CENTER FOR EXCELLENCE IN PRIMARY CARE

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

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In This Issue

FEATURED ARTICLE

Interview with Dr. Devin Sawyer

Providence – St Peter Family Medicine Residency Program, Olympia, Washington

Clemens Hong MD, editor of the Primary Care e-letter, interviewed Dr. Devin Sawyer to discuss his innovation – the mini-group visit

CH: Can you describe the St. Peter Family Medicine (SPFM) Clinic?

DS: It's a University of Washington family practice residency program-affiliated clinic at Providence St. Peter Hospital. It's staffed by 6 Family Physicians, 3 Nurse Practitioners, 1 Social Worker, an OB/GYN, a Pediatrician and 18 family medicine residents. A Medical Assistant (MA)-based support staff is made up of 18 MAs, 3 managerial nurses, and an RN office manager. We have a team of 2-3 MAs for 2 providers in clinic on most days. The patients closely resemble the Olympia community: primarily Caucasian, with smaller South Pacific Islander, Southeast Asian, and Mexican populations. The payer mix is about half Medicaid, a third private insurance, 10% Medicare, and 8-9% uninsured.

CH: Please describe your intervention, the mini-group visit, in more detail.

DS: The Mini-group visit morphed slowly out of larger diabetic group visits that I started as part of a community improvement project during residency. In a Mini-group visit, I see 3 diabetic patients simultaneously over an hour long visit. The three patients are scheduled in 20-minute slots, but come at the same time. The same group returns together for follow-up each time, and these visits can take the place of individual visits. That is, patients may not be seen again individually unless something else is going on. We bill for the three visits individually. The Mini-group conserves the patient-doctor relationship and is not that different from a regular visit.

The group is prepped ahead of time with individual pre-visits several weeks before their Mini-group visit appointment. During these planned visits, patients are seen by an MA. The MAs have a standing order set that instructs them to draw labs and do healthcare maintenance via an algorithm. The MA goes down a check list and orders labs, makes referrals, and gives immunizations. They also work with patients to make self-management goals. By the time of the Mini-group visit, all data, including lab work, is available in a registry. From this registry a summary of clinical info for the past 2 years is generated for the physician to evaluate and use before and during the group visit.

The visits take place in a small conference room. Before the patients arrive, I put each patient's name on a dry erase board with their HbA1C, LDL, weight change, and medications. I circle the important markers for each patient. The Mini-group visit is divided roughly into three parts. The first part is open-ended. I let the patients lead the way. In the second part, I refocus the discussion on the markers on the board – asking what they think about them. The patients help each other problem solve, teach each other, support each other and discuss the issues at hand. In the third part, I try to bring back the story they shared at the beginning, and bring closure with an action planning process for each patient. These action plans include any medication changes we have agreed to make and any patient self-management goals they have committed to. These action plans are documented in the EMR. The MA then follows-up with patients on the action plans by phone several weeks later.

CH: It sounds like your MAs do much more than the typical MA. They work both before and after the visit. Are they involved in the actual Mini-group visit, as well?

DS: Yes, they definitely are. The MA – usually the same one that performed the planned visit for each of the three patients – is present at the visit and serves as a scribe. They take notes that are used later in the EMR note. The MA transcribes what is on the dry erase board and, along with the provider, documents the session in each of the patient's electronic charts. When med changes are agreed upon during the session, the MA documents this in the note. It goes further than that, though. The MA is able to fax any medication changes directly to the pharmacy during the Mini-group visit so that medications are ready to pick up when the Mini-group visit is over!

CH: What was it like training them to do all this work?

DS: This took some time. First we ran a couple of focus groups and surveys with the MAs just to make sure the providers and MAs were on the same page. Then, with the help of Jan Wolfram, a diabetes educator, we morphed the existing patient diabetes curriculum into a concise 8 hr curriculum for the MAs. This provided them knowledge and some much needed confidence. Each of our 18 MAs went through the classes. This was followed by some specific skills training done by our lead MA that covered CDEMS Registry use, planned visit skills, patient phone support, and group visit support.

CH: How do you manage to maintain continuity among MAs for their planned visits?

