesis in war-gaming, in parallel but unrelated ways in several fields. These fields include management training, economic modeling, political and international relations studies, sociology, psychology, and education. In Part II, the author analyzes why simulations and games are used. The utility of simulation and games as theory building devices, their roles in research, their contribution to training and education, and their validity are analyzed.

3.2 Health Maintenance Organizations

3.2.1 Content Areas

The criteria for inclusion of articles in the HMO section of the state-of-the-art review is a content analysis of the following points:

- Relevance to health maintenance organization philosophy and concern.
  1. Does the literature identify key HMO concepts?
  2. Does the literature discuss the philosophical base of health maintenance organizations?
- Relevance to provider orientation and concerns.
  1. Is the question of changing roles for providers in HMO settings addressed?
  2. How have providers expressed concern over impact of HMO programs on their functioning? Are solutions identified?
  3. What orientation and information programs for providers have been developed.
- Relevance to quality of care issues.
  1. Are issues around quality of care in HMO's identified?
  2. Are solutions to the problem of determining quality of care and improving quality of care provided?
- Relevance to HMO service delivery systems.
  1. Are HMO service delivery systems described in detail?
  2. Are organizational structures identified and discussed?
- Relevance to HMO marketing issues.
  1. Are key issues in enrollment and other marketing procedures and solutions identified?
  2. Are patient complaint systems described?
- Relevance to HMO financing.
  1. Are mechanisms for financing HMO's described?
  2. Are clients rights and responsibilities for utilization described?
  3. Is the issue of utilization and costs addressed?

Case studies of less than five pages were usually excluded. An article, book, or study for which a positive response was given based on one or more of the questions in the above sub-headings was included.

The following articles in this section have been classified by their relevance to the following six areas. Each article has a reference to the particular pertinent area:

(1) HMO Philosophy and Concern
(2) Provider Orientation and Concern
(3) Quality of Care
(4) HMO Health Service Delivery System
(5) HMO Marketing
(6) HMO Financing

1. Ellwood, Paul M., "Health Maintenance Organization — Concept and Strategy," *Hospitals*, Vol. 45 No. 6, March 16, 1971, pp. 53-60, 67-76. (1)

   The author discusses health maintenance strategy and implications for hospitals and physicians. He identifies the assumptions behind the HMO concept: (a) the federal government as an initiator of change; (b) the health care crisis resolution through structural and organizational changes; and (c) federal health policy fostering, in the long-run, self-regulation in the health industry. Two models of service delivery are described: the group practice model, and the individual practice model. A detailed description of HMO components and rationale are included. Descriptions of several HMO prototypes are provided: Kaiser Foundation; Health Insurance Plan of Greater New York; San Joaquin Foundation for Medical Care; the Columbia Medical Plan; the East Baltimore Medical Plan; and Health, Inc.

2. Havighurst, Clark C., "Health Maintenance Organizations and the Market for Health Services, "*Law and Contemporary Problems*, 1970, pp. 716-795. (1)

   This paper is addressed to the policies needed to obtain the best possible implementation of the HMO concept. The ultimate thrust is toward detailing the policy choices necessary to create a market-oriented system of health care delivery, with HMOs as an essential element. These are: (a) a multitude of legislatively and professionally conceived and executed trade restraints have previously prevented the marketplace from functioning up to its potential effectiveness, and (b) that restoration of a market regime offers the best hope for solving the nation's health care problem in all of its numerous dimensions. The focus is on implementing the HMO concept in the context of a federally funded scheme covering the poor and the aged. A description of benefits that the market, supervised and supplemented by selective regulation, would be able to deliver is included. The model is then evaluated in the light of concerns about emphasizing the profit motive in health care and about monopoly tendencies in the health care marketplace. The final recommendation is vigorous antitrust enforcement, explicit federal pre-emption of restrictive state laws and a number of other policies designed to assist in recreating an unrestrained competitive market for health services.

3. MacLeod, G.K. and Prussin, J.A., "The Continuing Evolution of Health Maintenance Organizations," *New England Journal of Medicine*, 288;439-443, March 1, 1973. (1)

   Of the various health-care systems, health maintenance organizations most closely meet the objective of providing access to high quality comprehensive medical and health care services at the most reasonable costs possible. Preventive services, early disease detection diagnosis, and treatment of illness and injury are all equally emphasized in the HMO. Basic principles for developing an effective HMO include prepayment; a contractual responsibility; integrated services; and voluntary enrollment and comprehensive coverage. physicians' organizations; physicians' payment influenced by shared financial responsibility; integrated services; and voluntary enrollment and comprehensive coverage. An emphasis is placed on the need for both primary physicians and ancillary health persons working as a team to provide comprehensive care.

4. Myers, Beverlee A., "Health Maintenance Organizations: Objectives and Issues," paper presented to State CHP Agencies Annual Conference April 7, 1971, Washington, D. C. and published in *HSMHA Health Reports*, 86:585-591, July 1971. (1)

   The objectives for health maintenance organizations are focused on providing investment in and incentives to use prepaid and organized comprehensive health care systems serving defined populations. The objectives are: (a) to offer alternatives to the existing health care system; (b) to reform the system by bringing greater organizational efficiency together with more effective control of quality of care; (c) to introduce cost control through incentives within the delivery system; and (d) to provide incentives for health maintenance rather than crisis oriented medical care.

   The question of what is an HMO is discussed with emphasis on the necessity of having all elements present and active. These elements are:

   1. An organized health care delivery system which includes health manpower and facilities capable of providing or at least arranging for all the health services a population might require.

2. An enrolled population consisting of groups and individuals who contract with the delivery system for provision of a range of health services that the system makes available.
3. A financial plan which incorporates underwriting the costs of the agreed upon set of services on a prenegotiated and prepaid per person or per family basis.
4. A managing organization which assures legal, fiscal, public and professional accountability.

Issues of provider acceptance, consumer acceptance, and co-existence of prepayment and fee-for-service systems are discussed.

5. Freidson, Eliot, "Prepaid Group Practice and the new 'Demanding Patient'," *Milbank Memorial Fund Quarterly*, Vol. 51, Fall 1973, pp. 473-489. (2)

Based on an extensive field study of the practitioners in a large, prepaid service contract group practice, this paper discusses how a prepaid service contract and closed-panel practice brings a new dimension into doctor-patient relations and the response of physicians. Unable to manage "unreasonable" demands for service by use of a fee-barrier or encouragement to "go elsewhere" as in traditional, solo fee-for-service practice, physicians were particularly upset by a new type of "demanding patient" who claimed services on the basis of contractual rights and threatened appeal to higher bureaucratic authority. Modes of dealing with such patients are briefly discussed. One mode is to provide all services covered by the contract which were not inconvenient to the practitioner- office visits, referrals, and laboratory tests. The physician or gate keeper to the benefits can determine patient utilization of those benefits. Another strategy was one of the expert consultant who used his/her medical knowledge and skill to limit access of the demanding patient. And finally, a strategy of patient education and the development of a trusting relationship can also be used to cope with the demanding patient.

6. Brook, Robert H., "Critical Issues in the Assessment of Quality of Care and Their Relationship to HMO's," *Journal of Medical Education*, Vol. 48, No. 4, Part 2, 1973, pp. 104-134. (3)

The purpose of the paper is to examine the relevant components of the quality of care issue especially as they pertain to the medical care received by enrollees of prepaid group practices. The specific objectives are: (a) to discuss problems with the definition and use of the words "quality of care," (b) to present the different methods of assessing quality of care and to illustrate their weaknessess and strengths, (c) to summarize the literature concerning the quality of care received by people enrolled in prepaid group practices, and (d) to suggest future areas of research.

Donabedian's classification scheme is used to analyze different types of data for assessing quality of care: (a) structure assessment, which includes input measurements, such as the number of health facilities available or the ratio of physicians to population served; (b) process assessment, which includes the physician's technical and socio-economic management of health and illness as well as aspects of the patient-doctor relationship; and (c) outcome assessment, which includes what happens to the patient in terms of his symptom level, major activity level, whether he is still living, and how he functions in his community.

It is concluded that little is known about the quality of medical care in general, let alone about care received by enrollees of a prepaid group.

7. Morehead, Mildred A., "Evaluating Quality of Medical Care in the Neighborhood Health Care Program of the Office of Economic Opportunity," *Medical Care*, Vol. 8, No. 2, 1970, pp. 118-131. (3)

Twenty-four OEO Neighborhood Health Centers have been audited to determine the extent to which selected criteria were met in the fields of adult medicine, infant care, and obstetrical care. Two types of audits were used in the reviews: one based on the index approach to auditing, the baseline surveys; and the other, using the peer judgement approach, the clinical audit. Principles of group operation, sample selection, the scoring process and findings are presented. The centers were ranked by their scores and various characteristics were examined. Program design, patient volume, medical school affiliation and, most important, administrative know-how were concluded to be major factors associated with high performance ratings.

8. Barr, Daniel M., and Gaus, Clifton R., "A population-Based Approach to Quality Assessment in Health Maintenance Organizations," *Medical Care*, Nov.-Dec. 1973, Vol. 11, No. 6, pp. 523-528. (3)

   The conceptual basis for an approach to quality assessment is presented. This approach focuses on the accessibility, efficiency, and effectiveness of the system for providing care rather than of detailed characteristics of the care itself. The approach currently being developed at the Columbia Medical Plan in Maryland can be characterized as population-based and multidimensional. Population-based is defined by the inclusion of accessibility or a dimension of quality. It is multidimensional because of the inclusion of three of the many dimensions of quality. The approach is intended to be an on-going regular quality assessment procedure for an HMO which would be dependent on, and integrated with, clinical and administrative management information systems.

9. Hirsch, Gary S.M., and Miller, Sutherland, "Evaluating HMO Policies With a Computer Simulation Model," *Medical Care*, Vol. 12, No. 2, August 1974, pp. 668-681. (4)

   The development and design of a computer simulation model of a health maintenance organization is described. Simulation models permit experimenting with policy changes without the risk of actually making major alterations. The data for this model came from applying it to the issues facing a Children and Youth Project considering conversion to an HMO. To illustrate the models usefulness, simulations are presented showing the impact of different marketing approaches, benefit packages, and fitness programs. The model was designed to address a number of specific issues. These included:

   1. What resource levels are required to provide a given level of service?
   2. What levels of service requirements can be expected with various subscriber population mixes?
   3. How will the results of different marketing programs affect the subscriber mix and the financial viability of the HMO?
   4. To what extent can the delegation of tasks to paramedical personnel effect the overall costs of care delivery?
   5. What are the advantages and disadvantages of a marketing program with heavy emphasis on Medicaid and Medicare populations?
   6. What sets of population mixes and premium levels may make the HMO unattractive to the relatively healthy employee groups?
   7. How will various facilities, resources, and policies affect the HMO's costs and levels of service?
   8. To what extent can screening and fitness programs affect the over-all costs of care?

   The results of the study supported its usefulness in analyzing the long-term consequences of policies and decisions which affect the HMO.

10. Health Systems Research Program-Bionetics Research Laboratories, Inc., *Marketing of Health Maintenance Organization Services*, Vols. I through V, U. S. Dept. of Health, Education & Welfare, Health Services and Mental Health Administration, Health Maintenance Organization Division of Training and Technical Assistance, February 1972. (5)

    This series of volumes explains and develops a methodological approach to the marketing process. Volume I (Guidelines for Health Maintenance Organization Marketing) summarizes a general approach to developing and implementing a marketing program. Volume II (The Beneficiary Population) includes information and data requirements for the beneficiary population which are used as the foundation of a responsive marketing strategy. Volume III (Existing Systems and Services) defines those characteristics of the existing health intermediary and delivery systems which should be considered in developing a cogent market strategy. Volume IV (Market Definition) focuses on the foundations on which to develop a logical and phased marketing approach and plan. Volume V develops a marketing strategy and model.

11. Schenke, Roger S., and Spicer, Curtis J., eds., *Development of HMO's Within Existing Group Practices – A Symposium Jointly Sponsored by the American Association of Medical Clinics and the Medical Group Management Association.*, American Association of Medical Clinics, 1973. Also in *Medical Group Management*, Vol. 21, No. 1. Dec. 1973, pp. 22-24. (B-1; B-2; B-5; B-6)

HMO developers in five member group practices served as the symposium panel. The symposium focuses on HMOs as an integral part of fee-for-service group practice. The panels were:

1. Introduction to the clinics — a brief overview of the five participating clinics;
2. Why start an HMO? — an attempt to answer the question of the rationale for developing an HMO;
3. Legal structure — questions relating to existing and proposed legislation and regulations impact on HMO's were addressed;
4. Component linkages — the role of physicians in providing and linking the various service components of HMOs;
5. Benefits and health services — examples of how to design and negotiate the benefit package are provided;
6. Risk sharing issues;
7. Marketing plans and problems;
8. Management issues and organizational structures.

A general sharing of information and issues is the format of the symposium report.

12. Prussin, Jeffrey A., "HMOs — Organizational and Financial Models", *Hospital Progress*, Vol. 84, May 1974, pp. 56-59. (4, 6)

This article discusses the organizational and financial structures of three prepaid group practice plans — the Community Health Care Center Plan, the Group Health Association, and the Health Insurance Plan of Greater New York. The brief descriptions of each plan provide useful care materials for training on functional and operational aspects of health maintenance organizations. The two fairly dissimilar models of HMOs are identified. One is the medical care foundation which has the following elements:

1. Prepaid health plans;
2. Participating physicians remain in their previous fee-for-service solo or group mode of practice and bill the foundation for member services on a fee-for-service basis. The physicians incur risks insofar as they must accept lower fees for service if utilization is higher than anticipated;
3. Some form of peer review;
4. Review of hospital utilization rates;
5. Comprehensive coverage, including inpatient, ambulatory and health maintenance services; and
6. Free choice for patient between the medical care foundation and indemnity plans.

The other model is prepaid group practice. The elements contained in the model are:

1. Prepaid health plans;
2. Physicians organized in a multispeciality group that should be autonomous, self-governing unit;
3. Peer review;
4. Risk sharing;
5. Plan makes available all ambulatory and in-patient facilities that are necessary for the provision of comprehensive health care services;
6. Coverage is comprehensive including inpatient, ambulatory, and health maintenance services. Preventive medicine as well as early detection, diagnosis, and treatment of illness and injury are stressed; and
7. The individual has free choice among the physicians participating in the plan as well as between prepaid group practice and indemnity plans.

13. Division of Training and Technical Assistance of the Health Maintenance Organization Service, *Financial Planning Manual*. US DHEW, HSHMA. (6)

The focus of the manual is on the presentation of certain procedural information that will assist in sound financial planning for the establishment of a prepaid health care plan. It presents a structural approach for identifying major plan parameters that have impact on costs and resources, as well as a set of procedures for organizing and analyzing the major financial characteristics of the plan. Specifically, procedures are presented for:

1. Developing in a structured format the costs to be incurred by the plan;
2. Evaluating the impact that various plan parameters have on the overall costs of HMO activity;

3. Developing a revenue structure that is sufficient to offset plan costs and support the growth objectives set by the HMO sponsors; and
4. Determining the financial commitments necessary to start-up and sustain the operation of the HMO.

The manual also contains utilization and financial data that were collected from various existing HMO activities. This manual is a guide for the planner that will assist in the development of a clear understanding of the plan's financial requirements and expected activities.

14. Shalowitz, Mervin, and Trotter, S. Allan, "Intergroup — One Alternative, Part II, Benefits, Roles, and Marketing," *Medical-Group Management*, Vol. 21, No. 1, pp. 26-28, and "Intergroup — One Alternative, Part III, Management," *Medical Group Management*, Vol. 21, No. 1, pp. 21-22. (6)

The articles provide information on benefits, rates, and marketing for the Intergroup Prepaid Health Service Plan. Intergroup provides a comprehensive prepaid health program through a group subscriber population utilizing the services of 20 multispeciality medical groups in Illinois and Northern Indiana. Each group provides services through both a fee-for-service and capitation modes. The groups greatest problem has been educating the public as to the benefits available as well as the concepts which are inherent in the prepaid format. The copayment feature has been a plus factor in marketing. The success of the plan has been due to active participation of physicians in the management of the plan as well as in designing the benefits package. In Part III, Management, the physicians have found that the plan allows them to be totally obligated for patient care and reduces the conflicts between physicians and third-party payors.

For members, the stress on preventive and maintenance care allows them to budget their medical care on an annual basis.

15. Thompson, David A., "Financial Planning for an HMO, *Health Services Research*, Vol. 9, No. 1, Spring 1974, pp. 68-73. (B-6)

This article discusses the development of a financial simulation model for HMO's which could be developed into a training instrument. The model was designed to be sufficiently realistic in representing the anticipated situation to allow reasonably accurate planning, but not so complex as to be incomprehensible to those involved in the forecasting. The simulation model was evaluated as a highly successful method of determining the financial trade-offs of various health delivery rated decisions. In developing the simulation model, the "more rigid" parameters (less influenced by HMO's actions) were initially assumed to be the "independent variables": monthly health insurance premiums, maximum market, interest costs, and outside service costs. The more controllable or dependent parameters were: monthly growth rate for each potential plan, HMO operating expenses (assumed to have a fixed and a variable component), and the share of total premium revenue retained by the HMO for its administrative services. The model was developed on an interactive program, written to permit members of the HMO management team to "play with" the parameters to see which were the more sensitive ones and what various balances of values constituted feasible solution. The "goodness" of a solution was measured by its resulting maximum deficit and the length of time required for the HMO to break even.

4. TRAINING IMPLICATIONS

This paper has reviewed literature relevant to team training in health maintenance organizations. The concluding section will focus on implications for curriculum design and implementation. Section 3 is divided, in light of the preceding section on the literature review, into: (a) team training and curriculum development; and, (b) health maintenance organizations' literature and curriculum development.

4.1 Team Training and Curriculum Development

The training literature's relevance to curriculum development is evident in the three areas of methodology design, experience design and evaluation. The book by Havelock and Havelock provides a beginning understanding and framework for designing training programs. From theoretical considerations to goal setting, program design and evaluation, this book can serve as a useful tool and model for curriculum design. The articles by Nagi; Carlaw and Callan; World Health Organization; Pierleoni; Rubin and Beckhard all include discussion of methodological considerations which are pertinent to curriculum design. Books by Fordyce-Wesley; McTeenan and Hawkins; and Odiorne provide in-depth analyses of methodological issues and training objectives.

The specific techniques of role-playing, simulations and games, T-groups, audio-visual materials and general teaching methods are discussed and, in some instances evaluated, by the following authors.

