



A collaboration between the Department of Family and Community Medicine, University of California, San Francisco, and The Permanente Medical Group

FEATURED ARTICLE

Interview with Dr. Charles Burger

One of the most impressive primary care private practices in the nation can be found in Bangor, Maine. For over 20 years, Dr. Charles Burger has adopted one practice innovation after another. Tom Bodenheimer (TB) has visited Dr. Burger's practice and has had several discussions with Charles Burger (CB) regarding his practice. These are highlighted in interview format.

TB: Can you briefly describe your practice?

CB: It was formerly an independent practice and is now owned by the Eastern Maine Health Care System. Caring for about 5500 active patients from a variety of socio-economic backgrounds, the practice is financially stable with about 250 patient visits per week. About 60% of the patients are commercially insured, almost 30% are Medicare, 8% Medicaid and 3% self-pay. The practice has some of the highest marks in the state on patient satisfaction and clinical outcome measures. Staff turnover is very low. The practice is fully computerized and we have adopted a version of advanced access scheduling.

TB: Who is on your practice team?

CB: Two physicians including myself, one nurse practitioner, one RN, an office manager, 6-7 Patient Representatives, and 4 medical assistants. Overall, we have 3.4 support staff per clinician.

TB: I have watched the Patient Representatives on the telephone; can you describe their roles in the practice team?

CB: They serve 4 distinct functions: telephone work, greeter, scheduler, and in-basket manager. Let's talk about the telephone (front office) job. This is one of the most difficult tasks in a medical office. I have developed a tool called the "triage coupler." When a patient calls and reports his/her symptom, the patient representative, using the coupler on her computer, assesses the patient's complaint. The coupler contains questions that assess hundreds of symptoms covering the gamut of primary care. Its function is to allow the Patient Representative to rapidly determine when and where the patient should be seen, who should see the patient, how much time to allow, and whether other testing should be done before the patient is seen. For instance, a patient with a thunderclap headache or chest pain with nausea and vomiting may be sent directly to the emergency room by ambulance. A patient with cough for a month may be sent for an x-ray prior to the visit. When uncertainty exists, a provider is consulted. The coupler has a medication refill function with numerous standard treatment protocols, for example automatic treatment of a person with strep exposure and sore throat, or treatment of uncomplicated urinary tract infection in females.

TB: In my private practice, we used to put newly-hired receptionists on the phone after 2 hours of training.

CB: That's not how we do things here. We train Patient Representatives for an average of 6 weeks before they are ready to answer patient calls. Some learn faster, some slower. The front desk coordinator does much of the training in a daily one-on-one process.

TB: How about the other functions of the Patient Representatives?

CB: Greeter is a relatively simple job, involving registering the patient, obtaining or updating insurance information, and making sure the patient knows how to fill out his/her medical history. As Schedulers, they meet with

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patients after the visit, schedule diagnostic tests, referrals, and obtain insurance authorizations. However, providers schedule their own follow up visits, lab tests and simple x-rays in the examination room with the patient, so that many patients go from the exam room directly out the door. Patients leave the visit with a printed copy of the visit progress note and a complete list of medications. The practice did a survey and found that 85% of patients read the visit note when they arrive home.

The other Patient Representative task is to manage clinicians' in-baskets on computer desktops. Electronic messages come into the practice bringing labs and radiology results, information from other physicians and home care agencies, and directly from patients via secure e-mail. In addition, intra-office messages are an important part of team communication. If crucial information does not get into the proper hands to be acted on, serious errors can take place. We have protocols for who is authorized to handle which kinds of messages and to whom messages should be forwarded. For example, all patients are notified of normal and abnormal lab and x-ray results within 24 hours; Patient Representatives can inform patients of normal or some mildly abnormal results. To assure quality care, it is necessary to document what happened to all lab and x-ray studies ordered: did the patient actually do the study, did the appropriate person in the office see the results and do something about them, did the patient get the results, was a plan made for dealing with abnormal? Multiplying this process by all diagnostic studies ordered makes in-basket management a huge project. Second to the telephone triage role, the in-basket work requires substantial training time.

Each Patient Representative is cross-trained to master all 4 functions. Depending on the needs of each day they rotate from one function to another plus fill in where needed. Flexibility – shifting gears quickly – is a necessary quality of a patient representative.