DS: Some of the planned visits are done at 8:15 am and 1:15 pm before the provider session starts. Others are actually "double booked" into the provider schedule and done at the same time a provider is seeing patients. These can be challenging to do with the time crunch and multitasking that often comes with supporting a provider in clinic. Now, most of the MA planned visits are done during planned visit clinics which consist of 10 slots one afternoon and one morning each month. MAs schedule their own patients. One extra MA is assigned to the planned visit clinic each half day. All MA's perform their regular duties until their patients arrive for the planned visit. The extra MA then covers them so that each MA can see their respective patients. The planned visits are billed as a medical visit. All activities are pre-approved by the providers with their signature on the standing orders and the EMR note. They are billed accordingly based on the medical care provided, the onsite blood draw, and the immunizations given.

CH: What are the advantages of the Mini-group visit?

DS: Where to begin? There are so many advantages. Having one hour to spend with three patients changes the dynamics of the visit considerably. Patients begin to share their frustrations, their

successes, their barriers with each other, and a collaborative relationship begins to develop with the provider. Patients begin "owning" the medical plan because the decisions that are made are not just told to them but crafted by them with guidance from the provider. This increases the likelihood that patients follow through. The prep work done before the visit gives the provider the information they need for medical management. The perception of extra time allows the patients to participate, and the provider is able to be more non-directive with the treatment plan and counseling options. The provider stops telling the patient what to do. You see the benefits of the model when patients return with the same group three or four times. The patients go from passive "what do you want me to do, doc" responses to proactive participants in their own care. They start to really tell me what they think. They support and teach each other too. Teamwork is developed. They even remember each other's action plans. For example, Carol is a patient with diabetes and depression and sees me with two other patients in a Mini-group visit. The same three patients have been meeting with me this way for the last 2 years. To combat her isolation and loneliness Carol set an action plan to reconnect with her church. At the next Mini-group visit Polly, one of the other 2 patients, asked Carol what it was like going back to church. Self-efficacy, autonomy, active participation, and self confidence are all better. The patients love it.

From the doctor's standpoint, you are more likely to achieve recognized clinical guidelines because you have labs and data ahead of time, you have the MA working with you to "bridge the gap" between you and the patient, and you have the patients working together to a common goal of contributing to their care and "owning" their diseases.

From a practical standpoint the patient self-management action plans are entered into the EMR and registry by the MA and can be followed longitudinally over time. For each visit the last four goals are printed out and available to share with the patients at each visit. The MA can prompt the computer to send a flag to themselves as a reminder to call each patient two weeks after the Mini-group visit so that they can follow-up with each of the action plans.

CH: Although you stated earlier that the Mini-group visit isn't all that different from the standard patient-doctor visit, it really sounds like a pretty drastic shift for some. What are the challenges to seeing three patients at once?

DS: Time management is a challenge. That is why I try to break the visit up into parts; 20 minutes for open discussion, 20 minutes for reviewing medical care, and 20 minutes to wrap up. This structure helps me stay on task. When I precept residents in their Mini-group visits sessions (a part of their residency curriculum) they often get 45 minutes into the visit without addressing the medical issues or getting to the self-management plans. The patient's energy and need to share their stories with each other takes over. It is important to remember that these visits can be fun for the patients, providers, and MAs.

There are occasional challenges in group dynamics, as well. For instance, once, we unfortunately paired a fairly well-controlled schizophrenic with two other diabetic patients, but he had a particularly bad day with increased paranoia, and things did not go very well. On another occasion we had two 40'ish year old working men paired with an 80 year old woman who was hard of hearing. You can imagine they had few things in common. Also, on occasion, we have had "talkers" that tend to take over the conversation paired with "the silent types" that let them. When deciding whom to pair up you need to have some caution with those who suffer from real mental illness. You also have to be careful with patients who have nothing in common. Lastly it is important to have some skill with group discussion so you are able to deal with the "talkers" and "quiet types" so that each member of the group can participate and contribute.

CH: What about confidentiality?

