To...

Cc...

Bcc...

Subject: Primary Care e-Letter

Attachments:

Welcome to the Primary Care e-letter. We are launching the Primary Care e-letter to stimulate discussion on the current crisis and opportunities for innovation in primary care. You're being invited to subscribe to this monthly newsletter and participate in discussions about the abstracted journal articles and e-letter editorials. In this message, you'll find an original editorial "thought piece" as well as citations and abstracts on important topics in primary care.

What is the current crisis in primary care? Few medical students are entering primary care residencies; primary care clinicians are overwhelmed with too many responsibilities for acute, chronic and preventive care; and primary care practices are facing growing expenses with stagnant reimbursement.

What are the opportunities for innovation in primary care? Many primary care clinics and practices are trying out new ideas: scheduling same-day appointments, implementing the chronic care model, creating a team approach to care, experimenting with group visits, substituting phone and electronic encounters for some face-to-face visits, and trying to make life more manageable for caregivers in primary care.

The Primary Care e-letter, sent every month to interested clinicians and policymakers concerned with primary care, will 1) provide citations and abstracts of important policy articles from about 20 publications, and 2) solicit "thought pieces" from primary care innovators to stimulate provocative dialogues (or multilogues). Primary Care e-letter subscribers will be able to send responses to the article abstracts or thought pieces; selected responses will be published in the next e-letter.

Thanks to the following reviewers who scanned the journals for November to identify articles for all of us: Kate Colwell, Sean Gaskie, Margaret Handley, Khati Hendry, Mike Potter, Joe Roll and Bill Shore.

If you'd like to subscribe to this managed list, please reply to this e-mail.

Regards,

Tom Bodenheimer, MD
Editor, Primary Care e-letter
University of California San Francisco

Kevin Grumbach, MD
Chair, Dept of Family & Community Medicine
University of California San Francisco

The Primary Care e-letter is a project of the Center for Excellence in Primary Care and the UCSF Collaborative Research Network, and represents a collaboration between UCSF Department of Family and Community Medicine and The Permanente Medical Group

Primary Care e-letter editorial:
Physicians: we can't do it all. It's time to delegate

Physicians practicing in primary care face a wrenching dilemma. On the one hand, we believe in the founding principles of primary care: first contact care for

individuals and families, continuity of care, comprehensive care, and coordination of care throughout the entire spectrum of the health system. On the other hand, we cannot make good on our beliefs, which means that we frustrate ourselves and our patients.

The way primary care is organized - whether in a small office, a large hospital clinic, or an integrated delivery system - subverts the very principles on which primary care was founded. It is difficult to provide first contact care on a timely basis; from 1997 to 2001, the percentage of people unable to obtain a timely appointment rose from 23% to 33% [1]. To offer true continuity of care, we would need to work at least 40 hours per week - if not 24/7, in direct patient contact, a burden that would stress us out and burn us out in short order. In order to keep ourselves sane, many of us are working fewer hours, thereby diluting continuity of care. Comprehensive care -- acute care, chronic care, preventive care, and supportive care - cannot be done. Two recent studies tell us that it would take 7.4 hours per day to provide all indicated preventive care and another 10.6 hours to properly manage chronic conditions for a patient panel of 2,500 [2,3]. On average, physicians are providing only 55% of what evidence-based guidelines require [4]. Coordination of care has become a time-consuming challenge, with different health plans contracting with different labs, imaging centers and specialists, each mandating different and ever-changing drug formularies.

What should we do? 30 years in community primary care practice convinced me that primary care physicians should no longer be responsible for routine chronic and preventive care. We are experts in acute care, complex chronic care, acute-on-chronic, and unusual exceptions to routine chronic and preventive services. Rather than spending 15 minutes trying to do it all, we should see fewer patients per hour, spend more time with each patient, and delve deeply into the difficult problems that we were trained for. To allow such a transformation, other members of our team should be trained, and delegated the responsibility for, routing preventive services and the management of routine, stable chronic conditions such as hypertension, diabetes, dyslipidemia, asthma, and osteoarthritis. As physicians, we should have time available to mentor and consult with our team members. But we should no longer be responsible for the long list of routine tasks required for evidence-based prevention and chronic conditions management.

Is such a change easy to implement? Not at all. The first problem is us. On the one hand, physicians complain that there is too much work, not enough time, and too much stress. On the other hand, if someone suggests that we delegate tasks to non-physicians, we often respond: "Only I can do it." Let's get over it! If we train and provide oversight to nurses, pharmacists, health educators, or medical assistants to perform clearly defined chronic and preventive care tasks, they can do it as well as we do it (because in many cases, we don't do it.)

Tom Bodenheimer, November 2005

November 2005 Primary Care e-letter Abstracts

Baumgart DC. Personal digital assistants in health care: experienced clinicians in the palm of your hand? Lancet 2005 Oct 1: 366(9492):1210-22

Physicians and other health-care professionals are rapidly adopting personal digital assistants (PDA). Palm pilots and other hand-held computers are also increasingly popular among medical students. PDAs can be used for medical student education and physician training, daily clinical practice, and research. PDAs and their increasing integration with information technology in hospitals could change

the way health care is delivered in the future. But despite the increasing use of PDAs, evidence from well-designed research studies is still needed to show how much these devices can improve the quality of care, save patients' lives, and ultimately reduce health-care expenses. In this Review of PDA use in health care, the operating systems, basic functionality, security and safety, limitations, and future implications of PDAs are examined. A personal perspective and an introduction to medical PDA applications, software, guidelines, and programmes for health-care professionals is also provided.

CMS Announces Voluntary MD Quality Measures Reporting Program
California Healthline

California Healthline is published daily for California Health Care Foundation by The Advisory Board Company. © 2004 The Advisory Board Company. All Rights Reserved.