Issues around role-playing are identified and discussed by Maier, Salem and Maier; and Bradford and Lippitt. The values of simulation and gaming are discussed and evaluated by Roser. Laboratory groups are described and evaluated by Hall and Williams; Buchanan; Golembiewski; and Underwood. The use of audio-visual materials is discussed by the U. S. Civil Service Commission's article on Visual Materials; Green and Cotlar; and Robinson. Other teaching methods are discussed and compared within the context of the aforementioned articles. Specific emphasis on evaluation of training methods is provided in the articles by Baird; U. S. Civil Service Commission's Training Evaluation; Petty; Rubin and Beckhard; Bolman; Byars and Crane. Several evaluation models are also considered in the books listed under the methodology area.

Several recurring themes were presented in the literature review under methodology and evaluation. Methological concerns tended to focus on: (a) clearly defining training goals and objectives; (b) the use of training techniques, methods and aids which are appropriate to the trainees' comprehension level and the trainers' skill level; and, (c) an evaluation which is designed to test the effectiveness of the training program with particular emphasis on measuring the sustained change in trainee behavior.

4.2 Health Maintenance Organizations Literature and Curriculum Development

Several broad areas were considered in reviewing health maintenance organizations literature and its relevance to curriculum development. These areas were:

(a) Relevance of literature to HMO philosophy and concerns.
(b) Relevance to provider orientation and concerns.
(c) Relevance to quality of care issues.
(d) Relevance to HMO service delivery systems.
(e) Relevance to HMO marketing issues.
(f) Relevance to HMO financing issues.

Authors focusing on HMO philosophy were Ellwood; Havighurst; Myers; Morehead; and Schenke and Spicer. Their major emphasis was on identification of the conceptual basis of HMO legislation and implementation issues. Provider concerns were covered by Schenke and Curtis; and Freidson. The major emphasis was on the impact of HMOs on group practices and the demands for services by patients and third-party payors. Quality of care issues were identified by Brook; Morehead; and Barr and Gaus. The underlying theme was the difficulty in developing a meaningful measure of quality of care in prepaid settings. Some possible solutions to the problem were identified. However, the need for further research was stressed. HMO delivery systems were described by Prussin, Hirsch, and Miller. Prussin's article was purely descriptive. Hirsch and Miller provided an example of a computer simulation which can serve as a useful planning tool to develop a delivery system. The literature on marketing issues was limited to the Schenke and Spicer article and the Health Systems manual. Schenke and Spicer identify some practice issues in marketing. The manual outlines the ideal marketing process. HMOs and financial planning issues were discussed in Schenke and Spicer; Prussin; Shalowitz; Thompson; and the HEW financial planning manual. These articles provided

information on HMO financial planning problems, simulation models, and manuals for planning. The content in these six headings should be integrated into the curiculum since they highlight some major HMO issues and in some instances offer solutions.

4.3 Implications

Based on the literature review, there are several components that should be present to insure a successful training program. First, the goal and purpose of the training design should include a definition of trainer roles; specific training problems or needs identification, and an indication of training limitations. Second, the specific training needs of potential participants should be identified. Conflicts with their needs and program objectives should be resolved. Third, the anticipated training outcomes should be stated. Three areas of outcome focus should be clarified and elaborated:

1. Attitude and value outcomes;
2. Knowledge outcomes; and
3. Skills outcomes.

Long-term outcomes should also be included in the section.

Fourth, the training procedure should be delineated to include: (a) the training schedule; (b) trainer and trainee preparation; (c) readings and audio-visual aids; (d) outline descriptions of each training unit, delineating team building processes and HMO content; and finally, (e) the criteria for evaluation should include measure of process and contents impact both initially and over time. Alternative measures of training effectiveness should be designed to support the evaluation component. A system for feedback and use of evaluation data should be developed to increase training effectiveness.

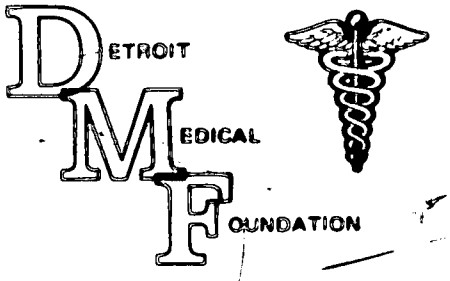
Further research needs to occur in the area of training methodologies and evaluation. The training section in this paper only begins to identify key concepts, issues and designs.

While the HMO section search was quite extensive, published materials relevant to curriculum design for a team training program were scarce. As HMO experiences increase, it is anticipated that there will be a greater body of knowledge from which training and learning can occur.

APPENDIX 4

DEMONSTRATION TRAINING PROGRAM

MHMOP INFORMATION MANUAL



DEMONSTRATION TRAINING PROGRAM

MHMOP INFORMATION

MANUAL

FUNDED BY: Division of Associated Health Professions
Bureau of Health Manpower (BHM)
Health Resources Administration (HRA)
Public Health Service (PHS)
Department of Health Education & Welfare (DHEW)
Bethesda, Maryland 20014

CONTRACT NUMBER: 1-MB-44196

November, 1975

PREPARED BY: Detroit Medical Foundation
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DEMONSTRATION TRAINING PROGRAM

MHMOP INFORMATION MANUAL

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TABLE OF CONTENTS

INTRODUCTION

This manual is Appendix 4 of a final report prepared by the Detroit Medical Foundation (DMF) in compliance with DHEW Contract No. 1-MB-44196*. The purpose of this manual is to provide Individual Practice Association (IPA) model Health Maintenance Organizations (HMOs) with a training program manual design which may be developed to facilitate the transition of medical, para-medical and other health professionals into an IPA model HMO setting. Secondly, it provides a description of Michigan HMO Plans, Inc., the only (IPA multiple group practice model HMO) DHEW funded, development grantee in the State of Michigan.

The contract title *"Deomonstration Training Program to Improve the Capacity of Primary Care Unit Staffs to Function within an HMO Setting"* (DTP) was awarded to the DMF July of 1974. ". . . Primary Care Unit Staffs . . ." (PCU) referred to in the contract title are the staffs of the contract health services provider groups of Michigan Health Maintenance Organization Plans, Inc. (MHMOP).

We recognize that no guide is complete, however, the DMF contract staff feels that this manual can serve as a valuable guide to other IPA model HMOs that are interested in developing training programs of this nature.

*Division of Associated Health Professions, Bureau of Health Manpower (BHM), Health Resources Administration (HRA), Public Health Service (PHS), Department of Health, Education and Welfare (DHEW).

WHAT IS AN HMO?

The Health Maintenance Organization , most commonly referred to by the letters H M O , has become a frequently used expression in the health field. For most people, a common reference point is the Kaiser Permanente Medical Program which has operated as an HMO type health delivery system since the early 1930's. But what is an HMO? In December of 1974, the HMO was defined by Public Law 93-222 (The Health Maintenance Organization Act of 1973). This legislation provides a more detailed definition of what an HMO is, and how they may be established. Final rules and regulations which provide the guidelines for establishing HMO's were finalized in October of 1974. In order to stimulate the development of HMO's, the federal government appropriated over 300 million dollars for grants, contracts and feasibility surveys for groups that would organize to establish HMO delivery systems.

SOME CHARACTERISTICS OF HEALTH MAINTENANCE ORGANIZATIONS

No doubt the most obvious question relative to the HMO is *"what is the basic difference between an HMO health plan and a traditional indemnity insurance plan."* The answer is that an HMO plan actually provides medical care and other health care services to its members, while traditional indemnity insurance plans either reimburse its members for health services that they have already received or reimburse the providers of health services. Other aspects of the HMO that are different from insurance companies are:

A. The Method of Payment

Payments (premiums) for health services by HMO enrollees *must be* based on a community rating system. While the Department of Health, Education and Welfare (DHEW) has not published a final policy on the interpretation of a community rating system, this system may generally be defined as one that does not set rates based on the actual past health services utilization experience of a *specific group*. In other words, all individuals in a particular community would pay a fixed amount for its health services based on the number of persons in that community. In addition, this fixed payment is to be paid on a periodic basis without regard to the frequency, extent or kind of services actually furnished. Additional nominal co-payments may be required at the time of service except "whenever they act as a barrier to utilization." The Secretary of DHEW will establish regulations concerning barriers and the amount of permitted nominal co-payments.

B. HMO Health Services

If you enroll in an HMO, the HMO must make available to you the following services:

Basic Health Services*

1. Physican services (including consultant and referral services by a physician).
2. Inpatient and outpatient health services.
3. Medically necessary emergency services.
4. Short-term (not to exceed twenty visits) outpatient evaluative and crisis intervention mental health services.
5. Medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs.
6. Diagnostic laboratory, diagnostic and therapeutic radiological services.
7. Home health services.

   Home Health Services means services provided at a member's home by health care personnel, as prescribed or directed by a responsible physician or other authority designated by the HMO.
8. Preventive health services (including voluntary family planning services, infertility services preventive care for children and children's eye examinations conducted to determine the need for visual correction. (This includes preventive dental care services).

Preventive Dental Care Means:*

A minimum of — oral prohphylaxis topical flouride application and surface sealant services as provided by regulations of the Secretary to children under the age 12.

Supplemental Health Services:*

These optional services, which may or may not be offered, include all or part of the following:

1. Services or facilities for intermediate and long-term care.
2. Vision care not included as a basic health service under 1 or 8.
3. Dental services not included as a basic health service under 1 or 8.
4. Mental health services not included as a basic health service under 4.
5. Long-term physical medicine and rehabilitative services including physical therapy.
6. The provision of prescription drugs prescribed in the course of the provision by the HMO of a basic health service or supplemental health service.

C. **Enrollment in an HMO - (DUAL CHOICE OPTION)***

Employers subject to the Minimum Wage Act, who employ twenty-five or more persons, *shall include in any health benefits plan offered to employees the option of membership in DHEW qualified HMOs*. No employer shall be required to pay more for health benefits than would otherwise be required by any prevailing collective bargaining agreement or benefit contract.

*See "Health Maintenance Organization Act of 1973" S. 14

D. **Open Enrollment***

HMOs cannot discriminate against enrolling high risk individuals or groups unless it can prove to the Secretary of DHEW that its financial solvency is threatened by doing so.

E. **Providers of HMO Health Services***

Health services provided by an HMO *must be* provided by qualified health professionals. "Health professionals", is defined as: physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services. Other operational requirements of HMOs are:

1. Fiscal viability.
2. The responsibility of the HMO for full financial risk on a prospective basis for basic health services, except that reinsurance may be obtained.
3. Enrollment of persons which are "broadly representative of the community it serves.
4. Governing body representation for HMO enrollees.
5. A grievance procedure for HMO members.
6. A Quality Assurance Program which emphasizes health outcomes and peer review.
7. Medical Social Services provided or arranged for.
8. Continuing education for its health professionals.
9. Maintain a monitoring system to evaluate costs, utilization patterns, availability of services, accessibility of services, and health status of enrollees.

The organizational structure of HMOs is specified in the HMO legislation. Essentially, there are two types:

I. **The Staff Model or Medical Group**

By definition, a medical group is defined as a partnership, association, or other group which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists and podiatrists), as are necessary for the provision of health services for which the group is responsible; a majority of the members of which are licensed to practice medicine or osteopathy; and the members of which:

1. As their principal professional activity and as a group responsibility engaged in the coordinated practice of their profession for a health maintenance organization;
2. Pool their income from practice as members of the group and distribute it among themselves according to a pre-arranged salary or drawing account or other plan;
3. Share medical and other records and substantial portions of major equipment and of professional, technical and administrative staff;
4. Utilize such additional professional personnel, allied health professional personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the members of the group; and
5. Arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group.

*See "Health Maintenance Organization Act of 1973" S. 14

II. **The Individual Practice Association***

An Individual Practice Association is defined as a partnership, corporation, association, or other legal entity which has entered into a service arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health professions in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide:

1. That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and
2. To the extent feasible:
   a. that such persons shall utilize such additional professional personnel, allied health professional personnel, and other health personnel (as specified) in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the persons who are parties to the arrangement;
   b. for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff; and
   c. for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.

Sponsors of HMO's generally fall into two categories — provider directed plans and consumer directed plans. They may also be for profit and non-profit.

Michigan Health Maintenance Organization Plans, Inc. is a physician sponsored multiple group IPA Model HMO. It is also tax exempt under section 501(c) (4) of the Internal Revenue Code of 1954, as amended.

In summarizing the intent of the HMO legislation, it is essentially an attempt to impact the organizational structure of the health delivery system and change the method of payment. It is also an effort to make comprehensive health services more available and accessible to HMO enrollees, while at the same time, emphasizing the practice of preventive and maintenance health care.

While the above-mentioned changes in the health care delivery system does not guarantee the delivery of better quality health services, to date much evidence indicates that, together, the HMO delivery mechanism and pre-payment may be a step in the right direction.

Per the HMO Program Status Report, May, 1975, "There are now 173 prepaid health care organizations across the country serving an estimated 5.7 million enrollees . . . Prepaid health care organizations are now operating in 33 states plus D.C. and Guam . . . The top ten states, in order of total prepaid enrollment are: California, New York, Washington, Oregon, Wisconsin, Hawaii, Illinois, Michigan, D.C., and Minnesota. The states with no operational prepaid plans are: Alabama, Alaska, Arkansas, Delaware, Georgia, Idaho, Iowa, Louisiana, Missouri, Montana, North Carolina, North Dakota, Oklahoma, South Dakota, Vermont, Virginia and Wyoming.

Insurance companies, consumer groups, labor unions, national and local Blue Cross and Blue Shield organizations, banks, universities, industrial firms and others in the private sector are becoming increasingly involved in HMOs."

*See "Health Maintenance Organization Act of 1973" S. 14

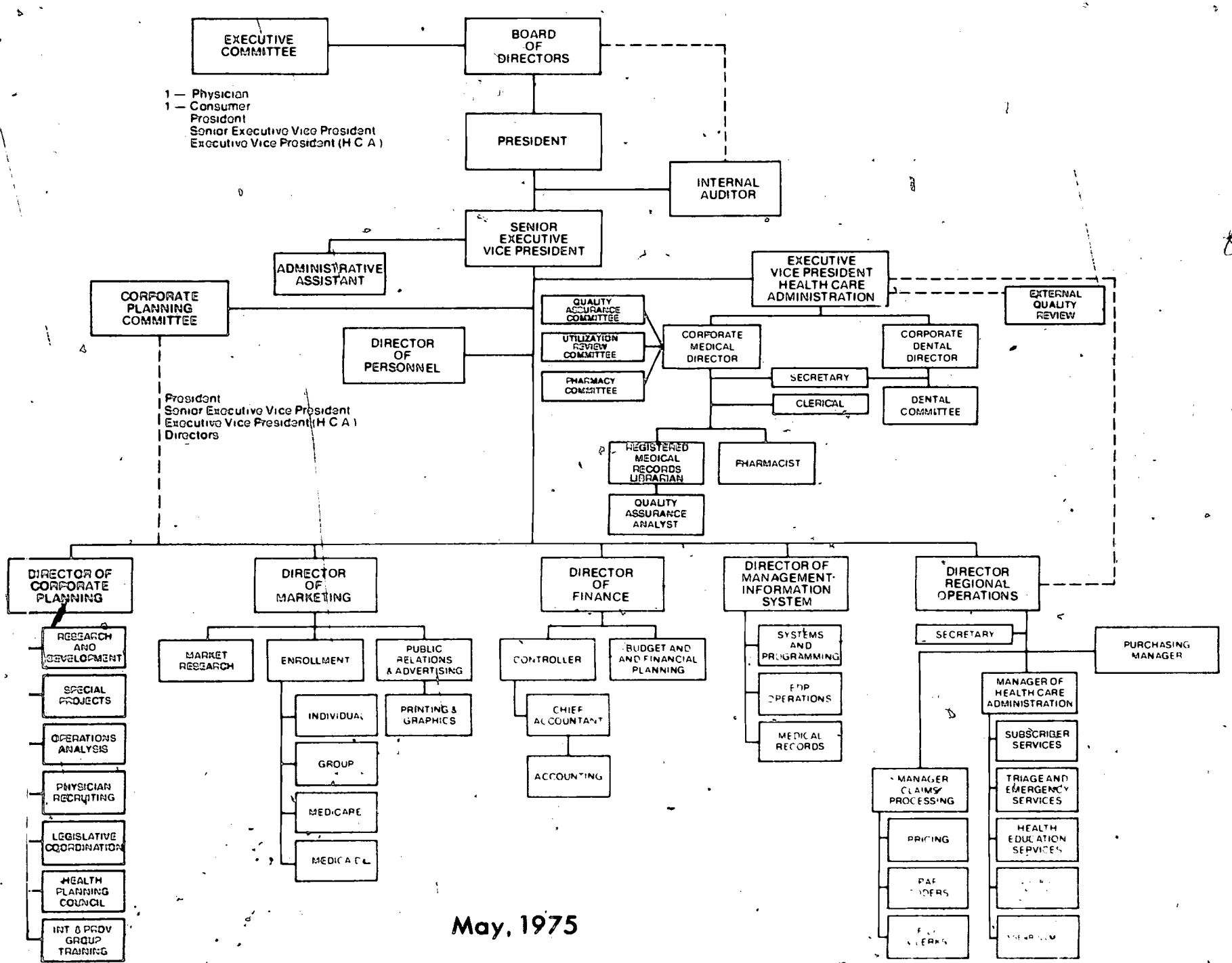
PROPOSED CHANGES IN THE HMO LEGISLATION

Although the evidence indicates that HMOs may be the answer to some of the nation's health delivery system problem, the Federal HMO Legislation (PL 93-222) has been criticized for having structural defects.

Proposed legislation to remedy these defects include:

1. Reduce the mandated basic benefit package.
2. Reduce the scope of mandated benefits.
3. Remove a requirement relative to physician aggregate time with HMO enrollees.
4. Remove the requirement that HMOs have open enrollment periods yearly.
5. Redefine the term "Medical Group."
6. Removal of the Dual Choice Option.

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INCORPORATED
APPROVED ORGANIZATION CHART



May, 1975

OVERVIEW OF THE MICHIGAN HEALTH

MAINTENANCE ORGANIZATION PLANS, INC. (MHMOP)

In May of 1971, a group of concerned inner-city physicians and consumers contributed four hundred ($400.00) dollars in seed money, and an immeasurable amount of time and effort, to establish the Detroit Medical Foundation (DMF); a 501 (c) (3) non-profit corporation. The objective of DMF was to plan and develop a Health Maintenance Organization (HMO) in the Detroit Metropolitan area. In the months that followed the initial $400.00 commitment, DMF applied to the Department of Health, Education and Welfare (DHEW) for an HMO planning grant. In January of 1972, just eight months after the formation of DMF, DHEW demonstrated its confidence in the efforts of DMF by awarding it $25,000.00 to plan an HMO. Continued hard work and development efforts by the Board and staff of DMF enabled them to obtain a continuation grant of $70,000.00 in June, 1972. With this additional monetary resource, DMF began the initial stages of finalizing its HMO plans and development activity. One year later, June of 1973, DMF was awarded a two hundred six thousand ($206,000.00) dollar development grant from DHEW's Health Maintenance Organization Service.