DS: Confidentiality has not been a significant issue. Patients are eager to meet other people and they want to share their problems. They also take pride in being able to play a small role in each other's care. We do have consent forms that each patient signs at each mini-group visit. We have had them reviewed to assure they are HIPPA compliant.

CH: What were the barriers to implementing this?

It takes a cultural change and a lot of prep work on the part of the provider. The planned visits are essential, and the summary data is helpful in preparing for the visits. It may be difficult to apply this model to a typical acute care practice that is very busy. They may not be ready for this. It's better to start on a small scale with Plan-Do-Study-Act (PDSA) cycles – one provider, three patients and one MA that thinks it's a good idea. You try it once knowing that it probably won't work the first time but you will learn from the experience. The MAs are key in that they are often the best at identifying appropriate patients for the group. It started off slow and there are still only a few faculty seeing patients like this. Residents cycle through as part of their curriculum and we hope they continue it in their own practices.

CH: What results have you seen as a result of your innovation?

The Mini-group visit was part of a bigger diabetes intervention. We have some very encouraging observational data that looks at longitudinal data over a four-year period that includes HbA1C and LDL. We were able to demonstrate 0.5 point reduction in HbA1C after implementation of the diabetes chronic care program within the first 16 months. There was a drop in mean LDL from 113 to 101 in the entire practice during the four years for patients who had at least 2 LDL's measured at least 12 months apart. It's unclear which components of the chronic care intervention caused these effects. The Mini-group visits may have played a role. I believe having patients "own" the medical plan improves adherence to treatment. Also, the planned visits allowed for labs to be completed ahead of time allowing providers to more readily prescribe statins. In addition, statins have been easier to start because there are other patients in the room taking them that give testimony to their benefits. They convince each other.

We also looked at participants with at least 7 planned visits or group visits and 10 goals/action plans in the registry. 42 patients met this criteria by the end of the four-year project. We tracked their average HbA1c over the four-year period and noted a positive divergence away from the mean 12 months into the project. This difference persisted throughout the project compared to average HbA1c of the entire practice.

CH: What is the next step? Are you trying this with other chronic diseases?

Sure, in my head there are lots of other ideas. My sense is that this is much more than just diabetes. A group of three 50-year old men with no medical problems but in need of preventive health visits would make a fantastic Mini-group visit. So would three young women who want to quit smoking. The trick is getting the infrastructure and time to do this, and getting docs and staff to come out of the comfort zone and try it. If we tried this in too many groups of folks here, the staff would implode. Right now we are just trying to get the diabetes program to stick. At Providence St. Peter, in order to spread this to other populations, diseases, and to disease prevention we will need to find resident leaders to champion these ideas and take us to the next level.

ABSTRACTS

Bodenheimer T, Berenson R, Rudolf P. The primary care-specialty income gap: why it matters. *Ann Intern Med.* 2007 Feb 20;146(4):301-6.

Abstract
A large, widening gap exists between the incomes of primary care physicians and those of many specialists. This disparity is important because noncompetitive primary care incomes discourage medical school graduates from choosing primary care careers. The Resource-Based Relative Value Scale, designed to reduce the inequality between fees for office visits and payment for procedures, failed to prevent the widening primary care-specialty income gap for 4 reasons: 1) The volume of diagnostic and imaging procedures has increased far more rapidly than the volume of office visits, which benefits specialists who perform those procedures; 2) the process of updating fees every 5 years is heavily influenced by the Relative Value Scale Update Committee (RUC), which is composed mainly of specialists; 3) Medicare's formula for controlling physician payments penalizes primary care physicians; and 4) private insurers tend to pay for procedures, but not for office visits, at higher levels than those paid by Medicare. Payment reform is essential to guarantee a healthy primary care base to the U.S. health care system.

Smith MD. Disruptive innovation: can health care learn from other industries? A conversation with Clayton M. Christensen. *Health Affairs Web Exclusive*, March 13, 2007.

Abstract
Clayton Christensen is one of America's most influential business thinkers. A professor at Harvard Business School, Christensen is perhaps best known for his writings on disruptive innovation in such books as The Innovator's Dilemma and The Innovator's Solution. In this interview with California HealthCare Foundation CEO Mark Smith, he argues that the answer for more affordable health care will come not from an injection of more funding but, rather, from innovations that aim to make more and more areas of care cheaper, simpler, and more in the hands of patients. Christensen has been an adviser to several new companies in health care.