- TB: Could we go back to something you said – that the Patient Representatives make sure the patient knows how to fill out the medical history. Are you saying that patients take their own histories?
- CB: Patients are members of the primary care team. Their job is filling out the medical history, both the past medical history and the present illness. Depending on the symptom, the patient accesses one of many present illness questionnaires and enters the answers to the questions. The completed questionnaire goes into the office computer system and is available to the clinician in the exam room. Patients can complete the questionnaires via internet from home or on a personal computer or electronic tablet in the waiting room. This history is one component of a computerized clinical decision tool we use for both diagnosis and management (Problem Knowledge Couplers). When physical examination is added, this tool assists providers in determining the etiology of the problem by presenting the entire array of diagnostic options for that unique patient situation, no matter how uncommon. It therefore minimizes the various defects in cognitive functioning we are all prey to. It further standardizes inputs so that the same information is collected on a given problem each time it presents.
- TB: How do medical assistants function in your practice?
- CB: They do the traditional things of rooming patients, vital signs, and keeping the flow going smoothly. In addition, they are cross-trained to do the Patient Representative job, they do medication reconciliation, and they may order routine chronic and preventive care studies. They may assist patients who have a hard time inputting their medical histories. For a period of time, medical assistants were trained to perform parts of the physical exam, using the same training principles as the Patient Representative training: direct observation and performance. This worked fine but some patients preferred the clinician to handle that part of the visit.
- TB: Do you have planned visits for patients with poorly controlled chronic conditions?
- CB: Our preferred chronic disease model is a RN planned visit tied to a clinician visit. In this model, for example, patients with diabetes spend 40 minutes with the RN who orders the proper labs, does foot exams, refers for eye exams, engages the patient in behavior change counseling and provides patient education. The clinician pops in for a 5-minute visit to complete the appropriate physical examination and define medication management. The physician/RN plan is documented by the RN. The RN also does chronic disease self-management support by telephone, is initiating group visits, and works the registry. The registry includes most chronic illnesses and is tied to a central data warehouse which allows the practice to receive performance data compared with similar data from other practices around the country.

TB: What do you see as the major barriers preventing other offices from emulating what you have accomplished?

CB: One is training – this is the key to a successful team. But perhaps most important is the scope-of-work conception that limits what different staff people can do by professional degree or educational certification rather than by competency based on performance evaluation. There is no reason why a Patient Representative cannot advise a patient, based on the triage coupler protocols, to get a chest x-ray before coming to the office -- as long as she receives training, mentoring and competency evaluation. Nor is there any logical reason why a medical assistant could not be trained to listen to a patient's lungs, since listening to lungs does not require courses in anatomy, physiology, biochemistry, pathology or pharmacology that make up medical school curriculum. The innovation-stopping effects of the legal system and of professional territoriality continue to haunt primary care team formation.

ABSTRACTS

We asked Dr. Leif Solberg, one of the authors, to introduce these first two articles on the implementation of the chronic care model in Minnesota. They were published last year in the Annals of Family Medicine.

Chronic Care Model Implementation Study Lessons

Leif I. Solberg, MD

These two articles demonstrate several important lessons for those who would transform medical practice as called for in the Future of Family Medicine REPORT. The first lesson is the importance of systematically studying major efforts in real life practices to improve care, or as we prefer to call it "Optimizing practice through research." It is unfortunately not easy to obtain timely grant funds for such studies, but if more and better proposals are submitted, it will help. A related lesson that is not so apparent in these papers (which did benefit from timely grant funds) is the importance of evaluating and publishing quality improvement work. In order to make that possible, we must collectively find solutions to the barriers that editors and institutional review boards often place in the way of such publication. A third lesson is the importance of utilizing both qualitative and quantitative methods in research studies of practice change, what is called multi-method research. Fourth is the need by medical practices for more specific guidelines for improvement than are provided by such overall conceptual frameworks as the Chronic Care Model, useful though they might be for thinking about the types of changes needed. Finally, the qualitative study highlights the need to pay as much attention to the change process as to the new practice care process. Real change is hard work, and it needs every possible advantage if it is to succeed.