Because of the Internal Revenue Code applicable to DMF and requirements imposed by regulations governing the issuance of a Certificate of Authority by the State, to DMF, a new organizational structure was mandated. This mandate caused the creation of Michigan Health Maintenance Organization Plans, Inc. (MHMOP) a 501 (c) (4) non-profit corporation on September 23, 1972. It now serves as the operating implementation entity for the health care delivery system which was planned and developed by DMF. *In addition to planning and developmental funding, HEW has provided DMF and its operating agency, MHMOP, the expertise and technical assistance of a wide variety of consultants and organizations at no expense.*

In April of 1973, MHMOP submitted a proposal to the Michigan Department of Social Services (MDSS). This proposal requested that MDSS contract with MHMOP to serve 40,000 Medicaid eligible (Title XIX) persons in Wayne County. Much time and effort was expended in negotiating the proposed contract with MDSS. This effort culminated with the signing of this proposed contract in December of 1973.

In February of 1974 the first Title XIX recipients, via the MDSS contract, were enrolled in MHMOP. From February to the present time (November, 1975) the MHMOP Public Relations and Marketing staff have exerted maximum efforts in educating the Medicaid market about the HMO concept and MHMOP. As a result, MHMOP's present enrollment is 28,640.

Concurrent with the public relations and marketing activity the delivery system grew from 8 to 19 MHMOP contract IPA provider groups. In addition, the MHMOP executive staff prepared and submitted an HMO development grant proposal to DHEW.

Approximately eleven months after MHMOP came into existence (October, 1974) DHEW accepted and funded this development grant proposal for $266,000.00. With this assistance, MHMOP became the only DHEW-funded (Multiple Individual Practice Association Model HMO) development grantee in the State of Michigan.

THE MHMOP DELIVERY SYSTEM

As a Multiple IPA group practice model HMO, MHMOP provides health services by contracting the physician corporations (Multiple IPA's) to delivery (Title XIX covered) health services to eligible individuals. These physician owned IPA's are pre-paid on a capitation basis with funds received by MHMOP from the Michigan State Department of Social Services. In exchange for this capitation payment the IPA's assume total responsibility for the delivery of primary health care services to individuals assigned to their IPA by the MHMOP marketing staff.

MHMOP's definition of primary health care services are pediatric, OB/GYN, surgery, general practice or internal medicine physician services.

Other health services, such as hospitalization, emergency care prescription drugs, transportation and physician prescribed supportive health services are provided and paid for by a second provider component of the MHMOP delivery system. Out-of-area medically necessary emergencies are also covered through this delivery component.

This second component of the MHMOP delivery system may be described as the administrative and coordinative resource of the IPA multiple group practice network.

At the present time (November, 1975) there are 19 MHMOP contract IPA's in the delivery system. These IPA's are located in the inner city of Detroit and suburbs surrounding the Detroit metropolitan area. This network of IPA's facilitates optimum convenience and accessibility for MHMOP enrollees.

There are numerous advantages to this provider network. For example, eligible enrollees who voluntarily choose the option to receive health care services from MHMOP may elect to receive these services at one of the MHMOP contract IPA's located near their home. A second advantage is the fact that many of the MHMOP contract IPA's were already operational at their present location and had also previously been the providers of primary medical services for the areas' residents. As a result residents in the area, that became MHMOP enrollees, experienced minimal (if any) interruption in the continuity of health services provided by the IPA. *In fact, the creation of MHMOP has optimized continuity of care by providing a mechanism for comprehensive health care. In the near future the MHMOP option will be available to non-Medicaid individuals and employer groups.* Through the use of existing health delivery structures and health manpower resources, MHMOP has been successful in developing a delivery system which required minimal expenses for facilities and capital improvement.

The MHMOP Enrollee

When Medicaid eligible recipients voluntarily elect to receive all of their health services from MHMOP, and their Medicaid eligibility is subsequently verified by the Michigan State Department of Social Services (MDSS), they become *MHMOP enrollees*. After enrollment by MHMOP account executives, they are given a membership kit. This kit contains the location and name of all MHMOP contract IPA's, the physician staff at these IPA's, all MHMOP participating hospitals and other specific information on how to utilize all of the available services of MHMOP. The new enrollee also exchanges the Medicaid card for a MHMOP membership card. This membership card can be used at

MHMOP contract IPA's and MHMOP participating hospitals. Since at the present time MHMOP does not offer dental services, the enrollee subsequently receives a "Dental Only" Medicaid card from the Michigan Department of Social Services. However, MHMOP does maintain a list of dental physicians who have indicated a desire to provide services to Medicaid eligible recipients. This list is made available to MHMOP enrollees upon request.

Developmental Problems

MHMOP's biggest problem is its accelerated growth rate. In February of 1973 MHMOP had a Detroit based administrative staff of 2 in an office area of 911 square feet. At the present time there are over 100 employees at a new office location in the downtown Detroit area. The square footage used by the MHMOP staff (on the 22nd floor of the Walker Cisler Building) is 23,000.

Present expansion plans include an additional 4,500 square feet (on another floor) at the present location, and enrollee service offices in Oakland and Macomb Counties.

MHMOP's (Detroit office) on-premises 90/60 UNIVAC computer is the nerve center of its Management Information System. Exceptional administrative leadership and management skills has enabled MHMOP to successfully survive the multitude of problems that are common to organizations that grow at an accelerated rate. For example, MHMOP's membership revenue in 1974 was $4,076,248. Its membership revenue for 1975 will exceed 12,000,000.

DEVELOPMENTAL OBSTACLES

MHMOP, unlike other Detroit area groups interested in HMO development, has managed to survive the HMO planning and, hopefully, the developmental stages. It has survived because of its organizational structure and its access to the management skills needed to plan and develop an HMO. Hence, two of the most difficult barriers have been overcome. Like other HMO's, MHMOP's opportunity for a fair or competitive market test (when it enters the non-government funded private market) is constrained by the special requirements of Public Law 93-222 that do not apply to other providers of health services. For example, open enrollment (little opportunity to exclude high-risk groups) and comprehensiveness and scope of coverage (a mandatory full coverage benefit package). The unfamiliarity of consumers with health maintenance organizations and a reluctance by most consumers to change their health utilization patterns to a preventive maintenance posture presents yet another obstacle for MHMOP.

Other obstacles to the development of MHMOP and other HMO's is the failure by health policy makers at DHEW to issue final guidelines on some key issues in the HMO legislation (see p. 5). In addition, HMO's are subject to state HMO legislation (where it exists) its promulgated rules, and regulatory authority.

Many proponents of HMO's believe that Federal, state and local *regulation* of HMO's is the single most significant impediment to their development.

UTILIZATION OF HEALTH SERVICES BY MHMOP ENROLLEES

At the present time, October, 1975, all MHMOP enrollees are Medicaid eligible. However, their health services utilization has not been dissimilar from that of other HMO enrollees in the United States. Current MHMOP hospital utilization data indicates that MHMOP enrollees projected hospital utilization for 1975 will be 608 hospital days per 1000. This utilization rate is approximately one-half the rate experienced by Blue Cross plans in the United States.* It is also comparable to the National Hospital utilization data of 550 hospital days per 1000* for other operational HMOS.

MHMOP Hospital length of stay data also indicates that the projected length of stay for 1975 is 5.5 days. Utilization of those health services (other than MHMOP IPA contract pre-paid capitation services) is only 4% of MHMOP's total cost.

The above data would indicate that the HMO concept, of placing emphasis on preventive and ambulatory care, does impact some health services utilization rates and hence dramatically reduces the overall cost of care. On the other hand utilization of health services by an HMO enrolled population only measures utilization and should not be confused with the effectiveness or ineffectiveness of a delivery system. Other variables such as need, accessibility, availability, income, education and pre-established health services use patterns, also dramatically impact service utilization. However, the MHMOP delivery system *is* designed to minimize the negative impact of these variables.

Exhibit I depicts MHMOP enrollee revenue administrative and health services cost allocation.

1. **Administration**

   "Administration" represents the administrative cost incurred to operate the MHMOP delivery system.

2. **Health Services Cost Allocation**

   "Ambulatory Primary Care Services" represents primary care capitated services.

   "Speciality Referral" represents those services not provided as capitated service.

   "Hospital Emergency Room Services" represents emergency services provided by hospital emergency rooms.

   "Hospital Inpatient" represents inpatient hospital cost.

The MHMOP delivery system is representative of one HMO mechanism that is increasingly being viewed by health professions as a means for lowering health care cost. Because the HMO is a "closed organized system" it theoretically can be operated more efficiently than a traditional "fee for service" open system. To date, the MHMOP experience suggests that this theory is valid.

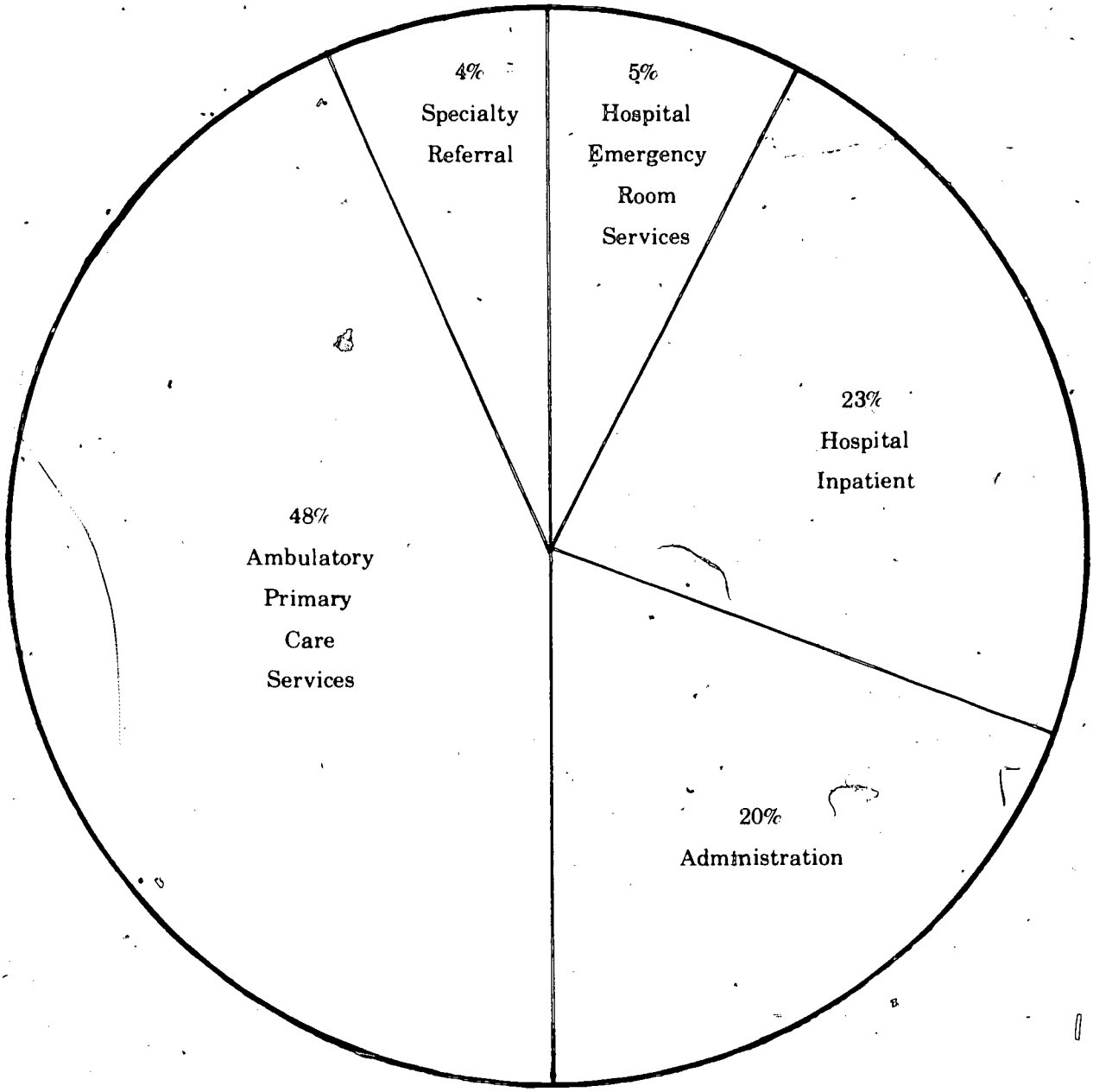
*Bloom, S.S., and Denny, R.P., "The Medical Corporation, Houston, Texas" Industrial Engineering, May, 1974.

EXHIBIT I

MHMOP

HEALTH CARE COSTS*

January-July, 1975



*For a more detailed analysis on enrollee revenue cost allocation see Finance Department Section.

HEALTH CARE SERVICES AND RESOURCES AVAILABLE TO MHMOP ENROLLEES

PREVENTIVE SERVICES

- Care and services provided by a MHMOP physician, including office visits, hospital care, etc.
- Physical examinations and diagnosis
- Immunizations
- Laboratory and x-ray services as required
- Out-patient care and treatment of allergies, illnesses and accidental injuries
- Well-baby care for all children up to 2
- Annual hearing and eye examinations for members age 40 and over.
- Biannual hearing and eye examinations for Members ages 2 to 40

SPECIAL SERVICES

- All drugs and medicines as prescribed by a MHMOP physician
- Corrective eyeglass lenses and-or frames, (not including contact lenses) as prescribed by the doctor as often as yearly
- Consultation and special health services including speech therapy, physical therapy, foot therapy and eye therapy, and all necessary equipment as requested by a MHMOP physician.
- Diagnosis and counseling for psychiatric disorders (not over one visit per week for a maximum of one year)
- Psychiatric in-patient treatment as is considered necessary by a MHMOP physician (limited to 45 days per stay in a special psychiatric care-unit)
- Home care nursing services (other than private duty nursing services) by a registered nurse or licensed practical nurse when required
- All home care medical supplies, equipment and artificial limbs as required while at home
- Health education
- Ambulance service to and from the hospital as ordered by a MHMOP plan physician
- Counseling for family planning
- Nutrition counseling
- Counseling for personal and environmental health problems

HOSPITAL SERVICES

- In-patient services in semi-private room accommodations (private room when considered medically necessary by a physician or surgeon)
- In-patient long-time care in hospital, nursing home, etc.
- All professional care services of attending, participating and consulting physicians and other health specialists
- All medical supplies, equipment and artifical limbs necessary for health care and treatment in the hospital
- In-patient radiation therapy, speech therapy and related services
- Emergency and follow-up treatment of accidental illnessess and injuries as is necessary for health care and treatment by a MHMOP physician

OUT-OF-AREA EMERGENCY SERVICES

- All necessary services for treatment of emergency illnesses or accidental injuries encountered while out of the MHMOP service area

  (An Enrollee receives all hospital and professional care services while out of the MHMOP service area, provided that such care and services are equal to the normal cost for them within the MHMOP service area.)

MATERNITY CARE SERVICES

- Complete before birth and maternity care for all female members
- All physician, surgeon, hospital and related care services for mother and child while in the hospital
- Complete after-delivery care for mother and newborn

- Orthopedic Shoes
- Hearing Aid
- Prosthetic Devices & Braces
- Eye Prosthesis
- Home Health Supplies (beds, wheel chairs)
- Speech & Language Evaluation
- Speech & Language Therapy
- Guidance in Hearing Aid Selection
- Aural Rehabilitation
- Manual Communication
- In Home Supportive Services (Domestic Assistance)
- Respiratory Home Services
- Pregnant Addicted Women
- Home Nursing
- Home Occupational Therapy
- Ambulance
- Cab
- Other Surface Transportation

MARKETING DEPARTMENT

MARKETING CONSIDERATIONS

Marketing a pre-paid group practice plan presents some unique problems. Traditional marketing techniques often perpetuate the slogan that "the consumer is always right". In the provision of health services, the consumer is often unable to accurately evaluate the quality or value of what he or she buys. As a result, the consumer's judgment is often based on personal satisfaction. Just as often, however, personal satisfaction may not mean that the consumer has received adequate health services. At the same time, the physician justifiably (and often validly) believes that he is always right. As a result, when there are areas of disagreement which involve consumers and the physician, *the Plan (MHMOP) is always perceived as wrong.*

Through the combined efforts of the Marketing Department and the Health Education Division, meetings are held with MHMOP enrollees on a weekly basis. These meetings are designed to help enrollees better understand the everyday problems of a pre-paid group practice delivery system. To date, enrollees have exhibited positive and negative responses to the MHMOP delivery system. However, because consumers are unfamiliar with the HMO health services delivery concept, many who enroll voluntarily, disenroll without utilizing the services.

Changing the inappropriate health services utilization patterns of consumers who are not familiar with an HMO delivery system presents yet another problem for the MHMOP Marketing Department. As a result, MHMOP's enrollment growth may be attributed to the accessibility of health services for enrollees and the continuing enrollee health education programs.

MHMOP has gained invaluable health services marketing experience in an extremely difficult market place. In the future, the experience gained by MHMOP in the Medicaid market will serve as an invaluable asset when the MHMOP delivery system is available to all residents in the Detroit and tri-county area.

Marketing Department Responsibility

The Marketing Department designs and implements marketing strategy decisions. A second and co-equal responsibility of the Marketing Department is to identify potential enrollees for MHMOP and to coordinate the activities of Marketing with Public Relations.

Organization of the Marketing Department

A Director of Marketing, a Marketing Manager and a Market Research Analyst serve as administrative staff for this department. Account Executives (MHMOP's sales staff) report directly to the administrative staff of the Marketing Department.

The primary responsibility of the Director of Marketing is to direct and coordinate all Marketing Department and Public Relations activities.

Marketing Department Activities

The Marketing Manager's primary responsibility is to supervise the Account Executives.

The Marketing Research Analyst provides the Marketing Department with current health care and public relations data needed to plan and coordinate marketing and public relations activities.

Account Executives are responsible for the day-to-day marketing of MHMOP's HMO program to the public.

The marketing activity does not stop after potential enrollees commit themselves to joining MHMOP. The Account Executives make themselves available (via telephone and/or personal visits) to continually advise enrollees of the services available to them as MHMOP enrollees. As a secondary responsibility, the Account Executives act as liaison persons or service representatives for MHMOP enrollees. This mechanism provides a vehicle for enrollee access to MHMOP via a personal representative.