Lester H, Hobbs FD. Major policy changes for primary care: potential lessons for the US new model of family medicine from the quality and outcomes framework in the United Kingdom. *Fam Med.* 2007 Feb;39(2):96-102

Abstract
The Future of Family Medicine project in the United States has identified a series of core values and a New Model of practice for family medicine aiming to transform the health and health care of the nation. There are, however, few empirical examples of its effectiveness and acceptability in practice. Recent experiences of changes to primary health care in the United Kingdom (UK), particularly the introduction of the Quality and Outcomes Framework, which rewards practices for delivering evidence-based care, may provide some useful lessons for practitioners and policy makers as they implement aspects of the New Model. In this paper, the authors, who lead the Expert Review of the Quality and Outcomes Framework, critique the five characteristics of the New Model that offer the most relevant learning points for both health care systems and reflect on lessons for both clinicians and policy makers, highlighted by the experience of implementing policy change in the UK. They suggest that incremental implementation, underpinned by robust pilot data and in-depth understanding of the influence of motivation on performance, are key and conclude that sharing issues that have worked well, and less well, are important in helping both countries develop good quality patient care.

Wilson JF. Lessons for health care could be found abroad. *Ann Intern Med.* 2007 Mar 20;146(6):473-6.

Summary
In this article, Jennifer Wilson compares and contrasts the U.S. health care system with other health care systems abroad. The author discusses the development of international health care benchmarks that allow the comparison of health markers between countries. She emphasizes the increasing opportunities to learn from other countries and argues that this emerging field of international research could provide countries with a new perspective on health care delivery. She goes on to use the examples of the electronic medical records and the value of primary care worldwide to illustrate these points, concluding that the lessons learned from studying international health care benchmarks are likely to be valuable in guiding health care reform.

Bohmer R. The rise of in-store clinics--threat or opportunity? *N Engl J Med.* 2007 Feb 22;356(8):765-8.

Summary
In this perspective piece, Richard Bohmer discusses the growth of in-store clinics. He notes the appeal to multiple stakeholders including payers, patients, and entrepreneurs and contrasts this with the concerns of physicians who have expressed concern over the quality of care at these clinics and the potential impact on their businesses. The author describes the "menu" based services (see table – taken from the article) provided and the benefits of the model, including: relatively low cost, convenience, and short waiting times of the visits. Next, he raises concerns about quality of care caused by lack of continuity and concerns that nurse practitioners, operating by rigid protocols, may miss opportunities to diagnose and address concomitant health issues. Dr. Bohmer then discusses the implications of in-store clinics on three issues in the future design of primary care delivery.

1. In-store clinics remove less sick patients from primary care practices resulting in revenue loss in practices that rely on income from simple cases to subsidize the cost of more time-consuming appointments, but benefit other practices due to improved access to care for their patients.
2. In-store clinics place patients in a new role as self-diagnosticians. The clinic's highly engineered models of care make them very sensitive to misclassification, and delay in diagnosis for some.
3. In-store clinics, in their current form or through integration into primary care practices and emergency departments, may partially alleviate the impending crisis caused by reduced physician supply and increased demand for health care by an aging population

In conclusion, Dr. Bohmer argues, "Whether or not this model becomes a permanent feature of the health care landscape, the thinking behind – in terms of operating-system alignment, alternative approaches to stratification and capacity creation, and the patient's role – may well influence the design of future delivery systems." He emphasizes the importance of building effective relationships with local primary care doctors to ensure continuity of care.

Sommers LS. Practice inquiry: clinical uncertainty as a focus for small-group learning and practice improvement. *J Gen Intern Med.* 2007 Feb;22(2):246-52.