Challenges of change: a qualitative study of chronic care model implementation

Hroschikoski MD, Solberg LI, et al. Challenges of change: a qualitative study of chronic care model implementation. *Ann Fam Med.* 2006 Jul-Aug;4(4):317-26.

ABSTRACT

PURPOSE: The Chronic Care Model (CCM) provides a conceptual framework for transforming health care for patients with chronic conditions; however, little is known about how to best design and implement its specifics. One large health care organization that tried to implement the CCM in primary care provided an opportunity to study these issues.

METHODS: We conducted a qualitative, comparative case study of 5 of 18 group clinics 18 to 23 months after the implementation began. Built on knowledge of the clinics from a previous study of advanced access implementation, data included in-depth interviews with organizational leaders and varied clinic personnel, observation of clinic care processes, and review of written materials.

RESULTS: Relatively small and highly variable care process changes were made during the study period. The change process underwent several marked shifts in strategy when initial efforts failed to achieve much and bore little resemblance to the change process used in the previously successful large-scale implementation of advanced access scheduling. Many barriers were identified, including too many competing priorities, a lack of specificity and agreement about the care process changes desired, and little engagement of physicians.

CONCLUSION: These findings highlight specific organizational challenges with health care transformation in the absence of a blueprint more specific than the CCM. Effective models of organizational change and detailed examples of proven, feasible care changes still need to be demonstrated if we are to transform care as called for by the Institute of Medicine.

Care quality and implementation of the chronic care model: a quantitative study

Solberg LI, et al. Care quality and implementation of the chronic care model: a quantitative study. *Ann Fam Med.* 2006 Jul-Aug; 4(4):310-6.

ABSTRACT

PURPOSE: We wanted to test whether improvements in care quality were correlated with changes in the Chronic Care Model (CCM) in a large medical group that attempted to implement the CCM.

METHODS: The leaders of 17 primary care clinics in this medical group completed the Assessing Chronic Illness Care (ACIC) survey measure of CCM implementation before and after care system changes were made. We used administrative data to measure care quality changes for yearly samples of patients with diabetes, coronary heart disease, or depression.

RESULTS: The total ACIC score for the CCM increased by an overall average of 1.4 points (from 5.8 to 7.2 on a scale of 1 to 11, $P = .02$) and significant increases occurred for 3 of the 6 components of the CCM. During this time, patients experienced a significant increase in the proportion meeting a composite outcome measure for low-density lipoprotein (LDL) and glycated hemoglobin levels (from 15.7% to 25.5%, $P = .001$). Heart disease patients meeting a composite measure for LDL values increased from 46.8% to 57.8%, and the percentage of patients with 1 or more cardiac events dropped from 17.2% to 11.4% ($P = .001$ for each). Persistent use of new antidepressants did not change, but more of these patients had follow-up visits ($P = .02$). Only the diabetes measure was significantly correlated with 2 CCM elements-clinical information systems and decision support.

CONCLUSION: Despite implementation of the CCM and improvements in quality measures for 3 chronic diseases, there were few significant correlations between these changes. Showing such a relationship may require larger changes, a larger number of clinics, changes in other CCM elements, or a more-sensitive measurement tool.

Practice-based research – “Blue Highways” on the NIH roadmap

Westfall JM, et al. Practice-based research – “Blue Highways” on the NIH roadmap. *JAMA.* 2007 Jan 24;297(4):403-6.

In this article, the authors argue for the importance of practice-based research and its role in bridging the gap between medical discovery and patients. The article begins with a discussion of the new NIH Roadmap that focuses attention on the need to “translate” basic research more quickly into clinical practice for the benefit of patients. The authors discuss the myriad of barriers to translation of research from bench to practice and the lack of current funding and research to answer the fundamental questions necessary to bring scientific discovery to widespread use in primary care. The authors then discuss practice-based research networks, outline the NIH Roadmap and identify a third translational step, involving research in ambulatory clinical practices, that is absent in the NIH framework. This third step seeks to solve the problems encountered by primary care physicians as they incorporate new discoveries into clinical practice. Dr. Westfall and colleagues argue that without translation to ambulatory practice, individual patient care will not change, and they present the expansion of practice-based research as a potential solution to this problem. Practice-based research and practice-based research networks can 1) identify problems that arise in daily practice and bridge the gap between recommended care and actual care, 2) demonstrate whether treatments with proven efficacy are truly effective and sustainable when provided in the real-world setting of ambulatory care, and 3) provide the “laboratory” for testing system improvements in primary care to maximize the number of patients who benefit from medical discovery. The article then further discusses the utility of practice-based research as the “final common pathway for improving individual patient care and outcomes.” It concludes by emphasizing the collaboration between academic institutions and community clinicians through practice-based research networks to ensure that biomedical discoveries are translated past academic medical center and that unanswered questions of day-to-day clinical practice are answered.