Account Executives may also be concurrently involved in the following activities.

1. Identifying potential provider groups.
2. Assessing the reaction of enrollees to services provided for them by MHMOP contract providers.
2. Making presentations to other interested community groups and/or organizations.
3. Monitoring the activities and marketing methods of competitors.
4. In-service training classes, on MHMOP marketing methods and techniques.

The Medicaid Market

Individuals eligible for Medicaid assistance fall into four general categories:

1. Old Age Assistance (OAA)
2. Aid to the Blind (AB)
3. Aid to the Disabled (AD)
4. Aid to Families with Dependent Children (AFDC)

Because of the disproportionate amount of the Title XIX, eligible recipients in category 4., over 95% of MHMOP's enrolled population consists of AFDC eligible persons.

THE PRIVATE MARKET
(NON-GOVERNMENT SPONSORED HEALTH PROGRAMS)

The term "Private Market" is used by MHMOP in reference to those individuals, employer-sponsored health plans, employee groups, union-sponsored health plans and others that wish to purchase health services from MHMOP.

However, before MHMOP can offer its plan to the private market it must await approval of its application for an expansion of its limited certificate of authority under Acts 108 and 109. (Act 108 for medical corporations, and Act 109 for hospital corporations). Approval under these acts will represent an interim step to the private market licensure process. When this licensing process is completed, MHMOP will join Michigan Blue Cross and Michigan Blue Shield as a fully licensed medical and hospital corporation, for whom these acts were originally created.

Simultaneously, MHMOP is also proceeding with those steps necessary to obtain a full license under Act 264 (the State of Michigan HMO Act). Act 264 is the act that specifically applies to HMO's that wish to operate in the State of Michigan.

(MHMOP looks forward to competing with the Blues)

THE PUBLIC RELATIONS DIVISION

As previously mentioned, Marketing and Public Relations are closely related activities at MHMOP. The Public Relations Division's activities encompass five basic and general areas:

1. Media Relations
2. Community Relations
3. Public Information and Education
4. Public Affairs
5. Internal Communication

Because of MHMOP's scope of operations it is essential to maintain an up-to-date, two-way communication flow between MHMOP and the various media in the area. The information received from the Public Relations Division must be concise, accurate, and informative due to relative unfamiliarity of the general public to the HMO concept.

When providing a needed health service for a community the image of the provider must be positive and believable. If MHMOP fails to express a true concern for the welfare of it's enrollees, the relationship between the organization and the enrollee will be threatened. Through a series of formal and informal, public affairs programs designed to be both informative and educational, the preceeding can be demonstrated. A trusting, one-to-one relationship must be cultivated, and it is the organization's role to provide the initiative.

In order for any organization to function properly, the internal communication network must be an efficient one. The Public Relations Division serves as the liaison between MHMOP's administrative and medical staffs. Other health professionals who may seek information or assistance from MHMOP in health related areas are first referred to the Public Relations Division.

It is clear that because the HMO concept, particularly the MHMOP model, is an unfamiliar concept, it is extremely important for the Marketing Department and its Public Relations Division to function as a team. By coordinating their activities and publications, conflicts relative to program information can be eliminated.

HEALTH CARE ADMINISTRATION DEPARTMENT

HEALTH CARE ADMINISTRATION DEPARTMENT NARRATIVE DESCRIPTION

The Health Care Administration Department (HCAD) is responsible for the coordination of Claims Processing (non-capitated fee-for-service health services) and Health Care Administration activities of the Michigan Health Maintenance Organization Plans, Inc., (MHMOP). *The Claims Processing Division* includes the review and audit of invoices for all vendors (e.g., fee-for-service referral physicians, hospital, ancillary services, etc.). *The Health Care Administration Division* includes: subscriber services; emergency medical triage service; health education; transportation and disenrollment service activities. The HCAD is also responsible for informing MHMOP's contract Individual Practice Associations (IPA's) of their reporting responsibilities to the Plan's Central Office.

THE CLAIMS PROCESSING DIVISION

The Claims Processing Division is responsible for the review and audit (preparation for payment) of all invoices (bills) received from health services vendors that have provided non-capitated health services to MHMOP enrollees. These are services that cannot be provided by the MHMOP contract IPA to which an enrollee has been assigned. For example; these invoices are received by MHMOP from hospitals for inpatient and emergency room services or other specialty services that may be required by enrollees.

The Claims Processing Department is also responsible for maintaining a record of all (fee-for-service) health care services provided for enrollees.

An average day's activity in the Claims Processing Division would include the review and approval or disapproval for payment of:

(a) The scope of the services provided

(b) Provider charges

(c) Comparison of Provider charges

(d) The appropriateness of these charges

When and if fee-for-service invoices show charges that are not consistent with the usual and customary charges received by MHMOP, they are forwarded to the Corporate Medical Director for medical review and disposition.

More specifically the Claims Processing Division does the following:

1. Eligibility Pre-Certification
2. Invoice Audit
3. Invoice (medical) Review

ELIGIBILITY PRE-CERTIFICATION

MHMOP's contract IPA physicians must notify MHMOP's pre-certification clerk before admitting a MHMOP enrollee as an elective in-patient. It is the responsibility of the pre-certification clerk to issue authorization for treatment after verifying an enrollees' eligibility. Pertinent information relative to hospitalization is recorded on an "Eligibility Pre-certification Form."

This form is used to monitor hospital utilization and project hospital cost. The post certification function begins when an in-patient hospital invoice is received at MHMOP's office. Invoices are checked for:

(a) Eligibility at the time of hospitalization.

(b) Whether or not admission was pre-certified.*

(c) Length of stay comparison by IPA.

*In the event that in-patient invoices are identified that were not pre-certified, a notification of failure to pre-certify is sent to both the hospital and the MHMOP contract IPA attending physician. Final decisions on non-pre-certified hospitalized patients are made by the (physician) Executive Vice President of HCAD and or the Corporate Medical Director of MHMOP.

INVOICE AUDIT

The Claims Processing Division Supervisor has responsibility for final review of all invoices (claims) to verify that the amount billed, to MHMOP, for a service is consistent with the reasonable and customary amount billed for the stated diagnosis. The criteria used reflects the standards established for inpatient services as well as quality assurance and utilization review standards developed in conjunction with the Corporate Medical Director. Questionable claims requiring sophisticated medical judgment are referred to the Corporate Medical Director. When the final approved payment for the claim is determined, this is noted on the claim form. Copies of the approved form are distributed to the Accounting Department, Data Services Department, the provider file, and the service provider. The service provider, if it is a physician, also receives xerox copies of any accompanying medical records. The original copy of the claim form and the medical records are returned to the patient's medical file.

INVOICE (MEDICAL) REVIEW

It is the responsibility of the Claims Processing Division's supervisor (a registered nurse) to review all invoices and assess the appropriateness of the services relative to the diagnosis and health care services received by enrollees. Also, invoices identified which appear to be inconsistent with length of stay distribution comparisons, by diagnosis, are referred to the Corporate Medical Director for final review. Length of stay comparisons between MHMOP contract IPA's are also calculated when the invoice audit is in process.

Invoices received from MHMOP providers are sorted by type of service. These invoices are not processed for payment until all appropriate medical data related to the invoice is received. When the above medical data is not received with the invoice, a letter requesting the additional needed medical data is sent to the provider. This activity facilitates and contributes to a health services demand data base and provides appropriate data for the purpose of utilization review.

This data is available for review and analysis by the Corporate Medical Director and the (physician) Executive Vice President of Health Care Administration for MHMOP corporate physician peer review.

HEALTH CARE ADMINISTRATION DIVISION

At the Michigan Health Maintenance Organization Plans, Inc. (MHMOP), direct health services are provided by MHMOP contract IPAs. Health Care Administration facilitates the delivery of services in the following areas:

a. Health Education
b. Subscriber Services
c. Provider Relations

HEALTH EDUCATION

Health Education has the responsibility of meeting the objective of adequate health education program planning as set forth in Public Law 93-222 which requires HMOs to actively provide for its members: health education services; education in the appropriate use of health services; and making members aware of the contribution that they can make to the maintenance of their own health. In order to meet this objective, Health Education is charged with the following responsibilities:

1. Increasing the ability of MHMOP enrollees to make informed decision affecting their personal and community well-being.
2. Educating MHMOP enrollees and provider groups about the HMO concept.
3. Informing MHMOP enrollees about the available services to them via MHMOP and appropriate utilization of the services.
4. Facilitating the transition from the traditional fragmented system of health care delivery to an integrated system of health care delivery in an HMO setting.
5. Development and implementation of MHMOP's Diet Control Class.

Health Education cannot work in a vacuum if it is to attain the above goals. Therefore, the Health Education Unit must work closely with the Information Systems Department to establish and define the data base necessary to make sound health education planning decisions. The Health Education Unit must work cooperatively, as well, with the Marketing Department. For example, the Health Education staff keeps the Marketing Staff advised of the areas new enrollees fail to understand at the time of their enrollment. Marketing responds by identifying for the Health Education staff, enrollees or groups of enrollees that may need special attention.

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC.
(MHMOP) DIET CONTROL CLASS

Narrative Description

There are four objectives of the MHMOP Diet Control Class:

1. To increase the utilization of Health Services by MHMOP enrollees.
    a. All class members are required to have a physical examination before joining the class.
    b. All class members are encouraged to have at least one visit per month, with their physician, to keep the physician informed of their progress and general health.
2. To increase the enrollees' ability to maintain a balanced diet while reducing the amount of food consumed.
    a. All class members are given a Diet Control Handbook (developed by the Supervisor of Enrollee Education) which explains what to eat, how much, and when. This book is reviewed each week during class session.
    b. Weekly menus are given to class participants with suggestions for well-balanced, non-fattening meals.
3. To attempt to impact the health hazards related to obesity, hypertension, diabetes, and ulcers via diet control.
    a. Class members' weight loss are charted weekly.
    b. Progress reports are given to their physicians and the class members each month.
4. To increase the enrollees' ability to plan nutritious meals at a lower cost through proper food buying and budgeting
    a. Class members are given food buying information each month.
    b. Members are encouraged to read local newspapers for information on food specials.
    c. Class members are informed of price selection methods.

Most available data indicates that the routine approach, for the treatment of obesity, does not work. This approach involves a short office visit during which the member is (1) handed a booklet of basic dietary instructions; (2) given a prescription for appetite depressants; (3) threatened, lectured, or counselled on self-control.

One reason this approach fails is because the individual is required to follow prescriptions amounting to drastic changes in lifestyle. It is unrealistic to expect a person to forsake long established, highly gratifying, habitualized responses without teaching them alternative reinforcing responses that are compatible with long-established habits. Hence, MHMOP's first step for diet control instruction is to provide relevant and realistic information on the subject to class participants. Weekly class sessions, between 30 and 90 minutes, are conducted over a period of several months to accomplish this step.

SUBSCRIBER SERVICES

Subscriber Services, plays an ombudsmen's role in MHMOP. It serves as a liaison between the enrollee and the provider. In addition, Subscriber Services is responsible for:

(1) Emergency Triage System (Hot Line).

(2) Enrollee Grievance System.

(3) Enrollee Orientation Program.

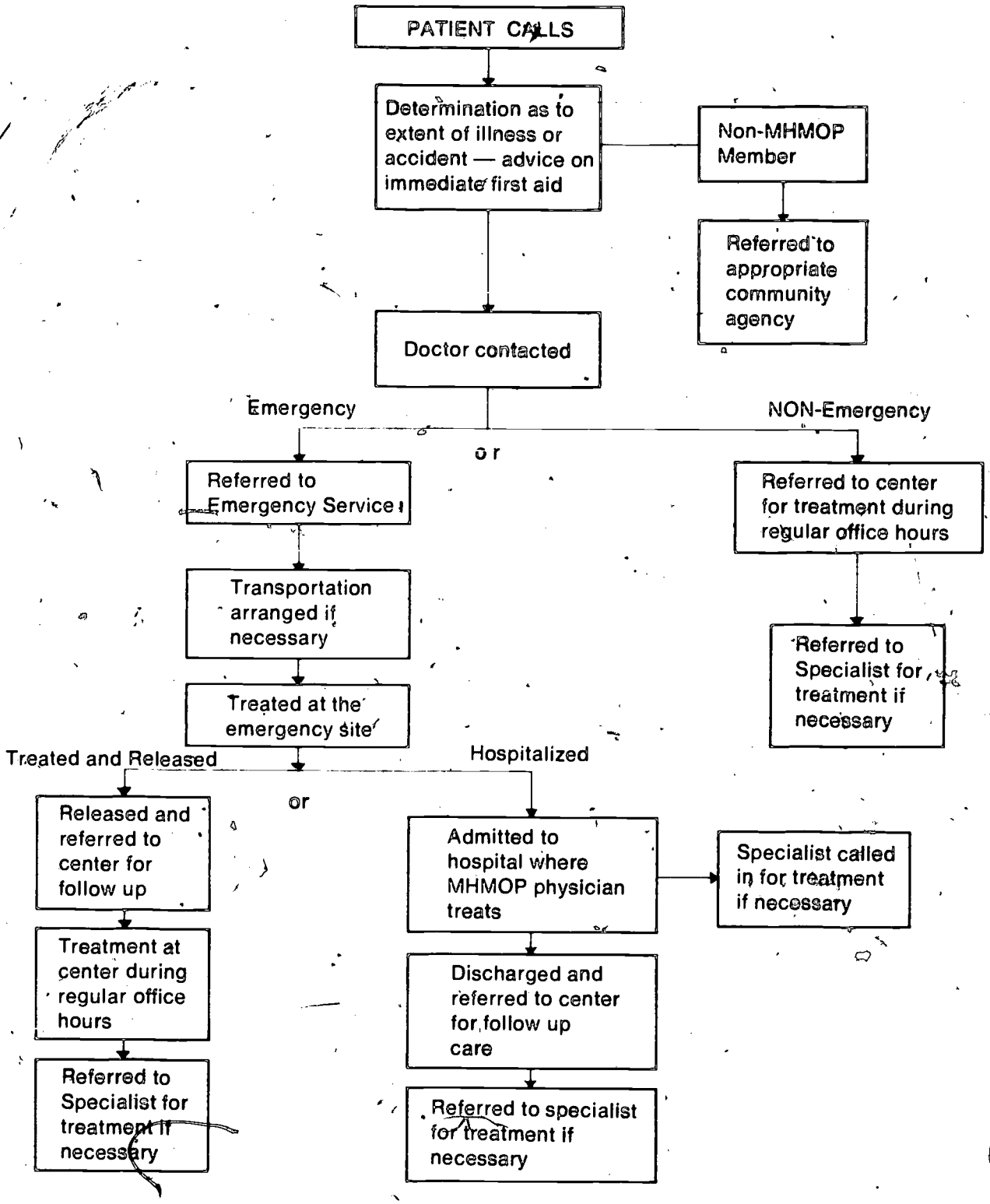
(4) Patient Transportation.

As part of the routine processing of the emergency triage system and follow-up process and enrollee grievances, Subscriber Services also responds to routine general information inquiries, billing and refund inquiries, and requests for primary care unit transfers by enrollees. Descriptions of the above mentioned activities of Subscriber Services are listed below.

(1) TRIAGE SYSTEM (HOT LINE)

Michigan Health Maintenance Organization Plans, Inc. (MHMOP) has developed a unique Medical Triage System. The triage system, commonly referred to as the emergecy Hot Line is a 24 hour, seven days a week telephone service. The emergency Hot Line is available to all MHMOP Inc. enrollees who need assistance if an emergency or crisis arises. MHMOP employs Registered Emergency Medical Technicians (REMT's) to answer Hot Line telephones. Most REMT's have completed three years of college and have had at least two years of direct patient contact experience in an emergency room and/or ambulance. In order to reach the level of a Registered Emergency Medical Technician, one must first complete a recognized course. The minimum class time is 81 hours of practical emergency room and/or ambulance clinical practice. The course involves an accelerated curriculum on the handling of the sick and injured. The curriculum also involves extensive study of anatomy and physiology.

WHAT HAPPENS WHEN SOMEONE CALLS MHMOP EMERGENCY



DETERMINATION OF ENROLLEES NEED FOR EMERGENCY MEDICAL SERVICES

With the exception of an immediate life threatening situation, physician guidance is always sought. The patients primary physician is contacted and advised of the patient's complaint. The physician will either call the patient directly or relay his recommended treatment through the Registered Emergency Medical Technician to the patient. If it is necessary to hospitalize a patient, the REMT will contact the hospital in advance, advising them of the impending hospitalization.

Further, throughout the night the REMT will check on the progress of the patient at home or in the hospital. Copies of all authorization of hospitalization are referred to the Pre-Certification Unit of MHMOP. (See MHMOP Emergency Flow Chart, p. 26).

