TRENDS & Ideas

PHYSICIANS

Tracking the Treatments

The hottest trend in the managed care market is the establishment of network-model and independent practice association (IPA)–model HMOs, which establish contracts with medical group practices and IPAs. In addition to assuming fiscal responsibility for providing care to a portion of the plan's members, the physician groups are also shouldering the responsibility for quality assurance (QA) activities, designed to assess and improve the quality of the care delivered.

But not all areas of QA are being equally addressed, according to Eve A. Kerr, MD, et al., writing in the *Journal of the American Medical Association.* During the winter of 1993-94, Kerr and her associates mailed questionnaires on QA activities to 133 physician groups that have capitated contracts with one of the largest network-model HMOs in California. They received responses from 94 (71 percent) of the groups, which care for 2.9 million capitated patients.

The researchers found that the groups monitored more areas associated with overuse—such as cesarean delivery and angioplasty—than areas associated with underuse—such as childhood immunizations and retinal examinations for diabetic patients. The groups also monitored underuse of preventive services more than they monitored follow-up services for patients with chronic diseases, and they used more reminders for preventive services than for follow-up services for patients with chronic diseases. The authors postulate that the emphasis on overused procedures may stem from financial incentives inherent in capitated care, while the focus on preventive services may be the result of the lack of adequate quality measurement tools for monitoring chronic disease care.

Although all the groups conducted some QA activities, the programs varied considerably in both focus and magnitude. The more profitable physician groups were associated with higher levels of QA activity, and groups that had been established for longer periods and had a higher percentage of capitated patients were also likely to perform QA at a high level. The authors conclude that "groups with solid foundations and a large stake in prepaid care are more likely to monitor and improve quality and that less well-established groups might need assistance in developing QA systems."

The authors recommend that further research focus on how capitated physician groups can expand their QA programs to include monitoring of underused procedures, especially for patients with chronic diseases. As they point out, this issue will become increasingly important as more elderly and chronically ill patients move into managed care environments.

ECONOMICS

Enterprise Zones—Expanding and Enticing

Enterprise zones and their offshoots, empowerment zones, appear to be here to stay—despite a lack of evidence that they are effective. Because they have proven to be politically attractive, some states now have a large percentage of areas where tax breaks, job-training classes, and government loans can be had. The empowerment zones created by Congress go even further, offering grants of up to $100 million for social programs and development efforts. So reports Justin Fox, writing in *Fortune* magazine.

The first enterprise-zone legislation was introduced in Congress 16 years ago. Since 1982, more than 40 states have enacted enterprise-zone laws. The idea, a British import in the late 1970s, was to establish troubled areas of a few big cities as "freeports," where bureaucracy, regulation, social services, and taxes would be minimal. But it proved politically impossible to exempt inner cities from safety regulations, minimum-wage laws, and the like, and enterprise-zone legislation soon consisted almost entirely of tax incentives.

States also began enlarging on the original targets, impoverished urban neighborhoods. Many extended enterprise-zone benefits to urban, rural, and suburban areas that were only slightly off economic par. More than 70 percent of Colorado is within the boundaries of an enterprise zone; Louisiana has 1,669 zones.

Although their proliferation is impressive and their economic lures enticing, it is difficult to know just how successful enterprise zones are. Enterprise zones in New Jersey and Indiana, where zone laws have been on the books since 1983, have been the subjects of studies, but the results have been inconclusive. Some surveys indicate sharp job gains in the zones, but other comparisons show that the zones have made little difference to either employment or property values.

But neither do they do harm. And as popular as they have proven to be, we can expect to see even more of them.

GERONTOLOGY

The Clash of Cohorts

What a supervisor might see as racial or ethnic animosity between two employees could actually be the result *of a difference in birth cohorts, writes* Julee Richardson in *Aging Today.*

"Cohort" is the term gerontologists use to describe people who, having been born within a 5- to 10-year span of one another, were affected by the same important historical factors. Because of this, such people are likely to share many similar attitudes, values, and behaviors.

