CENTER for STUDYING HEALTH SYSTEM CHANGE

Issue Brief

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THE CENTER, SUPPORTED BY THE ROBERT WOOD JOHNSON FOUNDATION AS PART OF ITS HEALTH TRACKING INITIATIVE, IS AFFILIATED WITH MATHEMATICA POLICY RESEARCH, INC.

THE COMMUNITY TRACKING STUDY:

A Focus on Change in the Health Care System

Number 1
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Recognizing that health care delivery is predominantly local, the Center for Studying Health System Change is investigating what is happening in health care financing and delivery at the community level. The Community Tracking Study focuses on changes in the health care system in 60 sites that are representative of the nation. Twelve of these communities are being studied intensively. The 48 additional communities studied less intensively will permit generalization to the nation as a whole and analysis of the relationship between health system characteristics and the effects of change on people. Data collection and analysis for the Community Tracking Study are planned in two-year cycles. The first cycle, which began in spring of 1996, will establish a baseline.

OBJECTIVES OF THE STUDY

The Community Tracking Study, which is funded by The Robert Wood Johnson Foundation, is designed to answer three broad questions:

How is organization of the health system changing?

More specifically, how are the organizational relationships among health plans, physicians, hospitals, and safety net providers being recast? How are these organizations being affected by and responding to changes in market structure? What role do employers, consumers, and public policy play in driving changes in the health care system?

How are outcomes changing?

That is, how are outcomes such as insurance coverage, access to care, use of services, health care cost, quality, and satisfaction changing over time? How do these changes differ across communities and population subgroups?

How are health system changes related to differences in outcomes?

From a qualitative and quantitative perspective, what is the relationship between health systems and insurance coverage, access, service delivery, cost, and quality?

COMMUNITY FOCUS

Focusing on communities is central to the design of the Community Tracking Study. Health care delivery differs from community to community for many reasons, including history, culture, and state policy. Collecting and analyzing information at the local level is critical for understanding institutional changes in the delivery system and their effects on people.

Two categories of communities have been selected for study through a process of stratified random selection; taken together, they will provide a representative profile of change across the United States. Twelve communities will be studied in depth: Boston, Cleveland, Greenville, S.C., Indianapolis, Lansing, Mich., Little Rock, Miami, Newark, N.J., Orange County, Calif., Phoenix, Seattle, and Syracuse. Intensive case studies will be conducted in these communities and sample sizes for surveys will be large enough to draw conclusions about health system change for each community.

An additional 48 communities are being studied less intensively. There will be no case studies in these communities, and survey sample sizes will be smaller. Because the smaller sample sizes do not permit meaningful site-specific estimates, data will not be analyzed by site and the 48 sites will not be identified.

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SITE SELECTION PROCESS

The process of random site selection ensures that the sites are representative of the U.S. population and protects against bias on the part of researchers. Potential sites were stratified by region and community size and type (metropolitan-nonmetropolitan). The 12 high-intensity sites were selected randomly from those of the 60 sites that were metropolitan areas with more than 200,000 people. The 48 low-intensity sites include small metropolitan and rural areas as well.

Information from the 48 communities studied less intensively will strengthen the study in a number of ways:

- It will enable the case studies conducted in the intensive sites to be placed in the context of health system change in the nation. This overcomes a common weakness of case studies—results that reflect unique features of the small number of communities visited.

- It will permit statistically reliable conclusions to be drawn about health system change in the nation. Inference to the nation from samples in only 12 communities would have an unacceptable degree of statistical error; increasing the number of communities to 60 will reduce this error to a manageable level.

- It will permit multivariate analyses to relate system change to changes in people's health care. In the conceptual framework that guides the study design, variables related to individuals' experience with the health system—their access, service use, quality, satisfaction—depend not only on individual factors, such as whether one is covered by health insurance, but also on community-level characteristics. For example, the nature of access to care that an uninsured person has may depend on the financial well-being of providers—both safety-net and mainstream. Increasing the variation in community variables from 12 to 60 distinct levels makes such multivariate analyses feasible.