ENROLLEE EDUCATION REGARDING USE OF EMERGENCY SERVICES

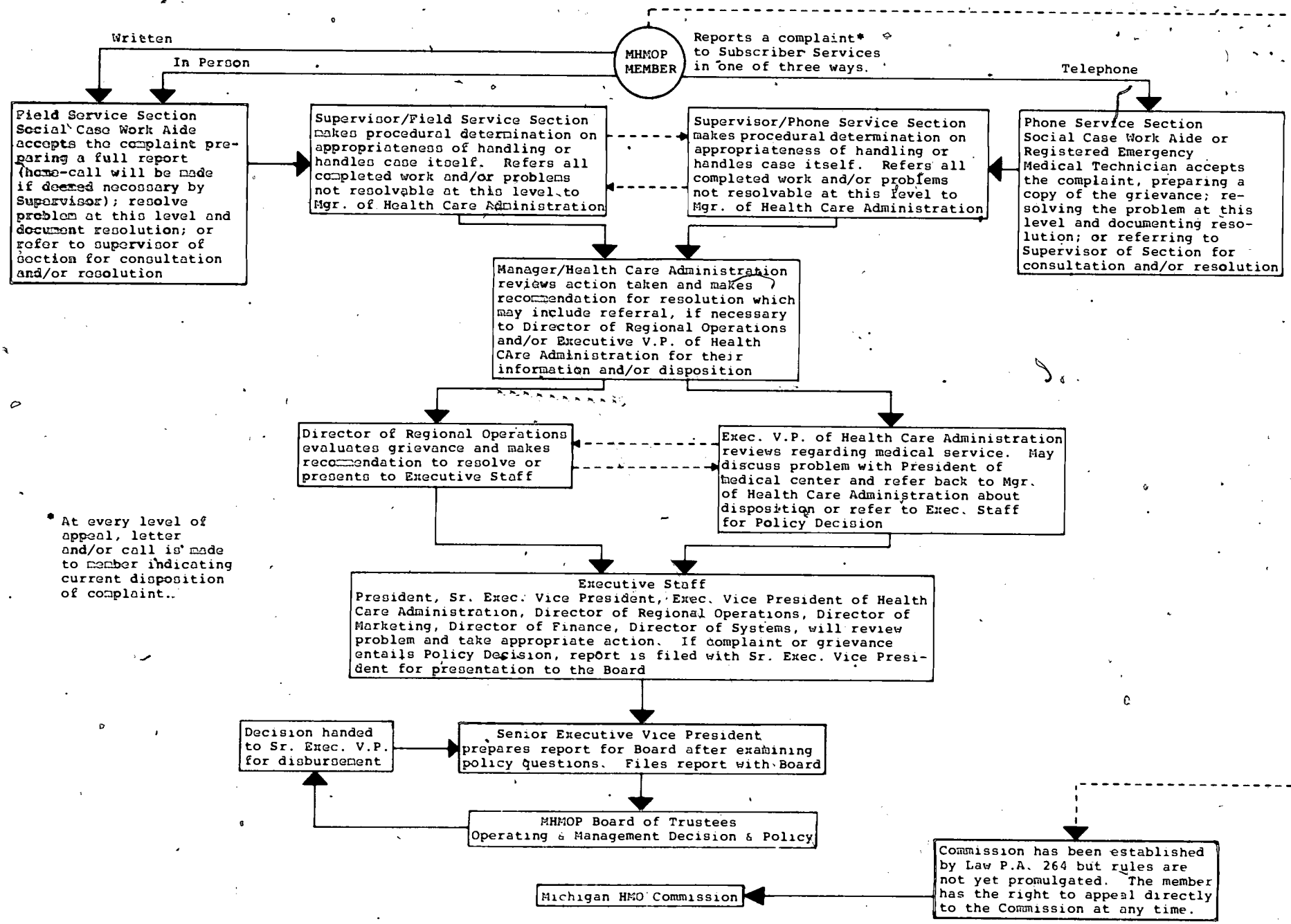
Enrollees are advised at the time of enrollment of the twenty-four hour hotline services provided by MHMOP. They are also mailed an adhesive sticker that can be attached to their telephone which indicates emergency hotline services twenty-four hours a day, seven days a week, call 961-3636. Appropriate use of the Hotline is reinforced during the enrollee orientation program.

EMERGENCY FOLLOW-UP

The Emergency Triage System Staff will closely follow an HMO enrollee's progress though an emergency room and check their condition at home, if the situation dictates. The Subscriber Services Unit Staff will then later contact the enrollee to assist in arranging for an appointment at IPA to which the patient is assigned. Subscriber Services is also equipped to assist in getting prescriptions filled, provide transportation to and from physician's office when necessary, as well as reinforce directions already presented to the patient. For example; Subscriber Services will readvise the patient to follow a strict diet, or to see the physician regularly for control of a medical condition.

MHMOP MEMBER ASSURANCE PROGRAM

ORGANIZATIONAL FLOW CHART



* At every level of appeal, letter and/or call is made to member indicating current disposition of complaint..

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ENROLLEE GRIEVANCE

An enrollee may present a grievance in one of three ways: via telephone, in person, or written. (See MHMOP Member Assurance Program Organizational Flow Chart, p. 28). At every step of the grievance process, the enrollee will be advised by a letter and/or a phone call of the current status of the complaint. If the enrollee choses to complain via the telephone, the Subscriber Services Staff Social Case Work Aide or the REMT will listen to the complaint and prepare a report of the grievance. Where possible, they will resolve the problem at their level and document the resolution. If this is impossible, they will refer the problem to the Supervisor of Phone Services for consultation and/or resolution. The Supervisor of Phone Services will make a determination on the appropriate direction in the handling of the resolution which may entail referral of the complaint to the Field Service Section. The Supervisor of Phone Services will refer all completed work and/or problems, not resolvable at the Phone Service Section or the Field Service Section, to the Manager of Health Care Administration.

The Manager of Health Care Administration will review the action taken by the Phone Service and Field Service Sections of Subscriber Services, making recommendations for resolution which may include referral to the Director of HCAD and/or the Executive Vice President of Health Care Administration for their information and/or recommendations and resolutions.

The Director of HCAD will evaluate the complaint and made recommendations for resolution and/or forward the complaint to the Executive Staff for their review. Likewise, the Executive Vice President of Health Care Administration will review the complaint regarding medical services. He may discuss the problem with the President of the patient's medical center and refer the resolution back to the Manager of Health Care Administration or he may determine to refer the question to the Executive Staff for a policy decision.

The Plan's President, Senior Executive Vice President, Executive Vice President of Health Care Administration, Director of HCAD, Director of Marketing, Director of Finance and Director of Systems comprise the Executive Staff Committee. The Executive Staff Committee will review the complaint and take the appropriate action.

If the complaint entails modification of policy, a report will be filed with the Senior Executive Vice President for presentation to the Board of Directors.

The Senior Executive Vice President will prepare a report for the Board after examining the policy questions. The Board will advise the Senior Executive Vice President of their decision, and he will disseminate the information to the appropriate parties so that the MHMOP member can be advised of the decision.

The member retains the right to circumvent the MHMOP appeal process and appeal directly to the Michigan HMO Commission (under the auspices of Public Act 264) at any time.

Resolution of the patient's problem may take the form of modifying the existing system, arranging for services, the interpretation of the MHMOP system to the client, or a disenrollment of

the enrollee from the program. The Member Assurance Program is viewed as a problem solving process rather than a disenrollment process. In any event, documentation of the patient's complaint and resolution of that complaint will be included in the patient's record.

ENROLLEE ORIENTATION

The enrollee orientation project was developed in compliance with the HMO promulgated rules.

The primary goal of this project is to incorporate the enrollees into the HMO delivery system and to keep them informed on how to solve problems that they may encounter when using the system.

Health Education Activities

There are four basic sub-objectives to this project:

1. To inform enrollees on how to utilize the health services provided by MHMOP.
2. To insure appropriate emergency room utilization.
3. To inform enrollees on how to solve service problems when they arise.
4. To reduce disenrollment which results from consumer ignorance of appropriate and equitable utilization of services.

Narrative Description of the Enrollee Orientation Sessions

Subject areas discussed and resources used occur in three areas: (a) Enrollee Education, (b) Subscriber Services and (c) Public Relations. The following is a brief description of the above.

(a) Enrollee Education

Addresses the MHMOP preventive and health maintenance care concept and how to utilize the services provided by MHMOP. Information is provided in the following areas:

a. A brief history of MHMOP.
b. The elements of an HMO via slide film presentation.
c. Review of educational brochures.
d. Informing enrollees of other health and health related programs that they may be eligible for as MHMOP enrollees.
e. Explanations of all MHMOP support staff functions.
f. How health data is collected and how it is used.
g. Conducts an informal pre and post test survey.

(b) Subscriber Services

Triage Personnel in the Subscriber Services area:

a. Describe MHMOP's Hot Line.
b. Explain emergency service procedures.
c. Explain how to arrange transportation, and resolve problems related to transportation.
d. Explain the function of transportation (e.g., prescription pick-up, medical appointments, and emergency transportation service.)
e. Explain the importance of teaching children how to dial the Hot Line number.

PATIENT TRANSPORTATION

(a) **Ambulance Utilization**

Ambulances are utilized in providing transportation from an enrollee's current location to an emergency room. Such transportation is utilized in "life threatening" emergencies as well as other situations which although not immediately "life threatening" do require the special equipment and/or trained personnel normally found on an ambulance.

A life threatening emergency is one in which a member faces serious, imminent consequences of a medical emergency. These consequences include, but are not limited to loss of life, paralysis, brain damage, loss of limb. Examples of life threatening emergencies which would be transported by an ambulance are the following:

- Respiratory Arrest.
- Cardiac Arrest.
- Severe Bleeding, e.g., injuries sustained to an artery.
- Shock, e.g., anaphylatic, electric, epigastric, hypoglycemic, insulin, mental, surgical, traumatic.
- Suspected Heart Attack.
- Respiratory Distress.
- Limb Severed.
- Unconscious.
- Major Penetrating Wound.

Other areas where ambulance transportation is necessary for an enrollee to receive services are the following:

- Suspected Broken Leg.
- Suspected Broken Hip.
- Open Type Fracture (any bone).
- Other Suspected Abnormality which cannot be practically transported by means other than an ambulance (e.g. a 500 lb. patient who cannot readily fit into the door of a station wagon).
- Woman in Labor.

(b) **Utilization of Other Transportation . . . Non Ambulance Form**

Other land transportation is also safely utilized for the following patient conditions:

- High Temperature.
- Abdominal Pain.
- Shortness of breath, e.g. shortness of breath being experienced by a known asthmatic.
- Non-severe bleeding.
- Return trip from hospital to home.

— Transfer from hospital to hospital when an ambulance is not needed and the transport can be safely done (hospital personnel are consulted for appropriate form of transportation).
— Suspected closed type fracture to upper extremity without severe angulation.
— Other similar circumstances where this form of transportation may be safely utilized without harm to the patient.
— Center appointments and pharmacy needs if the patients condition is not life threatening or does not require special equipment and/or trained personnel normally found on an ambulance.

Provider Relations

Provider Relations is charged with the responsibility for MHMOP's administrative relations with the contract IPAs. This unit does not deal with matters of a medical nature. Matters of a medical nature fall specifically within the purview of the Corporate Medical Director. Provider Relations develops and maintains a complete list of all the MHMOP providers. The providers are listed by MHMOP contract IPA, specialty, and hospital. The type of information presented on the provider list for each center includes the following:

1. provider's name and their specialty
2. provider hospital privileges
3. provider's telephone number
4. provider's emergency on call telephone number
5. and provider's office hours.

Attempts are made at all times to protect the provider's privacy. Therefore, departments within MHMOP's central office only have access to appropriate information from the provider list for that department. To facilitate the patient referral process at the primary care units, the Provider Relations Unit has developed a list of fee-for-service referral physicians. This list is made available to all contract IPAs.

Provider Relations is responsible for communicating to each primary care unit MHMOP's administrative expectations of them. It is also the responsibility of this unit to keep each MHMOP contract IPA apprised of enrollee complaints from enrollees assigned to their provider group.

FINANCE DEPARTMENT

FINANCE DEPARTMENT

Activity and progress in a health maintenance organization may be measured by encounter statistics and costs associated with providing services per enrollee encounter. The Finance Department of Michigan Health Maintenance Organization Plans, Inc. (The Plan) is primarily responsible for measuring the cost of services, ensuring that these costs are properly accounted for and participating in management policies and decisions as related to financial matters. In addition, all monies received by the Plan to pay for services to members are processed through the Finance Department.

The principle areas of activity can be summarized as follows:

a. Cash receipts (capitation checks from governmental agencies or employer groups)

b. Cash disbursements for —

   Medical costs

   Administrative costs

c. Financial and special reports

Each of these areas are of equal importance to the overall responsible financial management of the Plan. The Finance Department also has primary responsibility for dissemination of information that relates enrollee encounter statistics to dollars, and the evaluation of all financial management decisions.

The following sections contain a more detailed description of the activities previously outlined.

CASH RECEIPTS

At the present time, the Plan has a contractual relationship with the Michigan Department of Social Services (MDSS) to provide a designated group of Medicaid covered health care services to all Medicaid eligible persons who choose to join the Plan.

For each Medicaid eligible individual that enrolls in the Plan MDSS capitates, or pays, the Plan a pre-determined amount of money. This pre-determined amount of capitated cash must be allocated to cover those services which MHMOP has contracted to provide and most costs associated with the provision of these services.

The monthly capitation check received from MDSS is budgeted for the purposes described above and subsequently deposited into the Plan's general checking account.

CASH DISBURSEMENTS

Cash disbursements involves more than preparing and mailing a check. Prior to that activity many other tasks are performed. These tasks depend on the nature of the costs being paid.

Cash disbursements are summarized as follows:

	PERCENT
Prepaid capitation to IPA (primary care cost) — fixed expense	45.2
Fee-for-service cost — variable expense	28.8
Paraprofessional — variable expense	5.0
Administrative — variable expense	21.0
	100.0

Prepaid Capitation to IPA — Fixed

The term capitates was used in the cash receipts portion above to describe the monies received from MDSS by the Plan. The term is also used to describe the prepaid monies credited to MHMOP contract IPAs for providing primary health care services to Plan members for which a particular IPA is responsible. *The total MDSS capitation is paid to the Plan. The MHMOP contract IPA receives a percentage of this capitation; the IPA also receives credit for consultation/referral and risk-sharing deductions that are withheld.*

This mechanism is displayed in the following example.

	AMOUNT	PERCENT
Total capitation for members assigned to IPA	$ 84.19	100
Less consultation/referral retention	-12.65	(15)
Net capitation available for payment	71.54	85
Less 15% risk-sharing	-10.73	(13)
Capitation paid to IPA	$ 60.81	72

Total capitation for members assigned to the IPA is computed by applying a rate to each of the various member classifications. Specifically, $18.51 OAA, $28.25 AB, $21.33 AD, $7.88 AFDC over 21, $8.22 AFDC under 21. In the example above, it was assumed that each IPA had one member from each of the above classifications resulting in the total of $84.19.

A portion of the capitation is specifically designated for consultation/referrals. These monies are retained in escrow by the Plan to pay for non-capitated health services that may be needed by a Plan member, but are not available at the IPA. If an IPA physician decides that such a service is needed for a Plan member, he must *refer* that member to a physician or other health services provider that will provide the needed service (for example, a neuro-surgeon or a prosthetic vendor). After the service is provided, the consulting or referred physician is paid from the escrowed funds.

The Plan administers this fund on behalf of the MHMOP contract IPAs. At the end of the contract period, the balance in the fund is paid directly to the IPA.

Of the net capitation available for payment, 15% is deducted for risk-sharing to be used as a hedge against risk, a cost containment inducement or for the purpose of performing any of the Plan's obligations. If the cost of providing health care exceeds the MDSS capitation due to increased hospital costs or high utilization of hospital or emergency facilities, the Plan would pay these costs using the risk-sharing monies. If not used, the monies could be accumulated as cash reserves to cover potential excessive costs. The Plan may distribute unneeded portions of risk-sharing as a cost saving bonus to the IPA.

In summary, the IPA receives the net capitation, the balance of the consultation/referral retention and possibly, by board decision, a portion of the risk-sharing.

Fee-For-Service and Paraprofessional Costs — Variable

Cost of hospitalization, prescriptions, consultation/referral and ancillary services are typically referred to as fee-for-service costs contrasted with the contractual capitation costs of the IPAs.

Services that are rendered on a fee-for-service basis are billed directly to the Plan by the provider of the services. These bills are processed by the Plan's Claims Processing Division, where approval for payment is made. Upon approval, the claim is sent to the Finance Department for payment.

Prior to payment, the approved claims are reviewed by the Medical Payables Section of the Claims Processing Department to insure that the claim was properly approved and coded. Payment is then scheduled based upon cash budget requirements, generally within thirty days.

Medical Costs

Costs of hospitalization, prescription drugs, consulting or referral physician services and ancillary services (such as ambulance or special equipment) are defined as medical costs. In the Plan's Multiple IPA Group Practice HMO, capitation payments to MHMOP contract IPAs are also considered to be medical costs. Each of these types of costs results in a different processing procedure and are, therefore, disbursed separately.

ADMINISTRATIVE COSTS — VARIABLE

Every organization, health care or other, incurs administrative costs in order to deliver its services. The Plan is no exception. Payroll and related costs are the largest cost element. Other costs include rent and utilities, equipment leases, supplies, postage, informational and marketing, etc., materials.

The Finance Department reviews all bills received to determine that they relate to the Plan's operations and have a valid business purpose. This review is facilitated by a procedure which requires

that all purchase of services or goods is approved in advance by a designated member of management. Upon completion of this process, the bill is paid.

As an additional administrative costs control, corporate budgetary guides are observed.

Presently, there are various levels of controls to safeguard company assets. The major items are listed below.

ADMINISTRATIVE CONTROLS

Fixed capitated expenses and variable hospital-adminstrative costs are controlled as follows:

Fixed Capitated Expenses

MHMOP's computer printout identifies enrollees by category and MHMOP contract IPA. This eligibility list is compared to a second printout prepared by the Department of Social Services.

The final eligibility list balanced by clinic and category (attached) is developed by comparing the MDSS printout with the MHMOP printout.

Variable Expenses

a. **Administrative**

Purchase orders are used to control vendor purchases.

b. **Medical Fee-for-Service**

These disbursements are authorized on Payment Authorization Form (PAF). (This includes hospitalization, prescriptions, consulting or referring physician and ancillary service, such as ambulance or special equipment.)

Check Signing

All checks are reviewed for completeness and validity before disbursement from company funds. Authorization for completeness is the responsibility of the Finance Director. Authorization for validity is the responsibility of the Senior Executive Vice President.

Check signing requires two signatures from two of the following:

1. President - any amount
2. Senior Executive Vice President - up to $600.00
3. Corporate Secretary - any amount
4. Vice President Health Care Administration - any amount.

Under no conditions can a check signer sign any check made payable to himself.

FINANCIAL AND SPECIAL REPORTS

As previously stated, a primary function of the Finance Department is to present and to communicate information. Management needs information on operations, which is provided by the income statement. Management also needs information of financial condition. This is provided by the balance sheet. In addition to these reports, a variety of others are generated. Trend reports, which compare an activity for a period of time to a base period, analytical reports which disclose the composition of a particular item, and other financial reports on an as needed basis.

In addition to internal reports, the Finance Department works closely with the Plan's independent auditors. This is to insure that financial reports, received by those other than management, are accurate and validly reflect the results of the Plan's fiscal operation. This commutuality also insures that the Plan's financial position is properly stated.

The Plan also files reports with the Insurance Commissioner and the Internal Revenue Service. These are informational reports which are used to review financial soundness and the Plan's tax-free status.

Although the Plan currently does not file a separate financial report with the MDSS, MDSS performs an annual audit. The purpose of this audit is to review the Plan's medical and administrative cost. The results of this audit are used to compare the Plan's cost to MDSS's cost. Any capitation adjustments and cost savings are determined upon completion of this audit.

The IPAs are directly affected by the MDSS audit. They are requested and must submit an income statement for their IPAs (MHMOP) patient encounters on an annual basis to the MHMOP central office. The statements are summarized for a cost finding presentation to MDSS in connection with any revision of the capitation rates.

Careful budgeting and cash planning, which insures an orderly and balanced growth, is a necessity for an organization growing as rapidly as the Plan. The Finance Department works with the other Plan departments so that all corporate activities can be translated into dollars. This facilitates a coordinated effort in the areas of financial planning, measurement, evaluation and management.