Saving primary care

Rueben DB. Saving primary care. Am J Med. 2007 Jan;120(1):99-102.

In this article, Dr. Reuben, clearly delineates the crisis facing primary care, describing the exodus from primary care and the reasons behind it. He then recommends 7 steps that the profession, health care systems, academic medicine, governmental agencies and insurers can take to save primary care including:

1) discard the artisan model – relinquish the antiquated model of what a primary care physician is supposed to do so that the job description can be modified to make it more appealing 2) promote a new vision of primary care physicians as specialists in the comprehensive care of the patient – the quarterback and team leader, rather than a decathlete 3) fundamentally change the work of primary care physicians by applying systems approaches including information systems, decision support, integration of quality improvement into the patient care process, and delegation of patient care tasks to lower-level providers; thus primary care physicians will have time to rediscover the pleasure of talking to patients and being their advocates 4) expose students and residents, during their training, to desirable primary care practices that use systematic approaches and efficient health care delivery models and role models who practice primary care medicine for a living and enjoy it 5) accommodate the busy lifestyles of physicians outside of their careers by exploring creative solutions such as shared practices 6) recognize the impending crisis for health care that primary care physician shortages present and create loan repayment programs and other incentives to enter primary care 7) reform the reimbursement system to better compensate primary care physicians and reduce the income gap between generalists and sub-specialists

It ain't necessarily so: the electronic health record and the unlikely prospect of reducing health care costs*

Sidorov J. It ain't necessarily so: the electronic health record and the unlikely prospect of reducing health care costs. Health Aff (Millwood). Jul-aug;25(4):1079-85.

**Note: this article was brought to our attention by the Editorial and Author's response that follows this abstract.*

ABSTRACT

Electronic health record (EHR) advocates argue that EHRs lead to reduced errors and reduced costs. Many reports suggest otherwise. The EHR often leads to higher billing and declines in provider productivity with no change in provider-to-patient ratios. Error reduction is inconsistent and has yet to be linked to savings or malpractice premiums. As interest in patient-centeredness, shared decision making, teaming, group visits, open access, and accountability grows, the EHR is better viewed as an insufficient yet necessary ingredient. Absent other fundamental interventions that alter medical practice, it is unlikely that the U.S. health care bill will decline as a result of the EHR alone.

a) Shumaker P. System change, then EHRs. Health Aff (Millwood). 2006 Nov-Dec;25(6):1745; Author's reply 1745.

Comment by Patrick Shumaker

In his paper on the unlikely prospect of cost savings from electronic health records (EHRs) (Jul/Aug 06), Jaan Sidorov should have noted that the fundamental problem with EHRs, electronic medical records (EMRs), and clinical information systems (CIS) is the belief that implementing them will cure the variety of quality and process issues facing health care organizations. These systems are simply enabling tools; the benefits come only from real improvement in the way organizations work. Without investing in real changes to work processes and operating systems, EHRs, EMRs, and CIS investments are essentially worthless.

Author's Reply by Jaan Sidorov

My thanks to Patrick Shumaker for emphasizing an important point that I tried to communicate in my paper. In the last paragraph, I pointed out that the greatest promise of EHRs is to support a number of popular health care initiatives, such as disease management, the chronic care model, and group visits. The same could be said, however, of the effect of EHRs on any clinical quality and process improvement program. If properly configured, and then supported and used in the right environment, EHRs and their variants have great potential to enable real benefits for patients and their health care providers. My review of the literature suggests that although the potential is there, we have yet to make it happen consistently. Until it does, absent accompanying systematic changes, I cannot blame many of my clinician-colleagues for using the word "worthless" to describe the value of EHRs.

A comparison of outcomes resulting from generalist vs. specialist care for a single discrete medical condition: a systematic review and methodologic critique.