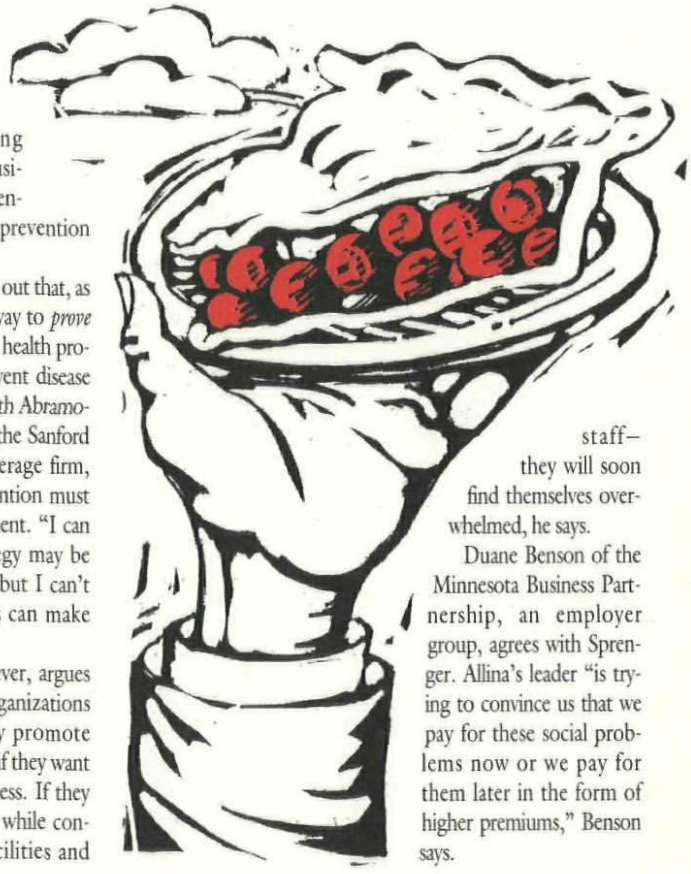
For example, members of a cohort whose values were formed during the Great Depression will probably always be wary of debt. Members of a post–World War II, baby-boom cohort, on the other hand, tend to be avid consumers who are used to living on credit. On financial issues, these two cohorts can be expected to frequently disagree.

Cohort issues are often seen in long-term care centers. A male resident who happened to be a Korean War veteran might, for instance, behave irrationally in the presence of an Asian-American staff member. A resident who had grown up in the segregated *South might act similarly with a staff* member who was African American. Such conflicts–perhaps exacerbated by pain and frustration on the part of the resident–are often only superficially racial; they may be better understood as the result of different historical experiences.

Cohort conflicts are also sometimes seen between younger and older nurses. Many older persons entered the profession in the days when, partly because it tended to be seen as a calling rather than a mere job, supervisors closely watched a nurse's personal appearance and behavior. Nurses trained in that era might well have trouble understanding today's more informal, apparently more irreverent young person who has become a nurse primarily because the work pays well.

PREVENTION

Pie in the Northern Sky?



Gordon M. Sprenger, the executive officer of Minneapolis-based Allina Health Systems, is a big believer in the adage about an ounce of prevention being worth a pound of cure. Under his leadership, according to Ron Stodghill II in *Business Week*, Allina is using social work and public advocacy to attack health problems at their source.

Allina's experimental prevention programs include:

- A free clinic at a local elementary school, where four Allina-paid nurses treat 400 pupils from mostly poor families. Allina hopes to involve parents in their children's care and thereby reduce expensive visits to hospitals and emergency rooms.
- An anti-teenage gang program in which Allina physicians collaborate with local police, counseling former gang members and removing their gang tattoos.
- A lobbying project in which Allina executives try to persuade state legislators to make cigarettes less accessible. By doing so, the executives hope to reduce smoking-related illnesses, which now cost Allina $36 million a year.
- Community assessments in which analysts employ data from schools, police, and state agencies to pinpoint the causes of injuries and illness. If such data were to indicate a possible flu epidemic, for instance, Allina could give vaccinations against influenza.

Nearly a dozen Minnesota employers have signed multi-year contracts with Allina's HMO, indicating that the state's business community tentatively backs the prevention philosophy.

But critics point out that, as yet, Allina has no way to *prove* that its community health programs actually prevent disease and injuries. Kenneth Abramowitz, an analyst at the Sanford C. Bernstein brokerage firm, believes that prevention must be left to government. "I can see how the strategy may be useful," he says, "but I can't see how hospitals can make money at it."

Sprenger, however, argues that healthcare organizations must aggressively promote community health if they want to remain in business. If they do not–especially while continuing to cut facilities and staff–they will soon find themselves overwhelmed, he says.

Duane Benson of the Minnesota Business Partnership, an employer group, agrees with Sprenger. Allina's leader "is trying to convince us that we pay for these social problems now or we pay for them later in the form of higher premiums," Benson says.