

## COMMENTARY

# The Benefits of Collaboration in Research: Who will Pay?

Barbara Dickey\*

*Department of Psychiatry, Harvard Medical School, McLean Hospital, 115 Mill Street, Belmont, MA, 02178, USA*

### Abstract

Collaboration between MCOs and researchers holds promise for benefiting consumers by working on quality-of-care-related research. There are at least three areas of collaboration that might benefit both researchers and MCOs: (1) the developing and validating of management and fiscal indicators, (2) developing and validating clinical indicators and (3) studying access to treatment for vulnerable populations. These three areas offer benefits to the MCO and unusual research opportunities for investigators. Barriers for both MCOs and researchers must be overcome before this work can be carried out, not the least of which is who will pay for the work to be done.

### The Benefits of Collaboration

In calling for new alliances between research and managed care organizations (MCOs), authors Goldman, Sturm and McCulloch also implicitly raise questions about the intersection between scientific research and information for the management of health care. They have discussed the barriers to such collaboration from the perspective of both researchers and the managed care companies. These barriers are indeed formidable, perhaps even greater than the authors imply. Feldman<sup>1</sup> has suggested that published research on managed care has little or nothing to do with how MCOs 'actually operate, what they do and how they could do it better' (p. 50).

These barriers will not be easily overcome unless researchers are working more closely with MCOs and in turn, MCOs become convinced of significant benefit from working with researchers. Such benefits, in this author's opinion, come from collaboration that promises to improve the quality of care, the point at which research and professional management interests intersect. The examples of collaboration provided by the authors led to support for legislation on insurance parity—in other words, policy-related research. In this particular case, time was a significant factor for congressional hearings and action. It is more

common for policy-oriented studies, using state or national databases, to take years, not months, for results to become available. As the authors quite rightly point out, this time lag may not be acceptable to the business world. Decisions about program management and strategic planning cannot wait for several years.

But in public-policy-related matters, some time lag may be unavoidable. The research carried out by the authors which is provided as an example of collaboration is of a very special variety. It was carried out under an unusually tight time schedule, and funded by the federal government. Unfortunately, neither of these special conditions is likely to be part of the kind of collaboration that the authors would like to see. If not, then under what conditions would MCOs find benefit in collaboration? And when would researchers feel the opportunity to work with MCOs enhances their academic portfolios?

There are at least three areas of collaboration that might benefit both researchers and MCOs: (1) the developing and validating of management indicators, such as risk adjusters, (2) developing and validating quality of care indicators, such as adherence to practice guidelines, and (3) specialized studies of vulnerable populations, such as the rate of denial for their treatment. These three areas offer benefits to the MCO and unusual research opportunities for investigators. As for MCOs, they need to manage their resources efficiently, ensure that providers offer effective treatment and provide prospective customers with quality of care data for marketing purposes. Moreover, investigators need to test hypotheses about the link between administrative data and clinical data in pilot studies that become the basis for larger, federally funded studies about quality of care. As the authors point out, both MCOs and researchers must be aware of and respect each other's perspective if the collaboration is to be fruitful.

### *Management Indicators and their Validation*

Managing care for MCOs is managing their resources. Administrative data are the primary source of financial accounts, data that are already heavily used in day to day operations. Research collaborators might be helpful in asking questions about how different management practices affect financial performance. Although these questions touch on

\* Correspondence to: Barbara Dickey, Ph.D. Associate Professor, Department of Psychiatry, Harvard Medical School, McLean Hospital, 115 Mill Street, Belmont, MA, 02178, USA  
Source of funding: none declared

the proprietary interests of MCOs, 'real world' data can and should be used to test economic theory. MCOs, in turn, should find some benefit in working with economists. For example, management might consider several approaches to reducing or increasing the number of outpatient visits for a particular population. Analyses that provide estimates of the financial effect of each possible choice would be helpful, especially if the research can bring sophisticated statistical analyses to bear on the data.