Abstract
PROBLEM: Many primary care physicians in nonacademic settings lack a collegial forum for engaging the clinical uncertainties inherent in their work. PROGRAM DESCRIPTION: "Practice Inquiry" is proposed as a set of small-group, practice-based learning and improvement (PBLI) methods designed to help clinicians better manage case-based clinical uncertainty. Clinicians meet regularly at their offices/clinics to present dilemma cases, share clinical experience, review evidence for blending with experience, and draw implications for practice improvement. From 2001 through 2005, Practice Inquiry was introduced to sites in the San Francisco Bay Area as a demonstration effort. Meeting rosters, case logs, a feedback survey, and meeting field notes documented implementation and provided data for a formative, qualitative evaluation. PROGRAM EVALUATION: Of the 30 sites approached, 14 held introductory meetings. As of summer 2006, 98 clinicians in 11 sites continue to hold regularly scheduled group meetings. Of the 118 patient cases presented in the seven oldest groups, clinician-patient relationship and treatment dilemmas were most common. Clinician feedback and meeting transcript data provided insights into how busy practitioners shared cases, developed trust, and learned new knowledge/skills for moving forward with patients. DISCUSSION: Ongoing clinician involvement suggests that Practice Inquiry is a feasible, acceptable, and potentially useful set of PBLI methods. Two of the Practice Inquiry's group learning tasks received comparatively less focus: integrating research evidence with clinical experience and tracking dilemma case outcomes. Future work should focus on reducing the methodological limitations of a demonstration effort and examining factors affecting clinician participation. Set-aside work time for clinicians, or other equally potent incentives, will be necessary for the further elaboration of these PBLI methods aimed at managing uncertainty.

Lin D, et al. Improving diabetes management – structured clinic program for Canadian primary care. *Canadian Family Practice.* 2007 Jan;53:73-7.
Available at: www.cfpc.ca/cfp

Abstract
PROBLEM BEING ADDRESSED: Adherence to diabetes treatment guidelines is often poor in primary care.
OBJECTIVE OF PROGRAM: To introduce simple accessible interventions in our clinic to improve both physicians' adherence to diabetes treatment guidelines and patient outcomes.
PROGRAM DESCRIPTION: A physician and a nurse practitioner used 3 interventions for diabetes care: 30-minute appointments, reminder telephone calls to patients, and standardized flow sheets. Evaluation of this structured program found that, after 3 years, these interventions had improved primary caregivers' adherence to diabetes care guidelines and several physiologic parameters in patients with diabetes (compared with outcomes of patients managed with the usual less structured approach).
CONCLUSION: This program improved delivery of diabetes care in our clinic. We believe a similar approach could help other physicians and nurse practitioners in primary care practices increase their adherence to guidelines and improve the clinical outcomes of their patients.

IN THE NEWS

Complete article from California Healthline

Safeway Traces Lower Health Costs to Preventive Care Plan
February 12, 2007

An employee health plan offered by supermarket chain Safeway that focuses on preventive care reduced company health care costs by 11% for nonunion employees in 2006, the San Francisco Chronicle

reports.

The plan, which was offered in January 2006 to the company's nonunion workers, includes a $2,000 deductible and limits out-of-pocket spending to $3,000 for family coverage. Out-of-pocket costs partially are offset by a company contribution of $1,000 to a health reimbursement account for the household, and unused funds in the HRA are rolled over to the next year.

The plan, administered by Cigna, covers all preventive care services that are appropriate for a beneficiary's age group. It also offers a 24-hour hot line staffed by registered nurses, services to help people manage chronic conditions and incentives designed to promote healthier lifestyles, among other benefits.

According to the Chronicle, "None of these ideas is new or earth-shattering," but "while many companies have adopted a few of these approaches to cut costs and promote health, Safeway seems to be trying almost everything at once."

Safeway CEO Steve Burd has spoken about the plan to more than 300 executives during the past three months. He said, said, "What is the revelation Safeway had two years ago that completely transformed our thinking? That 50 [%] to 60% of all health care costs are driven by behavior," adding, "If you design a health care plan that rewards good behavior, you will drive costs down."

This year, about 71% of the company's nonunion employees are enrolled in the plan, and Burd estimates that 95% will enroll in the plan next year.

