EDITORIAL

In This Issue: A Cry for Balance

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Individuals, groups, and systems often respond to the complexity of health care by clinging to a single, simple solution. Research, reflections, and commentary in this issue cry out for balanced understanding and intervention among competing aims. Many of these articles relate to quality reporting and practice change.

Bazemore and colleagues discover,[1] and Grumbach interprets,[2] the association of 2 different measures of family physicians' comprehensiveness of care with lower costs and fewer hospitalizations. This study hints at the potential benefits of balancing comprehensive attention to the whole person with the selective advantages of a narrower focus.

In a survey of patient-centered medical home (PCMH)–recognized practices participating in the Centers for Medicare and Medicaid Services (CMS) "Meaningful Use" Electronic Health Record Incentive Program, a balance of financial and technical support is found to be necessary to support care coordination objectives.[3]

In an analysis of response to health care delivery reforms, Sandy et al find that, among practices participating with a large commercial insurer, patient-centered medical home recognition seems to be positively associated with meeting quality benchmarks but negatively associated with efficiency parameters.[4] In their analysis, the authors ask,

> "Should a physician spend time and energy focusing on structural measures and process changes such as those embodied in NCQA [National Center for Quality Assurance] PCMH recognition? Or should they focus on improving quality and efficiency measures from private payers that could affect their fee schedule, degree of participation in narrow networks, or patient volumes? Or should they focus on making sure they report and improve on measures from CMS to avoid reductions in fees from the Medicare [fee-for-service] program?"

Complementary essays by family physicians with highly successful practices provide an on-the-ground perspective on abundant delivery reform, measurements, and incentive programs. Antonucci and Ho, even while achieving NCQA Level 3 recognition, find that the process "mismatches form and function, is costly and wasteful, and may succeed more in documentation of policies than in supporting improved outcomes in practices."[5] Bujold's practice has been at the cutting edge of reforms and certifications, but he now finds that the plethora of processes has reached a tipping point that takes too much away from the "important business at hand—taking excellent care of patients, practice improvement, patient engagement."[6]

Using a number of methods to mitigate potentially confounding factors, Cecil and colleagues examine all child hospitalizations in the United Kingdom and find evidence that the introduction of primary care reforms focused on improving chronic disease management in adults is associated with an increase in children being admitted to the hospital through emergency departments, and an increase in child hospitalizations for primary care–sensitive chronic conditions.[7]

Incentives for achieving quality of care measures are often targeted to the individual clinician and often include only a small percentage of total compensation. Greene et al study an unusual system in which 40% of compensation is based on practice-level quality performance. They find that team-level incentives result in taking shared responsibility for patients, but allow colleagues to ride the coattails of higher performers. Study participants recommend a mix of practice and individual incentives to enhance collaboration and individual performance.[8]

Other articles in this issue provide new information to help make balanced clinical decisions.

Mangione-Smith and colleagues link parent ratings of children's visits for acute respiratory infections with antibiotic prescribing. They find that suggesting positive actions that parents can take to reduce their child's symptoms is associated with less antibiotic prescribing, and that a combination of positive and negative treatment recommendations is associated with the highest parental visit rating.[9]

Postpartum depression screening is recommended at 4 to 12 weeks after delivery, but in a large pragmatic trial, Yawn et al find that repeat screening at 6 and

12 months identifies an additional 13.5% of high risk women who previously screened negative for depression. Family practices that care for whole families would seem to be particularly well positioned to provide this added value.[10]

A downside of screening for breast cancer is the psychosocial consequences of false-positive mammograms. Heleno and colleagues show that at multiple time points over 3 years, these consequences are similar for women whose false-positive mammograms required invasive and noninvasive follow-up procedures.[11]

Bernstein and colleagues find that weekend use of "recreational" drugs is less likely than weekday use to result in escalating drug use over time.[12] However, over a 6-month period, one-half of the weekend drug users became weekday users. Weekend use is both a favorable marker and a call for continued monitoring.