Smetana GW et al. A comparison of outcomes resulting from generalist vs. specialist care for a single discrete medical condition: a systematic review and methodologic critique. Arch Intern Med. 2007 Jan 8;167(1):10-20.

ABSTRACT

Background: Studies of clinical outcomes for generalist vs specialist care for diagnoses within a specialist's narrow domain have tended to favor specialty care.

Methods: A MEDLINE search from January 1, 1980, through April 1, 2005, and a hand search of retrieved bibliographies of English-language studies that compared generalist vs specialist care for individual patients with a single discrete medical condition were performed. Two reviewers determined eligibility for each study and abstracted data onto a standardized instrument.

Results: A total of 49 articles met our inclusion criteria: 24 studies favored specialty care, 13 found no difference in outcomes, 7 varied by individual outcome, 1 depended on physician experience, and 4 favored generalist care. Only 8 studies reported integration into health delivery systems, 4 considered physician experience, 3 documented information technology support, and 2 considered the impact of care management programs. Selection bias was adequately addressed in 58% of studies that favored specialty care and in 71% of studies that found no difference or favored generalist care ($P = .52$). Studies that favored specialty care were less likely to consider 4 key, potentially confounding physician or practice characteristics compared with studies that found no difference or favored generalist care (3% vs 15% of potential instances, respectively; $P = .009$).

Conclusions: The literature regarding the influence of generalist vs specialist care on outcomes for patients with a single discrete condition suffers from important methodologic shortcomings. Further research is needed to inform health care policy as it pertains to the optimal role of generalists and specialists in the physician marketplace.

Studies comparing quality of care by specialty: valid, relevant, or neither?*

O'Malley PG, O'Malley AS. Studies comparing quality of care by specialty: valid, relevant, or neither? Arch Intern Med. 2007 Jan 8;167(1):8-9

**Note: We have included this article in its complete version sans references. This editorial was published in the same issue as a review (not included in this e-letter) by Smetana et al that compared outcomes from generalist versus specialist care.*

**Studies Comparing Quality of Care by Specialty
Valid, Relevant, or Neither?**

It is not a question of how well each process works, the question is how well they all work together.¹

Everyone likes a good game. It seems that even professional societies in the field of medicine also like to compete, as there is continued publication of reports of specialty comparisons on quality of care. If you believe the numbers, it seems like the subspecialists are beating the generalists. Even among generalists, there is competition. One might argue whether the playing field can ever be fair in the first place, but a more important question might be why are we playing this game at all? One thing is clear, our patients are certainly not gaining anything by this type of comparative

research when there are larger health care delivery problems on which the performance of any specialty is intrinsically dependent.

In this issue of the ARCHIVES, Smetana et al² expertly summarize and appraise the landscape of research on the differences in quality of care by specialty. They found that a majority of the studies demonstrate that specialists perform better in the care of those individual diseases within their purview (though not by much) but that there are major shortcomings in the quality of the research, specifically in the observational nature of the designs and failure to adequately control for selection bias. While their article includes the elements of a good systematic review, there are significant concerns about inferring useful conclusions about actual quality of care from the studies reviewed. The first concern regards their validity, and the second concern is whether such studies are relevant, given the challenges to quality of care posed by the broader context of our health care system.

VALIDITY

There are many reasons why we should take a skeptic's view of research in this area. These include study design and the potential for confounding (resulting from selection bias and other factors), publication bias, and the choice of individual disease measures used to determine "quality" of care.

The studies reviewed were largely observational (of the 49 studies only 2 were randomized controlled trials). Nonrandomized allocation of type of provider for the management of a medical condition leads to inherent differences between groups. The comparisons are among groups of physicians whose patient populations differ greatly in terms of number of comorbid conditions, severity of the index condition, demographics, resources, geography, socioeconomic status, and access to care. Even the best case-mix adjustment, propensity score analysis, clustered analysis, and other statistical techniques make it difficult to rule out confounding in these studies.