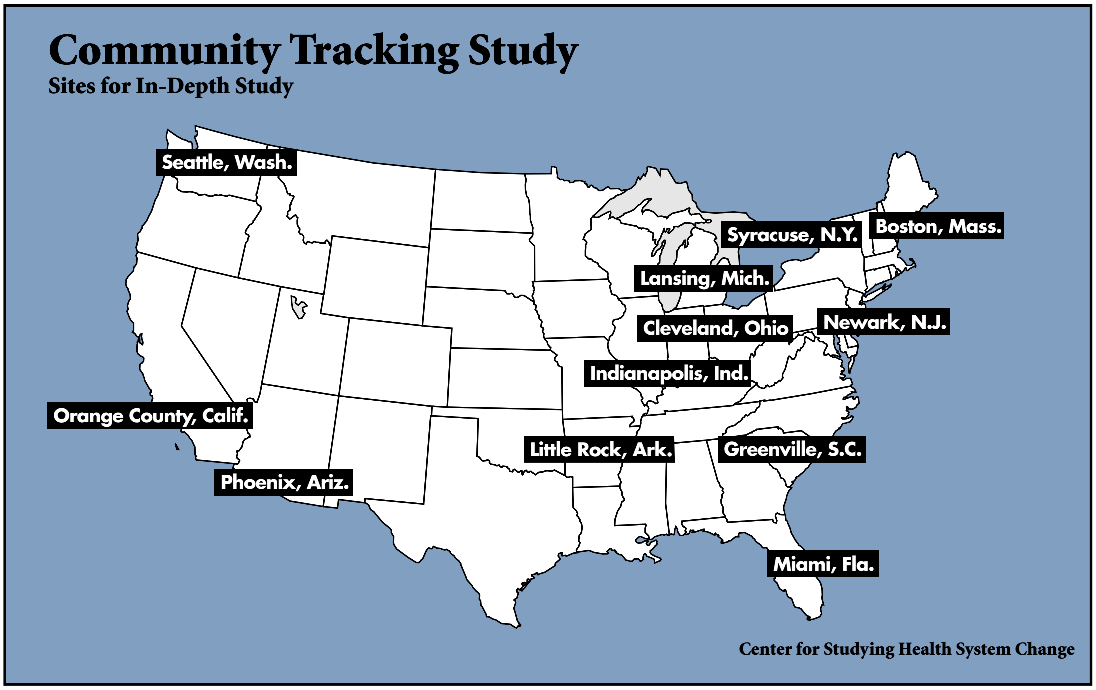
DATA SOURCES

Data for the Community Tracking Study will be collected from a variety of sources. Site visits will gather qualitative information from the major components of the health care system, including purchasers, state governments, health plans and insurers, hospitals, physician organizations, community health centers, public health departments, and consumer organizations. The site visits will provide a rich understanding of health system change and will help in interpreting quantitative data. The Lewin Group, in conjunction with Center staff, will conduct the site visits.

Much of the information on the effects of health system change on people will come from the surveys of households and physicians that the Center conceptualized and is directing. The household survey will obtain information about access to care, how individuals enter the health system, use of care, financial burdens, satisfaction with care, selected indicators of quality, and attitudes that predict demand for insurance. Respondents will be asked for the name of their insurance plan, and health insurers, in turn, will be asked to provide characteristics of that plan. Mathematica Policy Research, Inc., will conduct the household survey.

The physician survey will provide an additional perspective on changes in care provided to patients. Practice styles will be measured through clinical vignettes to assess physicians' decision making concerning use of discretionary procedures and referrals. Physicians' perceptions of their ability to meet patients' needs and expectations, including technical quality and clinical autonomy, will be measured. The Gallup Organization will conduct the physician survey.

Analysis of hospital discharge records (for those communities in states that have developed such data systems) will allow the study of care delivery and outcome indicators of quality. Hospital discharge records also may be useful in creating indicators of access, such as admission rates for conditions likely to result from inadequate ambulatory care.



Community Tracking Study

Sites for In-Depth Study

Center for Studying Health System Change

The process of random selection ensures that the sites are representative of the U.S. population and protects against bias on the part of the researchers. The 12 high-intensity sites were selected randomly from those of the 60 sites that were metropolitan areas with more than 200,000 people.