Cost Savings Incentive

The Plan also has a cost savings incentive agreement in it's MDSS contract. This agreement provides for the sharing of cost savings that may result if the Plan's cost for providing health services is less than the MDSS cost for providing the identical set of health services. At the end of each MDSS-MHMOP contract year, the Plan computes it's cost for providing the MDSS contracted health services. The Plan's cost is compared to MDSS's cost. This computation is referred to as the adjusted average per capita cost. If the Plan's cost is less than MDSS's cost, this difference is viewed as savings to MDSS, a portion of which is shared with MHMOP.

The following is an example of the adjusted average per capita cost computation.

EXAMPLE OF ADJUSTED AVERAGE PER CAPITA COST

MDSS	$ 35.00	Cost
MHMOP	28.00	Cost
Savings	$ 7.00	
Enrollee Months	200,000	
Annual Savings	$1,400,000.00	

MDSS = MDSS per capita cost (cost to MDSS for providing the identical set of health services which it has contracted with MHMOP to provide for Medicaid eligible MHMOP enrollees)

MHMOP = MHMOP cost for providing the MDSS contracted covered services.

Savings = Cost savings to MDSS which results from provision of health services via an HMO mechanism to Medicaid eligible individuals rather than the traditional MDSS mechanism of providing the same services to Medicaid eligible individuals.

Enrollee Months = The number of months that each Medicaid eligible individual has been enrolled in MHMOP times (x) the number of individuals enrolled.

Annual Savings = The amount of savings to MDSS which has resulted from contracting with MHMOP to provide health care services to Medicaid enrollees.

ENROLLMENT BREAKDOWN
BY
CATEGORY AND HEALTH CENTER
(Effective July 1, 1975)

Category / Health Center	OAA	AB	AD	AFDC (over 21)	AFDC (under 21)	TOTAL	% (#)
McDougall (01)	4	0	18	418	1,411	1,851	+11.98 (+198)
Metro (02)	3	0	8	285	952	1,248	+2.63 (+32)
Northwest (03)	0	0	11	164	535	710	—.84 (—6)
D.M. Associates (04)	2	1	11	594	1,860	2,468	—.60 (—15)
D.M.S.C. (05)	11	0	22	895	3,172	4,100	+8.52 (+322)
V.C.M. (06)	1	0	3	339	1,108	1,451	+4.46 (+62)
Tri-City (07)	15	0	19	113	365	512	—2.66 (—14)
Jeffries (08)	4	0	7	72	276	359	..... (0)
Detroit Family (09)	14	0	16	421	1,515	1,966	+.10 (+2)
Puritan (10)	1	0	4	182	490	677	+15.53 (+91)
Beech Daly (11)	1	0	0	51	158	210	..... (0)
Wilshire (12)	4	0	2	228	725	959	+39.80 (+273)
MHMOP							

ENROLLMENT BREAKDOWN
BY
CATEGORY AND HEALTH CENTER

(Effective July 1, 1975)

Category / Health Center	OAA	AB	AD	AFDC (over 21)	AFDC (under-21)	TOTAL	% (#)
Jefferson (13)	1	1	7	273	1,042	1,324	+25.98 (+273)
New Light (14)	3	0	10	362	1,231	1,606	+6.64 (+100)
Park (15)	2	0	10	157	555	724	—5.85 (—45)
Oakland (16)	1	0	6	418	1,408	1,833	+2.00 (+36)
Hodari (17)	1	0	3	238	975	1,217	+3.31 (+39)
Zieger (18)	3	1	11	537	1,719	2,271	—3.20 (—75)
Trail (19)	0	0	0	7	22	29	—75.21 (—88)
Prof. Plaza (20)	0	0	0	3	6	9	Infinite (+9)
S & S Med. (21)	0	0	0	10	34	44	+388.89 (+35)
TOTAL	71	3	168	5,767	19,559	25,568	+5.05 (+1,229)
Net Change from Last Month	+5.97 (+4)	No Change	+9.09 (+14)	+5.56 (+304)	+4.86 (+907)		

PURCHASE ORDER

No

michigan health maintenance organization plans

2200 WALKER CISLER BLDG. • 660 JONES STREET
DETROIT, MICH. 48226 • TEL. 313 / 961-3636

TO _____

DATE _____ 19

DATE REQUIRED _____ 19

TERMS NET 30 DAYS

PLEASE ENTER OUR ORDER FOR GOODS LISTED BELOW AND NOTIFY US IMMEDIATELY IF YOU ARE UNABLE TO SHIP COMPLETE ORDER BY DATE REQUIRED

✓	QTY. ORD'D	QTY. REC'D	STOCK NUMBER	DESCRIPTION	UNIT PRICE	TOTAL	ACCT. DIST.
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							

OUR ORDER NO MUST APPEAR ON ALL PAPERS AND PACKAGES RELATIVE TO THIS ORDER

STATEMENT FOR TAX EXEMPT PURCHASE

"Michigan Health Maintenance Organization Plans, Inc., qualifies for exemption under subsection (a) Section 4a of the Sales Tax Act, and the items being purchased are to be used or consumed in connection with the operation of this organization, and that the consideration for this purchase moves from the funds of this organization. Tax exempt number 38-2031377".

DATE RECEIVED	RECEIVED BY
/ /	

PURCHASING AGENT — DATE

PURCHASE ORDER

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WHITE-VENDOR, CANARY-ACCOUNTING, PINK-PURCHASING, ORANGE-NUMERIC CONTROL

PAYMENT AUTHORIZATION FORM

I PATIENT INFORMATION

LAST NAME

MHMOP I.D. NO.	GROUP NO.	RECIP. NO.	BIRTH DATE
3 10			

STREET | SEX

CITY | STATE | ZIP CODE

II PROVIDER INFORMATION

FACILITY OR PROVIDER NAME	FACILITY CODE
20 38	39 42

TYPE OR SPECIALTY CODE	MEDICAID I.D. NO.
43 48	49 52

STREET | PAY SUB: 1 PAY PROV: 2 | 53

CITY | STATE | ZIP CODE

III PRIMARY PHYSICIAN

NAME	I.D. CODE
	04 07

REFERRING PHYSICIAN	I.D. CODE

IV ELIGIBILITY CERTIFICATION

DATE ENROLLED	DATE PRE-CERT.	PROCESSOR INIT.
DATE POST CERT.	REJ. LETTER NO.	CONF. LET. NO.

V SERVICE INFORMATION

DATE ADMITTED	DATE DISCHARGED	DAYS OF CARE	PAS DAYS	TYPE OF ADMISSION	HOSP. CASE NO.
01 06	07 12	13 15		16 EMER: 1 REG: 2	14 10
STATUS CODE	H-ICDA CODE	H-ICDA CODE SEC.	H-ICDA CODE ADD.	DATE OF DELIVERY	ANESTHESIA UNITS
17	18 21	22 25	26 29		

A DATE OF SERVICE	B LOCATION CODE	C TYPE OF SERVICE	D PROCEDURE DESCRIPTION	E PROCEDURE CODE	F QUANTITY	G PROVIDER CHARGE	H ACCT. CODE	I APPROVED PAYMENT	J FORCE CODE	K ADJ. CODE (NP)	L LTR. CODE	M REVIEWER'S CODE
30 35	36	37		38 45	46 48	49 55	56 59	60 66	67	68 69	70	71

DESCRIPTION OF MEDICAL CONDITION OR DIAGNOSIS:

TOTAL | CHECK NO.

NO. OF ENCLOSURES

VI PRICING INFORMATION

DATE G.I. LETTER SENT	
LETTER NO.	
DATE G.I. INFORMATION RETURNED	

VII MEDICAL REVIEW

UPDATE LOG		CASE UTILIZATION FILE	
DATE	INITIALS	DATE	INITIALS

DATE REVIEWED	REVIEWER'S INITIALS

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS

DOCUMENT NUMBER:

FORM NO. 1 REV. 11/1/74 4 copies WHITE-PATIENT FILE, CANARY-SYSTEMS, PINK-ACCOUNTING, ORANGE-PROVIDER

MANAGEMENT INFORMATION
SYSTEMS DEPARTMENT

MANAGEMENT INFORMATION SYSTEMS DEPARTMENT

The purpose of the Management Information Systems (MIS) Department is to function as a service department for all other areas of Michigan Health Maintenance Organization Plans, Inc. (MHMOP).

The objectives of this department are to design, develop and implement a Total Health Information System to meet the present need and future demands of the community it serves. The ultimate goal is to improve the planning, control and scheduling of health care services which, hopefully, will reduce costs. To obtain these goals, the Management Information Systems Department has started with the basic data required to build a MHMOP enrollee health DATA BASE. Specifically, this basic data begins when enrollment information is received from the enrollee at the time of registration.

This initial data triggers the onset of our Enrollment System which incompasses the enrollment preparation process, enrollee capitation computation reporting and medical record chart preparation. From this base, the systems department is able to record all health care activity by enrollee and report in detail form all Fee-for-Service (FFS) and MHMOP contract IPA services during the enrollee's tenure in MHMOP. An additional objective is to report on all activities relating to health care services, patterns of care and those variables which enable us to monitor the quality of care. To do this efficiently requires the capability to instantly retrieve data. All of the above is possible because of MHMOP's on-line real time system which includes:

1. Patient History
2. Drug profiles
3. Statistical utilization relating to data

The three main sections of the Management Information Systems is the following:

1. Computer Services
2. Enrollment Processing
3. Medical Records Data Collection

1. Computer Services

Computer Services provides the necessary resources to fulfill Management Information Systems' objectives of recording enrollment, keeping track of enrollee activities related to health care and distribution of relevant information. It accomplishes these objectives by performing three basic functions:

a. data collection
b. storing
c. reporting

All personal data supplied by an enrollee, health related services provided by each MHMOP contract IPA (prescription drugs, referral and hospitalization services data) are collected and converted to a form readable by a computer. Personal data is obtained from the initial enrollment

form. Service encounter forms which are filled out by the provider group staffs provide health services data. Other needed data is provided from fee-for-service invoices.

Once collected, computer services supplies the capability for storing this tremendous volume of data. MHMOP's on-premises UNIVAC 90/60 computer has the capacity to file several hundred thousand records, and other data, within a very small space. Any portion of a record can be updated at an instant. The task of searching and examining a specific record or reviewing the complete file is reduced considerably to a matter of minutes, rather than hours or days.

Because of this special type of filing, each MHMOP enrollee record is made available on demand to authorized users. This enhances the ability to respond rapidly to physician and management inquiries. Although random inquiries are possible, the files remain protected from undesirable querry so that the records are always kept confidential.

Computer Services, through its reporting function, also serves as a central source of information for MHMOP and it's contract provider groups. Monthly printouts of membership rosters are produced to allow MHMOP's Central Office and MHMOP contract IPA staffs to identify enrollees eligible to receive health services. This reporting function also enables an authorized user to locate a specific enrollee when and if the need arises. Computer generated statistical reports, also provide MHMOP with demographic data on MHMOP's enrolled population. Because these reports of each patient encounter traces enrollees activity, assessments can be made relative to health services accessibility, availability and continuity of care. Other printouts may be used by management in predicting future demand for health care services by MHMOP enrollees.

Additional services provided via the computer are: enrollee correspondence, computerized check generation, and financial reports.

2. **Enrollment Processing**

The basic responsibilities of the Enrollment Section is to record, process, and file all enrollment and disenrollment applications. This Section is also responsible for the preparing and distributing all MHMOP enrollee identification cards. Telephone calls related to enrollee data changes, e.g., address, telephone number, name, etc., are additional responsibilities of the Enrollment Section of the Management Information System.

3. **Medical Records Data Collection**

The Medical Records Section provides technical assistance to the MHMOP Medical records division and MHMOP contract IPA personnel by explaining the established standards for an adequate medical records system. A second function of this Section is to assist in the development of a uniform medical records system that will eventually be used by all MHMOP contract IPAs.

The medical records kept in the physician's office are equally as important and should be given the same amount of attention as those used in the hospital. Quality patient care and proper documentation of treatment is one measure of appropriate medical record keeping.

MHMOP's concern for its contract IPA's medical records system is due to the mandates of the federal HMO legislation, which suggests monitoring enrollee health outcomes. One method used to accomplish this objective is the collection and analysis of (non-confidential) medical records data. In addition, the MHMOP must adhere to federal, state and local regulatory guidelines for medical records. These regulatory guidelines include:

a. "Maintenance of an individual medical record for each enrollee which should contain the following information on the enrollee:

   (1) health history

   (2) family history

   (3) social history

   (4) physical exam

   (5) other pertinent information

b. Development and maintenance of a chart order for material in the medical record.

c. Establishment of a reporting mechanism for services rendered to each enrollee" (MHMOP Encounter Form).

THE PRIMARY ENCOUNTER FORM

When an enrollee visits a MHMOP contract IPA a "Primary (MHMOP) Encounter Form" is used to report all categories of services of services provided, e.g., office visits, in-patient visits, immunizations, x-rays, laboratory tests, etc. The Primary Encounter Form is designed to provide data for patient encounter reporting requirements.

The following is a description of and instructions for completing the Primary Encounter Form.

PRIMARY ENCOUNTER FORM

In Section I, of the Primary Encounter Form enter the patient's nine digit MHMOP medical record number and the patient's full name as shown in the example below.

I PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE
DOE	JOHN	A.

PATIENT IDENTIFICATION NUMBER
12-345678-7

In Section II, of the Primary Encounter Form, print your Center's identification number and name and the I.D. number and name of the physician providing services to the MHMOP enrollee as shown in the example below.

II PROVIDER INFORMATION

PROVIDER CENTER NUMBER AND NAME
12 - WILSHIRE

PROVIDER I D NUMBER AND NAME
03 - SAM SMITH, M.D.

In Section III, of the Primary Encounter Form, print the date of service of the services being reported in the first block on the left. Use the next three blocks to indicate the appropriate four digit H.I.C.D.A. primary, secondary and additional diagnosis codes. The appropriate diagnosis code should be selected from the eighth revision of the *International Classification of Diseases*, adapted for use in the United States as published by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, second edition, September 1973. If the services being reported took place during a hospital inpatient admission, indicate the "date admitted" and the "date discharged" in the fifth and sixth blocks. In the seventh block indicate whether the patient's visit is by appointment, walk-in or no-show. The status code blocks are used to indicate the Michigan Department of Social Services' "status code" which indicates the status of the problem (diagnosis) being treated by the physician if known i.e., 1). active, 2). controlled, 3). preventive, 4). resolved, 5). ruled out, 6). redefined, 9). unknown.

III SERVICE INFORMATION

DATE OF SERVICE	H·ICDA CODE # 1	STATUS	H·ICDA CODE # 2	STATUS	H·ICDA CODE # 3	STATUS	DATE ADMITTED	DATE DISCHARGED	APPOINTMENT STATUS
1/10/75	412/9	1					12/15/74	12/24/74	WALK IN ☐ NO SHOW ☐ BY APPT ☒

The middle section of the Primary Encounter Form contains a list of the most common physician services provided to MHMOP enrollees. Check the appropriate block according to the services provided by the physician. In Section A, use the left hand column for established patients and the right hand column for new patients.

A OFFICE VISITS	ESTABLISHED PATIENT	NEW PATIENT
1. Brief Service	X	☐
2. Limited history exam and treatment	☐	☐
3. Intermediate history exam and treatment		☐
4. Comprehensive history and exam including initiation of diagnostic and treatment program	☐	☐
5. Periodic Medical Evaluation	☐	☐

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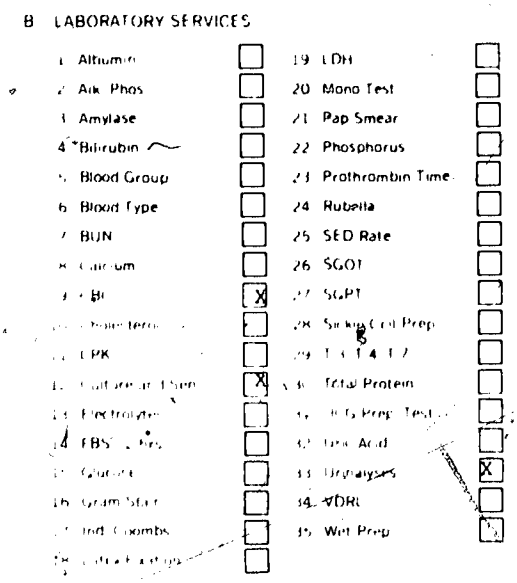
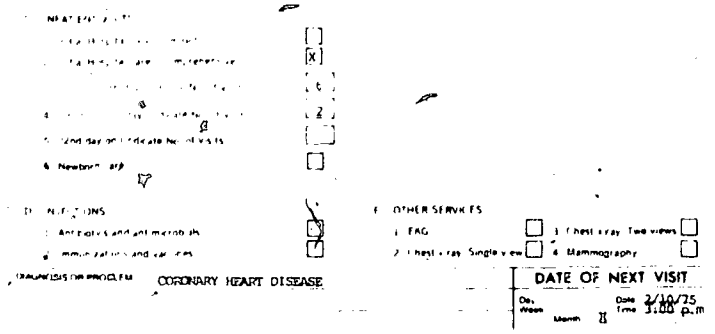
1. *REVISED PRIMARY ENCOUNTER FORM (continued)*

If laboratory tests have been requested in conjunction with the patient's office visit, check-off the appropriate tests as shown in Section B, below.



If the patient has been hospitalized for the condition the primary physician has been treating, indicate the "number" and "type" of visits to the patient in the hospital the physician has made, in the manner shown below. It is important, for items 3-5, below, to indicate the exact number of visits made by the physician.

Sections D and E, of the form are used to indicate the types of injections, x-rays and other types of services provided to the enrollee. If an appropriate H.I.C.D.A. diagnosis code cannot be located, a written description of the diagnosis should be provided in the remarks section. If the physician would like the patient scheduled for another visit the approximate date of that visit should be entered in the lower right hand corner of, Section III; Service Information, of the form.



If the service provided to the patient is not listed in Section III of the Primary Encounter Form, it must be entered in Section IV; Other Services, of the Primary Encounter Form.

IV OTHER SERVICES

DATE OF SERVICE	LOCATION CODE	TYPE OF SERVICE	PROCEDURE CODE	QUANTITY	DESCRIPTION AND REMARKS (Required only if no procedure code can be found)
1/10/75	2	2	1570	1	Anesthesia: Local
1/10/75	2	3	7200	1	Professional Component of Spinal X-ray
1/10/75	2	1	1570	1	Surgery - Drainage of Infected Burn

The date of service and the appropriate Michigan Department of Social Services' location, type of service and procedure codes should be entered in this section of the form according to the instructions provided in Appendix F, Pages A-24 through A-35, of the *M.D.S.S.'s Practitioner Manual.*

Location Codes:
1.—Home. 2.—Office. 3.—Inpatient.