A second issue is publication bias. Since we are only privy to published post hoc analyses, it would not be surprising that analyses that show no differences (or worse outcomes) might never have made it to manuscript form, never mind even to an editor's desk. The available literature in this systematic review may be biased toward more studies that have shown a difference in quality, though this would be hard to prove. Third, even if the differences in the particular disease-specific outcomes measured are reliable, they are not necessarily valid indicators of the quality of care for the whole patient in terms of the sum of his or her care across conditions and settings. In other words, what is not being measured? For generalists, patients normally present for care, not with a labeled diagnosis, but rather with symptoms and undifferentiated problems amidst their ongoing comorbid conditions. These people need comprehensive care by a physician skilled in the diagnosis and ongoing management of a wide range of conditions and who is also particularly skilled in communication and care coordination. Generalist physicians are trained to manage disease within the context of a patient's other comorbid health and psychosocial problems. In managing a chronic condition concurrently with multiple comorbid conditions, it is not always appropriate to follow guidelines on which the quality measure for the comparison study is being based.³ Thus, comparative studies such as those reviewed in the article by Smetana et al² set up an "unfair playing field" in that they compare generalist to specialist care for 1 particular condition under the purview of the specialist. This approach makes no more sense than would comparing specialists and generalists on the total quality of a patient's comprehensive care when that is in the purview of the generalist rather than of the specialist.

RELEVANCE

A larger concern than the validity of such studies, however, is whether they are relevant, given the broader context of our health care system. First, the rationale for such studies is weak and has been largely driven by professional societies' self-interest and competition during the managed care era when specialists had a financial interest in claiming that they provided primary care. Second, there are much larger systemic issues around the structure and processes of care that directly affect what generalists and specialists can do to provide patients with quality care. Larger issues include lack of universal access to primary care; a looming primary care workforce shortage and ongoing physician maldistribution⁴⁻⁵; the fragmentation of care that results from absence of an integrated system of care; perverse incentives created by current physician reimbursement mechanisms; and a lack of incentives for physicians to coordinate care.

Health care delivery in the United States is highly fragmented and has become increasingly specialist driven as a result of numerous factors including increased ability of patients to self-refer and a reimbursement system that

rewards the provision of costly procedural and diagnostic services, regardless of their cost-effectiveness. Combined with this, the disparity in pay for generalists compared with specialists has contributed to the looming primary care workforce shortage and lack of available access to primary care in many areas.⁶ Patients want primary care providers competent in providing comprehensive care, and such comprehensive management results in higher quality of care.⁷⁻⁸ Patients also value continuity of care and an ongoing relationship with a provider.⁹⁻¹⁰

To better understand how we can move our health care structures and processes toward more patient-centered, high-quality care, we need to further examine how to improve care integration and coordination across conditions and settings. Studies on the quality of care should measure whether a patient receives comprehensive and continuous care, ideally by a physician skilled in comprehensive care, with a rational and systematic referral process to specialists for care of particularly difficult or severe conditions as needed.¹¹ Aligning financial reimbursement that is commensurate with patients' needs would be an important step in solving some of these problems.

Demonstration projects should test models for revised physician reimbursement to determine which models foster care coordination across conditions, physicians, and settings. Collaborative and coordinated care has the potential to improve quality and to be cost-effective.¹²⁻¹⁴ We also need to focus on creating the structures and processes that facilitate generalist-specialist comanagement to ensure seamless information flow and coordination of care.

Until we have these basic systems in place (integration of care, equal access to basic and subspecialty care, and restructuring of reimbursement to encourage care coordination rather than care fragmentation), we should rethink the value of comparative studies by specialty, which tend to be divisive and distracting, even if it is possible to perform such a study in a valid way. We have a responsibility to patients to focus our attention on the larger issues of access, care coordination, and collaborative patient management. Let the games stop! And let's get serious about studying and improving our entire system more than merely focusing on comparing individual elements of care delivery within a dysfunctional system. We believe that this is more likely to lead to better integrated structures and processes and better patient outcomes.

On the front Lines of Care: primary care doctors' office systems, experiences, and views in seven countries

Schoen C, et al. On the front Lines of Care: primary care doctors' office systems, experiences, and views in seven countries. *Health Aff (Millwood)*. 2006 Nov-Dec;25(6):w555-71. Epub 2006 Nov 2.