October 31, 2005

CMS <http://www.cms.hhs.gov/default.asp?> Administrator Mark McClellan on Friday announced a new voluntary program for physicians to self-report adherence to certain evidence-based quality measures, CQ HealthBeat reports. Under the first phase of the program, beginning in January, physicians will be able to submit data on 36 quality measures for Medicare beneficiaries, including giving beta blockers to patients experiencing a heart attack and screening elderly patients for falls.

The measures were developed by physicians, physician organizations and quality-of-care experts, such as the National Quality Forum <http://www.qualityforum.org/> and the RAND Corporation <http://www.rand.org/>. Physicians will not receive higher compensation for reporting the measures, and results will not be made public.

McClellan said that physicians might be interested in participating because they will be informed about how their performance compares to that of their peers. McClellan added that there is a trend of moving toward "pay-for-performance" programs in the public and private sectors.

Advancing health care information technology and connecting Medicare providers' reimbursements to quality of care are "top health care legislative priorities" and are seen as a way to stop rising government spending on health care and upgrade quality of care, according to CQ HealthBeat.

"We don't think the administrative burdens will be large" in the new program, McClellan said, adding that there "could well be" a link between reporting data and receiving higher Medicare payments next year depending on congressional action this year.

The American Physical Therapy Association <http://www.apta.org/AM/Template.cfm?Section=Home> said it would like to see the voluntary program expanded to include physical therapists and other nonphysician groups.

"The transition to a payment system that assures high quality, effective health care services is vitally important to the beneficiaries that physical therapists serve under the Medicare program," APTA President Ben Massey said (CQ HealthBeat, 10/28).

Nagykaldi Z, Mold J, Aspy C. Practice Facilitators: A Review of the Literature. Family Medicine 2005; 37 (8): 581-8.

BACKGROUND: Practice facilitators (PFs) are health care professionals who assist primary care clinicians in research and quality improvement projects. Although they have been used in Europe and Australia for more than 20 years, the concept is relatively new in the United States. The recent evolution of primary care practice-based research networks (PBRNs) has led to greater awareness and expansion of this concept. Objectives: This study's objective was to review the literature on PFs and describe their origin, training, funding, roles, methods they use, and their impact on patient care outcomes in primary care. METHODS: We searched four electronic databases from 1966 through the present, reviewing all articles pertaining to PFs in an effort to understand the history, training, financing, roles, methods, and impact of PFs. RESULTS: Since the early 1980s, PFs have worked with individual practices on relationship building, education, and quality improvement (QI), particularly in the area of prevention. A number of publications provide information on the roles of PFs in primary care and methods they use to enhance practices. Many prospective, uncontrolled studies and a few randomized, controlled trials have documented the effectiveness of PFs but usually in combination with other interventions. A number of primary care PBRNs in the United States have begun to use PFs as a way to bridge the gap between research and practice. Limited information has been published about the training and funding of PFs. Conclusions: The PF concept seems to be a useful practice enhancement approach in primary care.

<< OLE Object: Picture (Metafile) >> Rosenthal MB, Frank RG, Li Z, Epstein A. Early Experience With Pay-for-Performance: From Concept to Practice. JAMA. 2005 Oct 12;294(14):1788-93.

Context The adoption of pay-for-performance mechanisms for quality improvement is growing rapidly. Although there is intense interest in and optimism about pay-for-performance programs, there is little published research on pay-for-performance in health care.

Objective: To evaluate the impact of a prototypical physician pay-for-performance program on quality of care.

Design, Setting, and Participants We evaluated a natural experiment with pay-for-performance using administrative reports of physician group quality from a large health plan for an intervention group (California physician groups) and a contemporaneous comparison group (Pacific Northwest physician groups). Quality improvement reports were included from October 2001 through April 2004 issued to approximately 300 large physician organizations.

Main Outcome Measures Three process measures of clinical quality: cervical cancer screening, mammography, and hemoglobin A1c testing.

Results Improvements in clinical quality scores were as follows: for cervical cancer screening, 5.3% for California vs 1.7% for Pacific Northwest; for mammography, 1.9% vs 0.2%; and for hemoglobin A1c, 2.1% vs 2.1%. Compared with physician groups in the Pacific Northwest, the California network demonstrated greater quality improvement after the pay-for-performance intervention only in cervical cancer screening (a 3.6% difference in improvement [P = .02]). In total, the plan awarded $3.4 million (27% of the amount set aside) in bonus payments between July 2003 and April 2004, the first year of the program. For all 3 measures, physician groups with baseline performance at or above the performance threshold for receipt of a bonus improved the least but garnered the largest share of the bonus payments.

Conclusion Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those

with higher performance at baseline.

Wolff JL <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Search&term=%22Wolff+JL%22%5BAuthor%5D>, Boult C <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Search&term=%22Boult+C%22%5BAuthor%5D>. Moving beyond round pegs and square holes: restructuring Medicare to improve chronic care. Ann Intern Med. 2005 Sep 20;143(6):439-45.

Department of Health Policy and Management, Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland 21205, USA. jwolff@jhsph.edu

Chronic disease is the norm rather than the exception among Medicare beneficiaries, yet Medicare's benefit structure and reimbursement mechanisms are poorly aligned with high-quality chronic care. This disconnect is thought to undermine the quality of chronic care, thereby contributing to excess program spending and placing beneficiaries at risk for undesirable health outcomes. Despite widespread recognition of this mismatch, there is little compelling evidence to suggest that successful quality improvement initiatives would reduce the costs of the Medicare program. This paper describes state-of-the-art chronic care innovations to date, discusses ongoing and planned efforts by the Centers for Medicare & Medicaid Services to test related changes to Medicare's benefit structure and provider reimbursement, and suggests opportunities for future progress in this area.