However, Glenn Melnick, a RAND economist and professor of health economics at the University of Southern California, questioned whether the decline in health costs was the result of offering a lower-cost health plan and whether the lower costs would continue. He added, "The experience in the first year may not represent the steady state."

Burd noted that nearly all of the savings generated in the program's first year came from changing the plan design. However, he said that even if spending remained flat, as is projected for the coming year, the company still would be ahead of the trend in providing health care to workers.

Arnold Milstein, chief physician of Mercer Human Resource Consulting, said, "Any time you see a multipronged attack, it is not unusual for there to be a savings. What is quite challenging is to attribute those savings to one intervention versus another" (Colliver, San Francisco Chronicle, 2/11).

Excerpt from the American Medical News

PROFESSIONAL ISSUES
Rethinking physicians' training in chronic disease management
Ten medical schools are developing curricula and will offer classes in the fall.
By Bonnie Booth, AMNews correspondent. Feb. 26, 2007.

Most experts agree that medical education needs a major revision so that future physicians are best able to treat the millions of patients expected to be living with chronic diseases in the foreseeable future.

The system under which medical students are educated and trained continues to be geared toward providing acute care in a hospital setting -- an outdated model when more and more care involves managing chronic conditions in an outpatient setting.

"At present, medical education is based on an acute care model in which patients are examined, diagnosed, treated and released," said David C. Thomas, MD, associate professor of medicine and medical director of the division of general internal medicine at Mt. Sinai School of Medicine in New York. "Chronic illness is much more longitudinal. That's not a culture that physicians have grown up in. Now doctors need to gather much more information from their patients and then partner with them."

Mt. Sinai is one of 10 medical schools to which the Assn. of American Medical Colleges awarded grant money to figure out the best way to shift the focus of medical education to chronic disease management in doctors' offices and clinics.

At the start of the 2006-07 academic year, each school received grants totaling $100,000 over two years, the AAMC said. The first year is reserved for planning. In the second year, the schools will implement curriculum changes. Funding for changes in residency programs has been issued to nine institutions, which each received a $75,000 one-year planning grant.

Excerpt from the American Medical News

BUSINESS
Public clinics: EMRs good for quality, not wallet
A recent study finds that electronic medical records can help provide better care but not cost savings in community health clinics.
By Pamela Lewis Dolan, AMNews staff. Feb. 19, 2007.

More safety-net facilities are looking to electronic medical record systems as a way to provide better care for the uninsured and help save money.

But a study published in the January-February issue of Health Affairs indicates that the savings part of that goal could be a pipe dream.

The authors of the study, "The Value of Electronic Health Records in Community Health Centers: Policy Implication," interviewed six community health clinics and evaluated the benefits of each facility's EMR.

While the quality improvement benefits of an EMR are promising, the study suggests little hope for EMRs to have any financial benefit for community clinics. Revenue enhancements are nearly impossible because of Medicaid's flat-rate-per-patient payment system and the Bureau of Primary Health Care's lump-sum payment system. And while EMRs can benefit private health centers through pay-for-performance incentives, few of these incentives are offered to community clinics, the study said.

Even though the clinics might not be focused on the financial return on investment, instead focusing on improved patient care, just getting financing to start the project is a burden too great for many community clinics to bear, the study found.

Excerpt from the American Medical News

BUSINESS
Citywide EMR network to link nearly all area physicians
In a few months, all but one practice in three Massachusetts communities will be using electronic medical records systems.
By Tyler Chin, AMNews staff. Feb. 19, 2007.

A three-year effort to get electronic medical records in the hands of every doctor in three Massachusetts cities could bear fruit soon, with almost every one of 450 physicians expected to be on a networked EMR system by the start of summer.

The lone holdout in the Massachusetts e-Health Collaborative's effort is a four-doctor internal medicine practice in North Adams that said it wasn't ready to convert to an EMR. Otherwise, every practice and hospital in North Adams, Brockton and Newburyport will have an EMR connected to a citywide health network by June, though the cities themselves won't be connected to each other.

In North Adams, that process, which includes 75 physicians, was scheduled to be complete by the end of February.