Another management need is to examine such efficiency measures as substitution of lower levels of care for higher levels, such as inpatient treatment. Decreases in inpatient admissions and increases in outpatient visits can be interpreted in a number of ways, not all of them to the benefit of the MCO. Careful analyses, by researchers who can bring special statistical techniques to bear on this question, can provide reassurance to the MCO that those most needing increases in outpatient visits are the ones who are getting them. Developing and testing the accuracy of risk adjustments are one of the major tasks that needs to be successfully completed before such analyses can be reported with confidence.

### *Quality of Care Indicators and their Validation*

Although there seems to be no movement away from purchasing care on the basis of price, it is hoped that quality of care will someday be a factor in the purchasing process. That will only happen, however, when data on measures of quality are available at the same speed and validity as cost data. We are a long way from being able to do that. Administrative data hold promise, but little has been done to date that can be useful in measuring quality of care. Performance indicators of continuity of care have been developed to do this,<sup>2</sup> but validation of these data, using clinical records or patient interviews, would strengthen the use of such methods.

Another aspect of quality is the selection of a provider network. MCOs are already using rough measures of efficiency in assessing their provider networks. Many providers question the 'profiling' approach,<sup>3</sup> but there has been little research to demonstrate that these rough indicators actually distinguish efficient (in both the short term and long term) providers from those who are inefficient. In fact, the whole notion of 'efficiency' must be balanced with 'effectiveness' but this effort is complicated by the lack of adequate risk adjustment techniques and sound research has not been reported. If we think of quality of care in the Donebedian framework<sup>4</sup> of structure-process-outcome, then selecting the best providers, one aspect of organizational structure, is clearly important. Selecting network providers by MCOs should be improved with collaborative research efforts.

A final (and especially complex) example of quality of care research is testing the effectiveness of practice guidelines. Which providers meet the standard? Do the patients they treat have better outcomes? We are just entering an era of more standardized practice of medicine, but it remains to be seen whether or not such standardization improves the health of the general population. What better way to

learn more than to enter into collaboration with MCOs willing to implement guidelines, test adherence to them and measure the impact on patient outcomes?

### *Specialized Studies of Vulnerable Populations*

MCOs are often called on to defend their treatment of high-risk vulnerable groups of beneficiaries. Critics worry that these high-risk groups are more likely to be denied access to appropriate care, receive lower-quality care or be discouraged from filing grievances if they believe their care is inadequate. To avoid such criticism, MCOs need to carry out special studies to demonstrate that vulnerable groups are treated appropriately. Such studies might well benefit from research that brings multiple methods to bear, combining secondary data analysis with ethnographic studies, surveys or other primary data collection efforts.

### **Who Will Pay?**

There is no mention in the Goldman article about who will foot the bill for all these admirable collaborative efforts. Competition for business means keeping administration and other overhead expenses down, making significant outlays for research by MCOs unlikely. Researchers themselves are unlikely to invest, in any significant way, in time and effort needed to plan and carry out the type of analysis outlined above. State governments are not a likely source, either, although some state agencies that are in a contractual relationship with an MCO may be willing to subsidize some of this work. The federal government, through one of several research grant mechanisms, is a possible source of funds, although, as we pointed out above, pilot data are needed to demonstrate feasibility and the potential for promising findings. At best, funding might be patched together, incrementally. It is likely that those MCOs and researchers who find it in their mutual best interests to collaborate will also find some way to begin working together, then use that work to leverage more funding, which then results in work that is the basis for additional funding. Hard work, if you can get it. But, I agree with the authors that such collaborations are the key to our understanding and improving how behavioral health care is delivered. In bringing to our attention the possibilities that exist in MCO databases, they will also spur creative thinking about how such collaborations might be supported.

### **References**

1. Feldman S. Strangers in the night: research and managed mental health care. *Health Affairs* 1999; **18**: 5.
2. Dickey B, Normand SL, Norton EC, Azeni H, Fisher W, Altaffer F. Managing the care of schizophrenia: lessons from a four-year Massachusetts Medicaid study. *Arch. Gen. Psychiatry* 1996; **53**: 945-952.
3. Bindman AB. Can physicians profiles be trusted? *J. Am. Med. Assoc.* 1999; **281**: 2142-2143.
4. Donebedian A. *Explorations in quality assessment and monitoring* Vol. 1. Ann Arbor, MI: Health Administration Press, 1980.