
February 2006 e-letter featured article

Most family physicians are experiencing an increasing time crunch. In these two companion articles, we start with a 'model family practice' including 2500 patients with an age and gender distribution, and with disease rates, similar to those of the US general population. We present data summarizing the time required to meet current guideline recommendations for preventive services and for chronic disease care.

Our estimates show that the amount of physician time needed to meet current clinical recommendations far exceeds the office time available. Based on analyses of national clinical care guidelines, the time needed to sufficiently address prevention and chronic disease in the model practice would require 18 working hours a day. That does not leave a lot of time for acute care!

We believe that a strong primary care system is central to improving health on a population level. The dilemma of not enough time adds further evidence that the American system of primary care requires broad, fundamental changes. We believe that academic medical centers should take the lead in the design and testing of new models of care, with the end goal of improving rates of primary care service delivery.

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Ostbye T, Yarnall KS, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Annals of Family Medicine* 2005;3:209-214

PURPOSE: Despite the availability of national practice guidelines, many patients fail to receive recommended chronic disease care. Physician time constraints in primary care are likely one cause. **METHODS:** We applied guideline recommendations for 10 common chronic diseases to a panel of 2,500 primary care patients with an age-sex distribution and chronic disease prevalences similar to those of the general population, and estimated the minimum physician time required to deliver high-quality care for these conditions. The result was compared with time available for patient care for the average primary care physician. **RESULTS:** Eight hundred twenty-eight hours per year, or 3.5 hours a day, were required to provide care for the top 10 chronic diseases, provided the disease is stable and in good control. We recalculated this estimate based on increased time requirements for uncontrolled disease. Estimated time required increased by a factor of 3. Applying this factor to all 10 diseases, time demands increased to 2,484 hours, or 10.6 hours a day. **CONCLUSIONS:** Current practice guidelines for only 10 chronic illnesses require more time than primary care physicians have available for patient care overall. Streamlined guidelines and alternative methods of service delivery are needed to meet recommended standards for quality health care.

Yarnall KS, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? Am J Public Health 2003;93:635-641.

OBJECTIVES: We sought to determine the amount of time required for a primary care physician to provide recommended preventive services to an average patient panel.

METHODS: We used published and estimated times per service to determine the physician time required to provide all services recommended by the US Preventive Services Task Force (USPSTF), at the recommended frequency, to a patient panel of 2500 with an age and sex distribution similar to that of the US population. **RESULTS:** To fully satisfy the USPSTF recommendations, 1773 hours of a physician's annual time, or 7.4 hours per working day, is needed for the provision of preventive services.

CONCLUSIONS: Time constraints limit the ability of physicians to comply with preventive services recommendations.

February 2006 e-letter abstracts

Reforms To Primary Care System Needed, Report States

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The U.S. primary care system requires immediate reforms, according to a report released on Monday by the American College of Physicians. The report "The Impending Collapse of Primary Care Medicine" can be found on www.acponline.org/hpp/statehc06.htm?hp

The report recommends reforms in how primary care is delivered, financed, organized and valued. According to the report, the number of primary care physicians who retire currently exceeds the number of PCPs who graduate from medical school, in large part because of decreased income, increased costs and more demands from health insurers. "Primary care is on the verge of collapse," ACP said in a statement, adding, "Very few young physicians are going into primary care, and those already in practice are under such stress that they are looking for an exit strategy."

According to ACP, PCPs -- "the bedrock of medical care for today and the future -- are at the bottom of the list of all medical specialties in median income compensation." The report recommends new reimbursement practices for Medicare and private health insurers that would place PCPs in charge of patient care and provide patients with more responsibility for their own health. The report also recommends that Congress revise the formula Medicare uses to determine the value of physician services. In addition, the report recommends that physicians receive reimbursements when they use e-mail to consult with patients on minor and routine issues to help reduce the number of expensive office visits (*Reuters/Houston Chronicle*, 1/30).

This highly-significant report pulls no punches. Anyone interested in primary care should read it.

Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, Taylor R. **Can electronic medical record systems transform health care? Potential health benefits, savings, and costs..** *Health Aff (Millwood)*. 2005 Sep-Oct;24(5):1103-17.