Finally, surveys of a number of health system organizations will be conducted. These surveys will build on site visit information, permitting more depth and objectivity on selected issues and more breadth through a larger sample of respondents. Organization surveys and secondary data will be the source of information about organization of the health system in the 48 less intensively studied communities. Surveys of hospitals, physician groups, and health plans and insurers will be developed and fielded. An employer survey to be conducted by RAND and the Research Triangle Institute will obtain information on health insurance premiums, types of health plans offered, and employer strategies for purchasing health care coverage.

TRACKING CHANGES IN OUTCOMES

One way to look at the information collected from the data sources is by type of outcome. The following illustrates how Center researchers will track insurance coverage, access, service delivery, cost, and quality by using data from the household, physician, and employer surveys.

Insurance Coverage

Respondents to the household survey will be asked whether they are covered by insurance and, if covered, about certain attributes of their coverage. For example, do they have to use doctors from a defined list? Can they use other doctors without incurring an extra charge? Additional data on insurance—whether employers offer insurance and what kind of products they offer—will come from the employer survey. From this information, the Center can estimate and track over time the percent of the population that is insured and uninsured, and key characteristics of the insurance plans of those with coverage.

Access

The household survey will provide insights into traditional indicators of access, such as ease and convenience of obtaining health care services. From the physician survey, researchers will learn how readily physicians can refer patients to specialists, whether they accept Medicaid patients, and the amount of charity care they provide. Hospital discharge records also will be used to track access to health care services. For example, a high rate of hospital admission for

To track changes in health systems and outcomes, selected communities will be followed over time. Initial site visits began this spring; a second round is planned for 1988. The first reports based on the data will be published next year.

asthma can be used an indicator of poor access to primary care.

Service Delivery

Of all the changes taking place in the health system, changes in the delivery of care are the ones most likely to have an affect on people. The household survey will help track changes in how many times respondents see a doctor and the type of health services they get. The physician survey will provide indicators about the way medicine is practiced, including information about the scope of care provided and physicians' perceptions about the effect of managed care. Hospital discharge records will contribute to the changing picture of service delivery by providing information on rates for surgical procedures that vary widely in use by geography.

Cost

Changes in cost will be studied primarily from the perspective of payers. Data about premiums for private insurance and employees' share of premiums will come from the employer survey, and information about out-of-pocket expenses will come from the household survey. Premiums will be tracked by type of insurance, which will permit researchers to study the extent to which changes in overall premiums are due to shifts among types of insurance. Per capita Medicaid and Medicare expenditures will come from government data.

Quality

The household survey will provide answers to the personal side of quality of care: how satisfied are people with the care, what kind of preventive services do they get, and how do they rate their health status. The physician survey will collect physicians' perceptions of their ability to provide quality care. Other quality measures will come from hospital discharge records, including rates of fetal deaths, newborns with serious health conditions, and postsurgical complications.

TIMETABLE FOR WORK

To track changes in health systems and outcomes, the 60 communities will be followed over time. The initial site visits, conducted during the second half of 1996, will be followed up with telephone calls to key respondents and ongoing monitoring of local media and state policy. The second round of site visits is planned for 1998, with subsequent rounds at two-year intervals. Surveys also will follow a two-year cycle, with fielding beginning in 1996. Surveys of organizations will be conducted in 1997.

For the household and physician surveys, half of the 1998 sample will be respondents to the 1996 survey and half will be new. This mixed design is a compromise between using a pure longitudinal panel and surveying an independent cross-section each time. The longitudinal cohort permits analysis of change for individuals and institutions at two different times. The new cross-section ensures that the sample is representative of the community's population.

Center staff will prepare papers and reports with analyses sequenced according to data availability. The first reports, which will be published next year, will be site-specific descriptions of health system organization and patterns of change for the intensely studied communities. These will be followed by cross-site comparisons on particular issues such as the integration of health care delivery. A national baseline description of the high-intensity sites and the nation, scheduled for fall of 1997, will report data from the household, physician, and employer surveys on topics such as insurance coverage, access to care, service use, and satisfaction with care.

Data from the organization surveys and site visits will be used to describe local market characteristics, such as the extent of market consolidation and integration, by early 1998. These data will be analyzed along with data from the household and physician surveys to study individuals' experiences with the health system in markets that differ according to characteristics such as the extent of capitation and consolidation. ■

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