Type of Service Codes:
-Technical Surgical Assistance. 3.—Professional Component (reading of x-ray by radiologist)
-Anesthesia. 9.—All other services.

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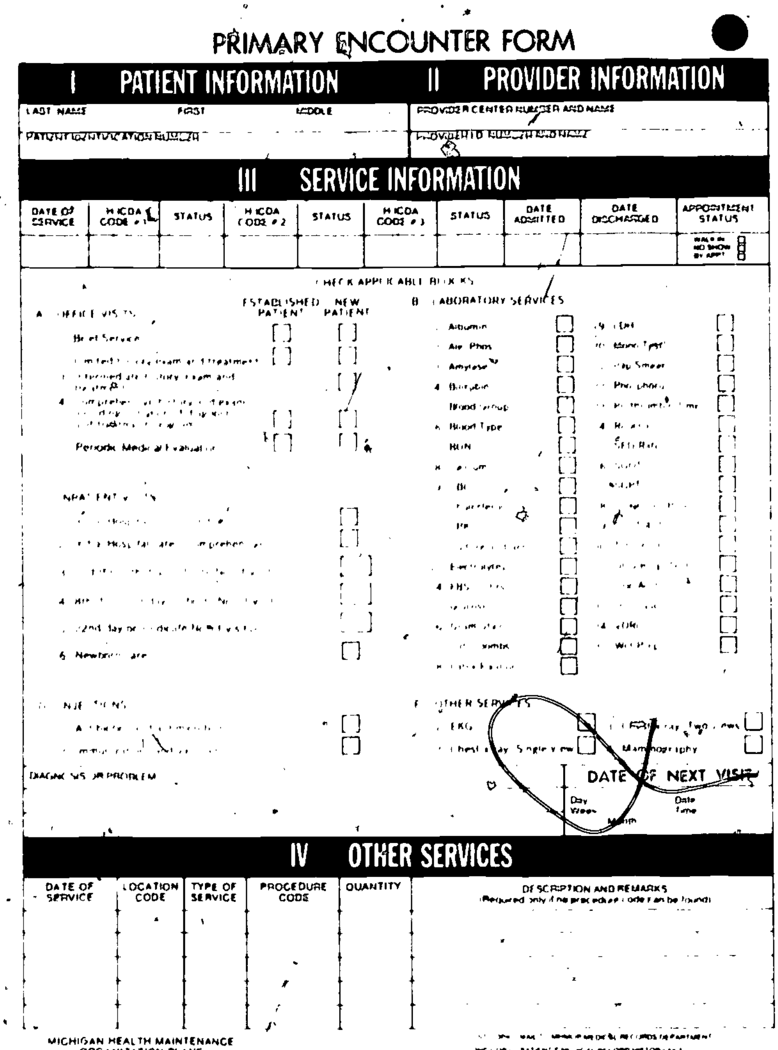
PRIMARY ENCOUNTER FORM (continued)

The amount of the capitation payment that MHMOP receives from M.D.S.S. is determined in part by the amount of patient services provided by our health care centers. If all of our centers do not accurately, completely and promptly report on encounter forms all services provided; this can result in capitation payments in amounts less the MHMOP is entitled. We hope the above described simplified primary encounter reporting system will encourage more prompt and accurate reporting by MHMOP's Primary Health Care Centers.


PRIMARY ENCOUNTER FORM

I PATIENT INFORMATION

LAST NAME FIRST MIDDLE

PATIENT IDENTIFICATION NUMBER

II PROVIDER INFORMATION

PROVIDER CENTER NUMBER AND NAME

PROVIDER NUMBER AND NAME

III SERVICE INFORMATION

DATE OF SERVICE	H ICDA CODE # 1	STATUS	H ICDA CODE # 2	STATUS	H ICDA CODE # 3	STATUS	DATE ADMITTED	DATE DISCHARGED	APPOINTMENT STATUS
									WALK IN / NO SHOW / BY APPT

CHECK APPLICABLE BLOCKS

A OFFICE VISITS — ESTABLISHED PATIENT / NEW PATIENT

Brief Service

Limited History Exam and Treatment

Periodic Medical Evaluation

INPATIENT VISITS

Newborn Care

B LABORATORY SERVICES

Albumin

Alk. Phos.

Amylase

Bilirubin

Blood Group

Blood Type

BUN

Electrolytes

Pap Smear

Phosphorus

DIAGNOSIS OR PROBLEM

E OTHER SERVICES

EKG

Chest X-ray, Single view

Chest X-ray, Two views

Mammography

DATE OF NEXT VISIT — Day, Week, Month / Date, Time

IV OTHER SERVICES

DATE OF SERVICE	LOCATION CODE	TYPE OF SERVICE	PROCEDURE CODE	QUANTITY	DESCRIPTION AND REMARKS (Required only if the procedure code can be found)

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS

IPA PHYSICIANS' RESPONSIBILITY FOR MEDICAL RECORDS

The physician is responsible for the qualitative review of a patient's medical records. They establish the standards that will control the quality of health care rendered.

The medical record should be sufficient in detail to enable authorized reviewers to determine what the patient's condition was and what procedures were performed. The medical record should also enable a physician, not currently treating the patient, to assume responsibility for that patient based on information contained in the medical record.

Occasionally, MHMOP contract IPA physicians may wish to delegate the task of the inspection of medical records for completeness and consistency to a qualified MHMOP medical records inspection team. For examples, inspection of the medical record to see if it is properly assembled, or if all the reports of medical encounters are present and accounted for in the proper sequence.

MHMOP'S RESPONSIBILITY FOR MEDICAL RECORDS

MHMOP has contractual arrangements with MHMOP contract IPAs to provide the following:

1. a list of eligible MHMOP enrollees
2. pre-numbered medical record charts for each enrollee
3. the basic forms to be used for the medical record chart (e.g., health history, physical exam and progress note)
4. patient encounter reporting forms

Each MHMOP enrollee is assigned a number that corresponds to the number of his medical chart. This number represents the enrollment number as well as the medical record number. Each enrollee is also issued a computer generated identification plate which consists of the following information:

a. Enrollee's name
b. Sex
c. Age
d. Birthdate
e. IPA number
f. Medical Records Number

RECOMMENDATIONS FOR MEDICAL RECORD MAINTENANCE

The Medical Records Section makes recommendations, time and personnel available to MHMOP contract IPAs for Medical Records review and evaluation. The MHMOP Medical Records staff suggest that location and facilities for medical records should be selected to provide:

a. prompt medical record services for the care of all patients
b. adequate space for records, personnel and equipment
c. An efficient and safe means for circulating records throughout all stages of their use and completion.

Periodic inspection of the medical record files should be made to assess if they are in the proper alphabetical or numerical order. A chart order should be established for the contents of the records. Backing sheets should be used for laboratory reports and there should be consistency in the size and shape of the forms and reports in the medical record charts. The periodic inspection of the medical records should be the responsibility of a specific person(s). This inspection serves as a control measure to keep MHMOP contract IPAs informed of how well its medical record files are being maintained. Information obtained from the inspection is used as a guide in determining what action should be taken and what priorities should be established in regards to the IPA's medical record system. There should also be a mechanism for corrective action whenever it is needed. In some instances, nothing more than better communication is required. In other instances, formal or informal training programs to improve an IPA's medical record staffs' skills is required to correct the medical record difficulties encountered.

The Medical Records Section of MHMOP is equipped to offer training programs to MHMOP contract IPAs Medical Record Staff if an IPA requests this training. If this type of training is desired, IPAs may contact the Medical Records' Staff at 961-3636.

APPENDIX 5 — "Evaluation Design"

EVALUATION COMPONENT DESIGN FOR THE DETROIT MEDICAL FOUNDATION DEMONSTRATION TRAINING PROGRAM

Submitted by

TARP, INC.

July 15, 1975

1. INTRODUCTION

Technical Assistance Research Programs (TARP), Inc. has contracted with the Detroit Medical Foundation to conduct an evaluation of the Demonstration Training Program for Primary Care Units. This evaluation will consist of two components.

- A *process* evaluation will document the origins of the project, planning activities, and the project's implementation. The objective of this evaluation component will be to orient others to the training program experience, to indicate strengths and weaknesses in the training experience, and to suggest ways other HMO's could launch their own training efforts.
- An *impact* evaluation will judge the effectiveness of the training methods and curriculum when developed and applied. This objective will be accomplished by assessing the nature and magnitude of changes in levels of information, and attitudes (perceptions) among participants in the training program before and after undergoing the training experience.

2. TRAINING PROGRAM OBJECTIVES

The *major objective* of the Demonstration Training Program is to improve the level of knowledge and information about important operational components of the Michigan HMO Plans, Inc. among the staff of selected primary care units (PCU) in attendance at the project's training seminars.

There are *four sub-objectives* to the project:

- To improve the level of knowledge about the difference between health maintenance organizations and traditional forms of health care delivery among PCU staff.
- To improve the ability of PCUs' staff to identify their responsibility to the major divisions of Michigan HMO Plans and the policies and procedures of the division which affect the PCUs.
- To improve the level of PCU staff understanding of what the Michigan HMO Plans has to offer its member PCUs.
- To improve the ability of the PCUs' staff to list the major divisions of Michigan HMO Plans and the areas of responsibility of each major division.

3. UNDERLYING PROBLEMS AND ISSUES

The major and sub-objectives of the Demonstration Training Program address problems of information communication and exchange which necessarily exist among units of any new complex organization. Because an HMO represents the conversion from traditional to non-traditional modes of health care delivery, participants in the transition necessarily require large amounts of information and guidance if they are to conform long-standing behavior patterns and attitudes to the new frame of reference.

Each training program sub-objective identifies a critical area of information and communication: a) that Michigan HMO Plans Central Office must clearly communicate to the members PCUs the operating policies of specific Plan divisions; b) that each PCU must learn what specific actions are required in order for them to conform to the operating requirements of each division; c) that each PCU must be made aware of the kinds of supportive services available through the Plan; d) finally, that Plan Central Office personnel must become sensitive to problems and issues being faced by PCUs and offer solutions to these problems.

4. TRAINING PROGRAM METHODOLOGY

Each of the four sub-objectives is being operationalized through the curriculum component for inclusion in the training seminar. Three data collection procedures have been utilized to both design the curriculum and to provide a baseline level of extant knowledge and information, from which to assess subsequent changes.

An *information protocol*, already in use at Michigan HMO Plans, which periodically appraises levels of information present among PCU and Central Office staff, was tapped into, in order to assess information levels prior to the implementation of the training program.

A *needs assessment* protocol was utilized at three PCUs to get staff inputs into what topics they think should be covered in the training program.

A *state-of-the-art* literature review assessed training programs and the HMO literature, gleaning relevant information for the curriculum.

These three data sets are serving as valuable inputs to curriculum design. Accompanying the design of the curriculum is the development of training materials, procedures and formats. Together, the curriculum, training materials, procedures, and formats constitute an integrated demonstration training seminar, which will be conducted July 25-27, 1975.

5. EVALUATION COMPONENT METHODOLOGIES

5.1 Process Evaluation Methodology

The process evaluation for this project will consist of a detailed narrative documentation of all aspects of the origins, planning, and implementation of the Demonstration Training Program. Members of the TARP evaluation team helped design the original proposal in March, 1974 and have observed all significant planning meetings during the project design phase. In addition, transcripts are available for all major planning sessions. The documentation record, then, is quite extensive.

The narrative record of the project's genesis will be critically reviewed by TARP in order to highlight significant problems experienced by the DMF team, how they were resolved, and implications for the planning and development of training programs by other HMOs.

5.2 Impact Evaluation Methodology

Evaluation, broadly speaking, is a systematic, controlled research effort which collects and analyzes data to test if a specified or "expected" change has taken place as a result of the training activity.

This definition immediately suggests the required research design, data elements and the form of analysis in order to conduct the present impact evaluation.

The research design required is a pure experimental design which establishes the presence, or absence, or the level of the relevant objects of analysis at the beginning of exposure to training and at the end of the exposure. The comparison of the "before and after" statuses provides the measurement of impact or change. The analysis is concerned with arriving at a judgment that the change (or the impact) found in the "before and after" comparison is the expected one.

The attribution of the impact to the "stimulus", that is, the training experience, depends on the ability to assess the aspect or portion of the observed change that is due to the effect of all other events, experiences, and changes that occurred to the individuals being trained. This "control" is achieved by a "before and after" study of some individuals from the population undergoing the training who are deliberately not exposed to the training effort. Any "before and after" differences found in this control group is attributable to all other factors which operate on the total population during the training time period. Consequently, a comparison of the change found in the experimental and the control groups identifies that portion of the observed change in the experimental group which is *not* attributable to the training.

The data elements that are required for the "before and after" assessments are defined by the changes that are to be measured. The data units which provide a before and after status are the relevant ones.

5.3 Specific Requirements of the Impact Evaluation

The objectives of the training effort are not limited to the acquisition of defined pieces of knowledge; they also relate to a change in the relationship between the personnel in the Primary Care Units and the staff at the Central Office. The change in this relationship is a change in the way in which interaction occurs and involves changes in perceptions and attitudes between PCU staff and Central Office staff. The change is to be brought about by deliberate involvement of the two groups in a common planning process — the development of the curriculum — and the imparting of information which will fill gaps in existing knowledge and correct misinformation. The areas selected for this "teaching" effort are perceived as relevant to the current sets of attitudes and perceptions of the two groups; and it is expected that accepting new or correct factual information will facilitate changes in attitudes and modes of interaction.

6. IMPACT EVALUATION DESIGN REQUIREMENTS

The specific research design was developed to accommodate the nature of the training method. The method consists of 1) involvement in the design of the curriculum, and 2) participation in the training.

The *experimental groups* are the central office "decision-maker" level staff and staff in the PCUs who are involved in direct delivery of care and interaction with the Central Office.

The *impact measurements* must assess attitudes, modes of interaction, and degree of correct information before and after the training effort.

Following are the specific phases of the proposed evaluation design.

7. PROPOSED DESIGN

Figure 1 presents the structure of the total evaluation and the groups involved in each evaluation component. These groups are the various members of the MHMOP organization, structured as follows:

- *Group A*: The staff of 3 PCUs who participated in the needs assessment and training conferences.
- *Group B*: The staff of 3 PCUs who did not participate in the needs assessment, but did participate in the training conferences.
- *Group C*: The staff of 2 PCUs selected for "control group" purposes, neither involved in the needs assessment nor the training conferences.
- *Group D*: All MHMOP staff and consultants, utilized as faculty and trainers for the training conferences.

These groups will be arranged into a quasi-experimental evaluation design. An explanation of this approach follows, keyed to each step outlined in Figure 1.

(1) — (3) PCU study groups and Central Office group are identified and selected.

(4) PCU study groups are divided into two experimental groups ("A" and "B") and group "C", a control group. The experimental group "A" will be involved in the two major activities: planning the curriculum (through needs assessment) and training. Group "B" will be involved in the training activity only and *not* in curriculum planning, so that group "B" will serve as a control for group "A" for assessment of the impact of involvement in planning the curriculum. Group "C" will serve as an overall control, not participating in either planning or training.

(5) — (6) The data collection for the "before" or baseline assessment must be completed before the two phases of the training process can begin. Analysis (6) consists of comparisons among the four groups as to their responses to the information protocol. Levels of knowledge about "MHMOP" will be recorded. Group "D" will be asked to assess knowledge levels of Groups "A", "B" and "C".

(7) — (8) Phase one of the training effort — involvement in curriculum design, or participation in "needs assessment" — is now instituted and completed. Groups "A" and "D" are involved in this phase. Data analysis (8) consists of determining what each group thinks should be included in training curriculum and comparing differential perceptions between groups "A" and "D".

(9) Next, groups "A", "B", and "D" are exposed to the second phase of the training effort.

(10) Data collection for assessing the "after" or "outcome" status is now instituted, groups "A", "B", "C", and "D" are included.

(11) Additional data for "outcome" assessment will now be collected for "A", "B", and "D". A further set of data is collected for "D". The first set of data will assess changes due to participation in phase 1, the needs assessment and curriculum planning, (groups "A", "B", "D"). The second set will assess the effect of participation in the training for group "D".

(12) The final step will be the analysis of the body of data collected so that (a) "before" and "after" statuses can be determined, (b) impact, if any, can be described and (possibly) attributed to the two training phases.

ACTIVITY	GROUP INVOLVED
1) Collect preliminary information from all PCUs	All PCUs; Central Office staff
2) Determine selection criteria for selection of study PCUs	All PCUs; select 8 PCUs from total universe
3) Select PCUs	Selected 8 PCUs divided into: A=3 PCUs B=3 PCUs C=2 PCUs
4) Select 3 study groups	A= Involved in planning and training; B=not involved in planning; involved in training; C=Control — no involvement in training or planning
5) Administer information protocol; "Before" (1)	A B C D=Central Office
6) Analysis I	Each of 4 groups with each other, also A+B◗C, A+B+C◗D, A+B◗D, A◗B, A◗C, A◗D, B◗C, B◗D, C◗D
7) Needs Assessment	A D
8) Analysis II	A D
9) Training Seminar (1)	A B D
10) Administer information protocol, "After" (2)	A B C D
11) De-briefing Training Seminar (2)	A B D
12) Analysis III	Repeat Analysis I and Analysis II, i.e., A,D relative to II.

FIGURE 1

8. EXECUTION OF THE IMPACT EVALUATION

8.1 The Population

(1) *Staff from PCUs.* The MHMOP encompasses twenty-one PCUs which are under a variety of contracts, vary in size, staffing, type and range of medical specialization, and length of time affiliated.

A decision had to be reached whether all the individuals, regardless of professional status or type of work, should be considered as a "pool" from which a sample was to be drawn for inclusion in the training project, or whether the PCUs as such should be considered the universe. It would be necessary to select only a limited number of individuals for the training session since first, funds would not cover accommodation for all and, further, not everyone could be spared since services to the enrollees must, necessarily, continue.

It was decided to select the PCU as the unit for selection since the functioning of units is of primary interest. The Central Office and the individuals in the PCUs relate to each other in terms of PCU identity, not as individual members of a uniform system.

Data was collected on each PCU in terms of its type of services — speciality or general services —, length of functioning, types and numbers of personnel. The Board and administration approved a suggested list of eight PCUs to be included in the training project. These selections were based on five criteria — maturity of the PCUs; willingness of the PCUs to cooperate in the project; size of the PCUs staff (can't be too large so all may participate); and lack of staff conflicts.