This 2006 survey of primary care physicians in Australia, Canada, Germany, New Zealand, the Netherlands, the United Kingdom, and the United States reveals striking differences in elements of practice systems that underpin quality and efficiency. Wide gaps exist between leading and lagging countries in clinical information systems and payment incentives. U.S. physicians are among the least likely to have extensive clinical information systems or incentives targeted on quality and the most likely to report that their patients have difficulty paying for care. Disease management capacity varies widely. Overall, findings highlight the importance of nationwide policies; Policy changes in the United States could lead to improved performance.

The quality of chronic disease care in U.S. community health centers

Hicks LS, et al. The quality of chronic disease care in U.S. community health centers. *Health Aff (Millwood)*. 2006 Nov-Dec;25(6):1712-23.

Community health centers (CHCs) are responsible for providing care for more than fifteen million Americans, many of whom are members of groups who have been documented to receive low-quality care. This study examines the quality of care for patients with chronic disease in a nationally representative sample of federally funded CHCs. Fewer than half of eligible patients received appropriate care for the majority of indicators measured, and uninsured patients received poorer care than insured patients. Although the quality of chronic disease care in CHCs compares favorably with that of care received in other settings, gaps in quality were observed for the uninsured.

IN THE NEWS

Doctor morale shaky as practice stressors surge

Adams, Damon. Doctor morale shaky as practice stressors surge. American Medical News. 2007 January 15.

In this article, the author describes the effects of increased stressors and declining physician morale, based on an American College of Physician survey of 1,200 physician executives -- most of whom see patients -- about their morale. The results, published in the November/December issue of *The Physician Executive*, showed that low reimbursement rates and loss of autonomy were the top two reasons for poor morale. Bureaucratic red tape, patient overload, loss of respect and the medical liability environment were among the other reasons physicians cited. These work problems caused fatigue in 77% of physicians, emotional burnout in 67% and marital/family discord or depression in about one-third of physician respondents. To combat these problems, more than half of these physicians talked to colleagues about their morale problems, one-third searched for a job outside of health care, and others received counseling or sought relief by lobbying for changes in the health care system. The article concludes with ideas on how physicians can deal with these stressors in their individual lives.

Unmet expectations: Doctors, patients give each other mixed reviews

Damon, Adams. Unmet expectations: Doctors, patients give each other mixed reviews. American Medical News. 2007 January 29.

The author highlights a new, nationwide Consumer Reports survey of 39,090 patients and 335 primary care physicians in the February issue of Consumer Reports. The results showed that patients and physicians disagree on key issues. The article offers suggestions on how to improve the patient-doctor relationship. In the Consumer Reports study, issues that were raised by patients were long wait times and short consultations with the doctor. Physicians complained that patients do not follow treatment and request unnecessary tests and prescriptions. The report also detailed differing perspectives of doctors and patients on drug ads, internet information and adherence to treatment plans. For example, nearly all patients said they completely or mostly obeyed doctor's orders, but 59% of physicians said their patients often failed to stick to treatment plans. Based on the results, Consumer Reports told patients to: bring limited and credible health information from the Internet to the doctor, prepare a short list of questions, speak frankly about symptoms, follow doctor's order, and change physicians if unsatisfied. The magazine admitted that its survey of subscribers might not be representative of the population. Physicians saw the report as an opportunity to dialogue with patients about the doctor-patient relationship and explore ways to make it a better union; better communication is essential.

Walgreens plans to expand in-store clinics

Chin, Tyler. Walgreens plans to expand in-store clinics. American Medical News. 2007 January 29.

This article describes Walgreen's foray into in-store, urgent care clinics. Walgreen Co. announced on January 10th that it would expand the number of in-store clinics from 50 to 252 by the end of August, 2007. These "retail" clinics are generally operated by outside contractors that have a nurse practitioner or physician assistant seeing patients for minor problems with an on-call physician back-up. The clinics are a relatively new business model that tailors to minor urgent care needs of individuals in the retail setting. Some focus on offering a narrow set of services and work to get insurers to cover the services; others offer a larger number of services, including wellness and prevention, to reach a wider customer base. Walgreens' version is one example of this increasingly popular model.

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Contact Us

For comments, questions, or suggestions, please email us at ezres@fcm.ucsf.edu.

If you have interest in becoming a reviewer for the **e-letter**, there are still a number of publications left. Please send an e-mail to Clemens Hong at clemenshong@gmail.com.