To broadly examine the potential health and financial benefits of health information technology (HIT), this paper compares health care with the use of IT in other industries. It estimates potential savings and costs of widespread adoption of electronic medical record (EMR) systems, models important health and safety benefits, and concludes that effective EMR implementation and networking could eventually save more than \$81 billion annually—by improving health care efficiency and safety—and that HIT-enabled prevention and management of chronic disease could eventually double those savings while increasing health and other social benefits. However, this is unlikely to be realized without related changes to the health care system.

Lang E, Afilalo M, Vandal AC, Boivin JF, Xue X, Colacone A, Leger R, Shrier I, Rosenthal S. **Impact of an electronic link between the emergency department and family physicians: a randomized controlled trial.** *CMAJ*. 2006 Jan 31;174(3):313-8. Epub 2006 Jan 6.

BACKGROUND: Electronic information exchange is believed to improve efficiency and reduce resource utilization. We developed a Web-based standardized communication system (SCS) that enables family physicians to receive detailed reports of their patients' care in the emergency department. We sought to determine the impact of the SCS on measures of resource utilization in the emergency department and family physician offices. **METHODS:** We used an open 4-period crossover clusterrandomized controlled design. During 2 separate 10-week intervention phases, family physicians received detailed reports of their patients' emergency department visits over the Internet, and in the alternating control phases they received a 1-page copy of the emergency department notes by mail. The primary outcome was the number of repeat visits to the emergency department within 14 days of the initial visit. Secondary outcomes included duplication of test and specialty consultation requests by the emergency and family physician. Outcomes were measured using the hospital database and questionnaires sent to the family physicians. **RESULTS:** A total of 2022 patient visits to the emergency department from 23 practices were used in the study. Use of the SCS failed to reduce the number of repeat visits to the emergency department within 14 days (odds ratio [OR] 1.10, 95% confidence interval [CI] 0.8-1.51) and 28 days (OR 1.01, 95% CI 0.8-1.27). There was no significant duplication of requests for diagnostic tests between the emergency and family physician during the intervention and control phases (24 v. 22, $p=0.93$), but there was significantly greater duplication in specialty consultation requests in the intervention phase than in the control phase (20 v. 8, $p=0.049$). **INTERPRETATION:** An electronic link between emergency and family physicians did not result in a significant reduction in resource utilization at either service point. Investments in improved electronic information exchange between emergency departments and family physician offices may not be substantiated by a reduction in resource utilization.

Schoen C, Osborn R, Huynh PT, Doty M, Zapert K, Peugh J, Davis K. **Taking The Pulse Of Health Care Systems: Experiences Of Patients With Health Problems In Six Countries.** Health Aff (Millwood). 2005 Nov 28; [Epub ahead of print]

This paper reports on a 2005 survey of sicker adults in Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States. Sizable shares of patients in all six countries report safety risks, poor care coordination, and deficiencies in care for chronic conditions. Majorities in all countries report that mistakes occurred outside the hospital. The United States often stands out for inefficient care and errors and is an outlier on access/cost barriers. Yet no country consistently leads or lags across survey domains. Deficiencies in transition care during hospital discharge and coordination failures among patients seeing multiple physicians underscore shared challenges of improving performance across sites of care.

Schoen C, Osborn R, Huynh PT, Doty M, Davis K, Zapert K, Peugh J. **Primary care and health system performance: adults' experiences in five countries.** Health Aff (Millwood). 2004 Jul-Dec;Suppl Web Exclusives:W4-487-503.

This paper reports on a 2004 survey of primary care experiences among adults in Australia, Canada, New Zealand, the United Kingdom, and the United States. The survey finds shortfalls in delivery of safe, effective, timely, or patient-centered care, with variations among countries. Delays in lab test results and test errors raise safety concerns. Failures to communicate, to engage patients, or to promote health are widespread. Aside from clinical preventive care, the United States performs poorly on most care dimensions in the study, with notable cost-related access concerns and short-term physician relationships. Contrasts across countries point to the potential to improve performance and to learn from international initiatives.

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