2) *The Central Office Executive/Administrative Staff.* Group D consists of those Central Office staff who will serve as instructors in the training seminars.

William O. Mays, M.D.	President
W. Melvin Smith, M.B.A	Senior Executive Vice President
O. Larkin Isaac, M.B.A.	Director of Operations
Sandra Billingslea, M.S.W.	Manager, Health Care Administration Division
Bruce Mullican	Manager, Claims Processing Division
Fred Prime	Director of Marketing
Karl Haiser, C.P.A.	Director of Finance
Barbara Sue Brown	Supervisor, Subscriber Services
Andrea Williams	Supervisor, Enrollee Education
Alegro J. Godley, M.D.	Director, Corporate Medical Planning
Jack Conway, M.B.A.	Health Systems Analyst
Dorothy Douthitt, A.R.T	Medical Records Librarian

8.2 Data

The data to be collected must permit assessment of knowledge and attitudes as well as type of interaction. Some of this data can be obtained only through direct observation; some from data obtained more systematically by tapping into MHMOP's periodically administered information collection system.

1) *Information and attitudes.* MHMOP periodically gathers baseline data from both new and long-term PCU staff in order to assess levels of staff information and to pinpoint problem areas requiring resolution. In order to utilize this on-going data collection instrument for the Demonstration Training Program, the most recent data from the eight PCUs involved in the project was pulled from the files and analyzed. Analysis of responses to the information protocol for the non-participating PCUs will also be available for comparison.

The information protocol probes for levels of information about HMO activities and determines attitudes towards the Central Office held by PCU staff.

Group D, the Central Office trainers, also are responding to the information protocol. These individuals are being asked to estimate the response distribution to each item that they believe will be elicited from PCU staff. In other words, Central Office personnel are being asked to "second guess" information levels present among PCU staff.

In addition, group D's attitudes will be assessed by an analysis of the tapes and records of several planning and working sessions with TARP personnel. These sessions dealt with overall planning at the project, the development of the curriculum, evaluation, practical details of scheduling, requirements for the workshop, etc.

9. THE ANALYSIS OF THE IMPACT EVALUATION

The analysis will consist of establishing "before" status and "after" status of the various groups, and the comparisons of "before and after" statuses.

In addition, for both the "before" and the "after" statuses, there will be the following comparisons to assess the possibility of projecting data for group A onto all PCU's. Therefore, the following comparisons will be possible:

A-B	A-D
A-C	B-D
B-C	C-D
A+B+-C	A+B+C-D
	A+B-D

D_{before} D_{after}

10. THE CONSUMER PANEL

No systematic data will be available but, general assessments of conflicting expectations and degree of knowledge will be presented as a dimension of the analysis.

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APPENDIX 6

YOUR OPINION PLEASE

PLEASE CHECK THE APPROPRIATE BOX FOR EACH ITEM BELOW:

1. The information given during the conference was:
   a. _____ too much _____ just right _____ not enough
   b. _____ very helpful _____ somewhat helpful _____ not helpful at all
   c. _____ very clear _____ okay _____ confusing
   d. _____ interesting _____ all right _____ boring

2. Put a check mark by the *one* presentation you liked best in Column A and a check mark by the *one* presentation you liked least in Column B.

TOPICS COVERED	LIKED BEST Column A	LIKED LEAST Column B
a. "What is an HMO?"		
b. "Patient Rights"		
c. "How Michigan HMO Plans, Inc. Operates"		
d. "Health Services Available via MHMOP Central Office Referral"		
e. "Fee-for-Service Utilization"		
f. "How Michigan HMO Plan is Marketed"		
g. (PHYSICIANS ONLY) "Financial Structure of the Plan"		
h. (PHYSICIANS ONLY) "Effective Patient Management"		
i. (PHYSICIANS ONLY) "Corporate Dental planning for MHMOP"		
j. (ALLIED HEALTH PERSONNEL ONLY) "Account Executive"		
k. (AHP ONLY) "Enrollee Orientation"		
l. (AHP ONLY) "MHMOP's HOTLINE"		
m. (AHP ONLY) "Enrollee Concerns"		
n. (AHP ONLY) "Medical Records"		
o. (AHP ONLY) "MHMOP's Encounter Form"		

PLEASE TURN TO PAGE 2

3. Is there any topic or subject that was not covered that you think should have been covered?

CIRCLE ONE YES NO
If YES, describe TOPIC.

4. Is there any topic or subject that was covered which could have been left out?

CIRCLE ONE YES NO

If YES, describe TOPIC.

5 a. Please indicate your Primary Care Unit on the line below.

PCU # _____

Please indicate your function in your health center by checking the appropriate box.

- ☐ Patient Care: Physician
- ☐ Patient Care: RN, LPN, Medical Assistant or Aide, Receptionist
- ☐ Office : Administrator or Administrative Assistant, Manager, Typist, Clerk, Secretary, Billing, Accounting, Bookkeeping
- ☐ Other: Medical Records, Laboratory or X-ray Technician, etc.

6. Other Comments.

THANK YOU!

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APPENDIX 7 — "After" Questionnaire

PHYSICIANS

I. Following are some terms; for each, there are several definitions. Place a check in the box next to the one you think is most nearly correct when used in relation to HMOs.

a. **Capitation** (for HMOs) can be defined as:

☐ 1. An insurance premium, of which the amount depends on who the enrolled person is.

☐ 2. Some fixed dollar amount paid per enrolled person.

☐ 3. A predetermined fixed dollar amount paid per enrolled person for a fixed set (package of services).

B. **Physician Fee-for-Service** Feature of HMOs is:

☐ 1. A portion of the funds which pays the higher compensation rates of members (doctors) who are classified as consultants or specialists.

☐ 2. The usual and customary payment to the physician specialist on a referral or approval basis from the primary care physician for covered health services.

☐ 3. A portion of the funds which pays for physician services rendered to the patient while in hospital.

C. **Risk Sharing** in HMOs:

☐ 1. Is a form of malpractice insurance.

☐ 2. Means that any deficit incurred by your health center will be directly paid by your group and your group alone.

☐ 3. Is a portion of the total capitation set aside into a reserve fund to cover unforseen financial hazards for the plan.

— Continued —

I. (Cont'd)

D. **Benefit Package** in HMOs:

☐ 1. An identical range of health services which are guaranteed by MHMOP, regardless of the medical group in which the individual is enrolled for care.

☐ 2. The range of health services to which an enrollee is entitled and which is defined by the individual medical group contract.

☐ 3. Those health services deemed necessary by the patient's physician.

E. **Referrals to Specialists** who are not under a capitation contract with MHMOP are paid for by:

☐ 1. The group to which the doctor making the referral belongs.

☐ 2. Out of capitation with prior approval of MHMOP.

☐ 3. Out of the risk-sharing fund with prior approval of MHMOP.

☐ 4. Out of the fee-for-service fund with prior approval of the medical group.

☐ 5. None of these. (Please describe your understanding of this payment arrangement).

— Continued —

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II.A. For each of the items below, check the column which you feel is appropriate.

Health Service	A. Included in basic HMO Package and available to enrollees	B. Can be made available if needed & ordered by physicians	C. Not provided by HMO contract under any circumstances	D. Don't Know
1. Prenatal Care				
2. Eye Glasses				
3. Plastic Surgery (cosmetic)				
4. Outpatient X-Ray Studies				
5. EKG & EEG				
6. Abortions				
7. Dental Care				
8. Psychiatric Care Outpatient				
9. Contact Lens				
10. Emergency Room Services				

(Continued on next page)

Health Service	A. Included in basic HMO Package and available to enrollees	B. Can be made available if needed & ordered by physicians	C. Not provided by HMO contract under any circumstances	D. Don't Know
11. Tubal Ligation				
12. Inpatient Hospital-ization				
13. Dermatologists				
14. Allergists				
15. Podiatrist				
16. Health Care (domestic)				
17. VNA				
18. Psychiatric Inpatient				
19. General Surgery				
20. Health Education				
21. Prescriptions				
22. Ambulance				
23. Transportation (other than ambulance)				

— Continued —

II. (Cont'd)

B. When you think about enrollee service request which are not granted, this most often happens because: (CHECK *ONE* BOX ONLY)

☐ 1. The enrollee hasn't understood what the Plan in fact provides.

☐ 2. P.C.U. Staff is not correctly and completely informed as to the range of services to which the enrollee is entitled.

☐ 3. MHMOP's Central Office has not explained the provisions to the P.C.U.

☐ 4. MHMOP's Central Office has always oversold the enrollee.

☐ 5. Some instances of each of the above reasons, no one in particular.

III. Which of the following statements is TRUE? (CHECK ONE OF THE 3 BOXES).

☐ A. The primary contractual relationship is between the P.C.U. and the enrollee assigned to it.

☐ B. The primary contractual relationship is between MHMOP's Central Office and the enrollee.

☐ C. Don't Know.

IV. By placing the Emergency Care "HOTLINE" in MHMOP's Central office, the Central Office is: (CHECK *ONE* OF THE FOLLOWING 3 STATEMENTS)

☐ A. performing a reasonable, necessary part of patient care efficiently.

☐ B. intruding in patient care under the guise of providing an efficient service.

☐ C. No Opinion.

B. Considering the paper work required of the P.C.U. by Central Office: (CHECK *ONE* OF THE FOLLOWING STATEMENTS)

☐ A. All of its seems reasonable and there seems to be a justification for all of it.

☐ B. Some of it seems reasonable and is justified but some is not.

☐ C. Very little seems reasonable and very little seems justified.

—Continued —

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A. Please indicate your health center on the line below.

P.C.U. # _____

B. Please indicate your function in your health center by checking the appropriate box.

☐ 1. Patient Care: Physician

☐ 2. Patient Care: RN, LPN, Medical Assistant or Aide, Receptionist

☐ 3. Office: Administrator or Administrative Assistant, Manager, Typist, Clerk, Secretary, Billing, Accounting, Bookkeeping.

☐ 4. Other: Medical Records, Laboratory or X-ray Technician, Etc.

THANK YOU!

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APPENDIX 8 — "After" Questionnaire

ALLIED HEALTH PERSONNEL

I.A. For each of the items below, check the column which you feel is appropriate.

Health Service	A. Included in basic HMO Package and available to Enrollees	B. Can be made available if needed & ordered by physicians	C. Not provided by HMO contract under any circumstances	D. Don't Know
1. Prenatal Care				
2. Eye Glasses				
3. Plastic Surgery (cosmetic)				
4. Outpatient X-Ray Studies				
5. EKG & EEG				
6. Abortions				
7. Dental Care				
8. Psychiatric Care Outpatient				
9. Contact Lens				
10. Emergency Room Services				

(Continued on next page)

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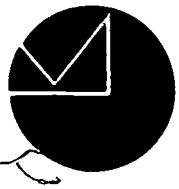
I. A. (Cont'd)

Health Service	A. Included in basic HMO Package and available to enrollees	B. Can be made available if needed & ordered by physicians	C. Not provided by HMO contract under any circumstances	D. Don't Know
11. Tubal Ligation				
12. Inpatient Hospitalization				
13. Dermatologists				
14. Allergists				
15. Podiatrist				
16. Health Care (domestic)				
17. VNA				
18. Psychiatric Inpatient				
19. General Surgery				
20. Health Education				
21. Prescriptions				
22. Ambulance				
23. Transportation (other than ambulance)				

— Continued —



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I. (Cont'd)

B. When you talk about enrollee service request which are not granted, this most often happens because: (CHECK *ONE* BOX ONLY)

☐ 1. The enrollee hasn't understood what the Plan in fact provides.

☐ 2. PCU Staff is not correctly and completely informed as to the range of services to which the enrollee is entitled.

☐ 3. MHMOP's Central Office has not explained the provisions to the PCU.

☐ 4. MHMOP's Central Office has always oversold the enrollee.

☐ 5. Some instances of each of the above reasons, no one in particular.

II. Which of the following statements is TRUE? (CHECK *ONE* OF THE 3 BOXES)

☐ A. The primary contractual relationship is between the PCU and the enrollee assigned to it.

☐ B. The primary contractual relationship is between MHMOP's Central Office and the enrollee.

☐ C. Don't Know.

III. By placing the Emergency Care "HOTLINE" in MHMOP's Central Office, the Central Office is: (CHECK *ONE* OF THE FOLLOWING 3 STATEMENTS)

☐ A. performing a reasonable necessary part of patient care efficiently.

☐ B. intruding in patient care under the guise of providing an efficient service.

☐ C. No Opinion.

IV. Considering the paper work required of the PCU by Central Office. (CHECK *ONE* OF THE FOLLOWING STATEMENTS)

☐ A. All of it seems reasonable and there seems to be a justification for all of it.

☐ B. Some of it seems reasonable and is justified but some is not.

☐ C. Very little seems reasonable and very little seems justified.

— Continued —

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V. A. Please indicate your health center on the line below.

PCU#_____

B. Please indicate your function in your health center by checking the appropriate box.

☐ 1. Patient Care: Physician

☐ 2. Patient Care: RN, LPN, Medical Assistant or Aide, Receptionist

☐ 3. Office: Administrator or Administrative Assistant, Manager, Typist, Clerk, Secretary, Billing, Accounting, Bookkeeping

☐ 4. Other: Medical Records, Laboratory or X-ray Technician, etc.

THANK YOU!

APPENDIX 9

TRAINING CONFERENCE PARTICIPANTS

Ernest Ajluni, D.P.M., Detroit Medical & Surgical Center
Mary Austin, Family Medical Health Center
Toni Austin, Detroit Medical & Surgical Center
Barbara Baker, Detroit Medical & Surgical Center
Helen Baker, McDougall Medical Center
Heyam Bazzy, Detroit Medical Associates
Colette Bell, Psycho Therapeutics, Inc.
Arthur W. Boddie, M.D., Detroit Medical & Surgical Center
Nancy Bowen, Vincent, Combs & Massé Health Center
Barbara Brazill, Tri-City Comprehensive Health Center
Barbara Brooks, Detroit Medical & Surgical Center
Essie Butler, Detroit Medical Associates
Joyce Chambers, Detroit Medical & Surgical Center
Benjamin Clawson, D.D.S.
Julia Colbert, Psycho Therapeutics, Inc.
Mary Cole, Family Medical Health Center
Annette Collins, Vincent, Combs & Massé Health Center
Julius Combs, M.D., Vincent, Combs & Massé Health Center
David Conley, Psycho Therapeutics, Inc.
Norma Jean Cooper, Detroit Medical Associates
Leona Crittendon, Detroit Medical Associates
Nancy Davidson, Tri-City Comprehensive Health Center
Anita Davis, Psycho Therapeutics, Inc.
William Doss, Jr., M.D., Psycho Therapeutics, Inc.
George C. Evans, M.D., Detroit Medical & Surgical Center
William Farmer, M.D., Oakland Internists Associates, P.C.
Thomas M. Flake, M.D., Detroit Medical Associates
Ernestine Franklin, Tri-City Comprehensive Health Center
Daryl Freeman, D.D.S.
Floorie Guzman, McDougall Medical Center
Freda Hall, McDougall Medical Center
Gladys Hardy, Detroit Medical & Surgical Center
Harcourt Harris, M.D., Detroit Medical Associates
Lynne Haugabook, McDougall Medical Center
Joseph C. Haynes, Psycho Therapeutics, Inc.
Stella Hector, Detroit Medical Associates
Corine Henry, Detroit Medical & Surgical Center
Kassandra Hill, McDougall Medical Center
Gloria Hinton, Detroit Medical & Surgical Center
Almetta Holland, Vincent, Combs & Massé Health Center
Franzetta Houston, Detroit Medical Associates
Delores Jackson, McDougall Medical Center
Deborah Jenkins, Detroit Medical & Surgical Center
Mary Jennings, Detroit Medical & Surgical Center
Rudy Johnson, Detroit Medical Associates
Ruthie Johnson, Detroit Medical & Surgical Center
Eileen Laston, Detroit Medical & Surgical Center
Earlene Locust, Detroit Medical & Surgical Center
Gwen Lovelace, Detroit Medical Associates
Marnise Madison, Detroit Medical & Surgical Center
Brenda Malone, Vincent, Combs & Massé Health Center
Carol McArthur Detroit Medical Associates
Marion McCall, M.D., Ophthalmology
William McPhail, M.D., Family Medical Health Center

Vera Miggins, Detroit Medical & Surgical Center
Katherine Miller, Detroit Medical Associates
S. B. Milton, M.D., Tri-City Comprehensive Health Center
Oscar C. Mitchell, M.D., Family Medical Health Center
Joy Moore, McDougall Medical Center
Edward Nash, M.D., McDougall Medical Center
Dorothy Nichols, Detroit Medical Associates
Evelyn Olive, McDougall Medical Center
Helen O'Neal, Detroit Medical Associates
Carol Orange, Vincent, Combs & Massé Health Center
Jocella Page, Vincent, Combs & Massé Health Center
Mohamel G. A. Patel, M.D., Detroit Medical & Surgical Center
Jessie Pickett, Psycho Therapeutics, Inc.
Richard Pillon, R. Ph., Tri-City Comprehensive Health Center
Rudolph A. Porter, M.D., (Deceased), Tri-City Comprehensive Health Center
Hetra Powell, Vincent, Combs & Massé Health Center
Rhonda Price, Detroit Medical & Surgical Center
Jewell Reese, Detroit Medical Associates
Maurice A. Richard, M.D., Detroit Medical & Surgical Center
Jorge F. Rosé, M.D., McDougall Medical Center
Yvonne Ross, Detroit Medical & Surgical Center
Particia Royal, Vincent, Combs & Massé Health Center
Chaman L. Sarin, M.D., S & S Medical Health Center
Elie Sarraf, M.D., Detroit Medical & Surgical Center
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Barbara Simmons, Detroit Medical Associates
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Alma Summers, Vincent, Combs & Massé Health Center
Lionel F. Swan, M.D., Detroit Medical & Surgical Center
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Rosalind Taylor, Detroit Medical & Surgical Center
Bettye Thompson, Detroit Medical & Surgical Center
Willie Mae Thompson, Detroit Medical Associates
Gussie Thornton, Detroit Medical & Surgical Center
Clifford Tinsley, Psycho Therapeutics, Inc.
Linda Traylor, Detroit Medical Associates
Ann Truvillion, Detroit Medical & Surgical Center
Zondra Turner, Detroit Medical & Surgical Center
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Lillie Williams, Detroit Medical & Surgical Center
Norma Williamson, Psycho Therapeutics, Inc.
Lulu Wilson, Psycho Therapeutics, Inc.
Salathiel Witherspoon, Psycho Therapeutics, Inc.
Oscar Woodard, Psycho Therapeutics, Inc.
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