A related research brief finds that a screening, brief intervention, and referral to treatment (SBIRT) program that aims to reduce and prevent problematic use of alcohol and illicit drugs is associated with doubling the rates of diagnosis of depression and substance abuse, and with large increases in rates of referral.[13] Low rates of kept appointments in both intervention and control groups point to the need for continued work in tailoring interventions to meet patient needs and capabilities to respond.

Several essays balance the hard work of science and practice improvement with sources of personal meaning.

Ventres provides a framework for understanding clinician-patient interactions as interacting presentations of self related to meaning, community, agency, anxiety, and organism. He describes how balancing these individual identities can reduce relational challenges and enhance communication effectiveness.[14]

De Schweinitz introduces readers to a particular patient for whom knowing the story and deepening the conversation did not guarantee change, but served as a reminder of the core values of patience, humility, and faith.[15] And a story from an impoverished outreach clinic in Beirut reminds a young physician of the meaning of her profession.[16]

We welcome your reflections at http://www.AnnFamMed.org.

References

1. Bazemore AW, Petterson SM, Peterson LE, Phillips RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. *Ann Fam Med.* 2015;13(3):206-213.
2. Grumbach K. To be or not to be comprehensive. *Ann Fam Med.* 2015;13(3):203-205.
3. Morton S, Shih SC, Winther CH, Tinoco A, Kessler RS, Hudson-Scholle S. Health IT-enabled care coordination: a national survey of patient-centered medical home clinicians. *Ann Fam Med.* 2015;13(3):250-256.
4. Sandy LG, Haltson H, Metfessel BA, Reese C. Measuring physician quality and efficiency in an era of practice transformation: PCMH as a case study. *Ann Fam Med.* 2015;13(3):264-268.
5. Antonucci J, Ho L. The dissenter's viewpoint: there has to be a better way to measure a medical home. *Ann Fam Med.* 2015;13(3):269-272.
6. Bujold E. When practice transformation impedes practice improvement. *Ann Fam Med.* 2015;13(3):273-275.
7. Cecil E, Bottle A, Sharland M, Saxena S. Impact of UK primary care policy reforms on short-stay unplanned hospital admissions for children with primary care-sensitive conditions. *Ann Fam Med.* 2015;13(3):214-220.
8. Greene J, Kurtzman ET, Hibbard JH, Overton V. Working under a clinic-level quality incentive: primary care clinicians' perceptions. *Ann Fam Med.* 2015;13(3):235-241.
9. Mangione-Smith R, Zhou C, Robinson JD, Taylor JA, Elliott MN, Heritage J. Communication practices and antibiotic use for acute respiratory tract infections in children. *Ann Fam Med.* 2015;13(3):221-227.
10. Yawn BP, Bertram S, Kurland M, Wollan PC. Repeated depression screening during the first postpartum year. *Ann Fam Med.* 2015;13(3):228-234.
11. Heleno B, Siersma VD, Brodersen J. Diagnostic invasiveness and psychosocial consequences of false-positive mammography. *Ann Fam Med.* 2015;13(3):242-249.
12. Bernstein J, Cheng DM, Wang N, Trilla C, Samet J, Saitz R. Recreational drug use among primary care patients: implications of a positive self-report. *Ann Fam Med.* 2015;13(3):257-260.
13. Dwinnells R. SBIRT as a vital sign for behavioral health identification, diagnosis, and referral in community health care. *Ann Fam Med.* 2015;13(3):261-263.
14. Ventres W. ABCDE in clinical encounters: presentations of self in doctor-patient communication. *Ann Fam Med.* 2015;13(3):276-278.
15. de Schweinitz P. One cold autumn day. *Ann Fam Med.* 2015;13(3):279-281.
16. Ramia MS. Smiling toothless. *Ann Fam Med.* 2015;13(3):282-283.