The collaborative has worked since 2004 on this project. It received $50 million in funding from BlueCross Blue Shield of Massachusetts. The money was used to buy EMR software and hardware for physicians and hospitals in the three cities, as well as to hook them up into a network.

Many other parts of the country have created integrated networks, called regional health information organizations, or RHIOs. They are the backbone of President Bush's plan to have a national health network in place by 2014. The Massachusetts group believes, though, that it is the first to have virtually every practice and hospital linked.

Shared data on a centralized database will include medications, allergies, test results and diagnoses, said Micky Tripathi, the organization's CEO. But the system is set up so that physicians and hospitals do not actually tap into each others' systems, he said. Instead, the system will compile information and push it to a centralized database…

Complete Article from the California Healthline

More Physicians Go Solo To Address Primary Care Decline
February 23, 2007

The Wall Street Journal on Friday examined how a "small but growing number of physicians" have begun "converting to high-tech, low-overhead practices" -- or "micropractices" -- to "counter a sustained decline in primary care medicine." The number of primary care physicians in the U.S. has decreased by about 50% during the past 10 years, according to a series of surveys conducted by the American Academy of Family Physicians.

In addition, the inflation-adjusted average income of primary care physicians has decreased by 10% over the past eight years, as the average income of specialists has remained about the same, according to a series of surveys conducted by the Center for Studying Health System Change. The HSC surveys also found that the incomes of primary care physicians in 2003 were about one-third less than those of most specialists.

In response, some physicians are "trying to harness technology to make family practices more manageable and profitable," the Journal reports. The Journal profiled Gordon Moore, a physician who left a medical practice owned by a hospital to begin a micropractice. Moore said that his overhead costs account for 35% of his revenue. Overhead costs account for an average 60% of revenue for other small, primary care group practices, according to the Medical Group Management Association.

In addition, Moore said that about 70% of patients who recently completed an online survey titled "How's Your Health" are satisfied with the quality and timeliness of the care he provides. According to the same

survey, about 30% of patients nationwide are satisfied with the quality and timeliness of care their physicians provide.

However, most physicians who "take the plunge" and begin micropractices "initially find it hard to sign up patients," and many "make less money than they did before," the Journal reports. Gary Seto, a physician who left Kaiser Permanente in 2004 to begin a micropractice, recently wrote in his blog, SoloDoc, that his practice remained unprofitable for two years and that his income largely has decreased. "That's the trade-off," he wrote, adding, "But it's much more enjoyable to me and my patients" (Naik, Wall Street Journal, 2/23).

Excerpt from the American Medical News

PROFESSIONAL ISSUES
Many questions, little time: Physicians' tight schedules at odds with patient demands
Open-access scheduling and other approaches can free doctors to spend more time on patient concerns.
By Damon Adams, AMNews staff. March 12, 2007.

Jim Jirjis, MD, remembers a patient who came in with a long list of questions -- 17 to be exact. He set aside 40 minutes for the physical exam, but the visit lasted 90 minutes, much to the disappointment of other patients in his waiting room. Several years later, Dr. Jirjis is more savvy on how to cover a lot in a little time: He often asks patients to pick their top two or three concerns and deals with those during the encounter. The patient who had 17 questions now comes in with three or four.

"What happens is the important [issues] may be shortchanged if the doctor wants to get through 12 things," said Dr. Jirjis, director of general internal medicine and chief medical information officer at Vanderbilt University Medical Center in Tennessee. "Most patients understand you only have a certain amount of time."

A new national study of older patients found that physicians handle an average of six patient problems during a routine office visit, leaving precious few minutes to address them all adequately. About five minutes was devoted to the main topic, and the remaining concerns received about one minute each, according to the survey published online Jan. 24 in the journal Health Services Research.

Some of those remaining topics may have deserved more time, said lead study author Ming Tai-Seale, PhD, MPH, associate professor, School of Rural Public Health, Texas A&M Health Science Center. Researchers reviewed videotapes of 392 visits to 35 primary care doctors by patients age 65 and older between 1998 and 2000. They examined the length and content of the encounters.

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Contact Us

For comments, questions, or suggestions, please email us at ezrres@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.