National Health Service (NHS). Those attending Dr Roland's session at the 2003 NAPCRG Annual Meeting had already heard about the plan to implement a contract in the United Kingdom for general practitioners that tied income to a detailed set of quality markers. Dr Roland returned for a plenary presentation at the 2005 NAPCRG meeting to discuss physician reimbursement systems and was now able to share some of his work evaluating the anticipated and unanticipated effects of the P4P strategy in the NHS. Expected and realized outcomes include improvements in certain measures of care, increased computerization and administrative costs, and more health care being provided by nurses and larger health care teams. He also discussed the unintended risks and effects of the program, including poor care for unincentivized conditions, more fragmented and less holistic care, and misrepresenting data to achieve practice goals.

Roland's report of the UK experience adds more urgency to finding answers to questions about P4P raised by US physicians. What should be measured, and how should this be done? Many of the demonstration projects involve large groups, but what about small- to medium-sized groups, where the great majority of patients get their care?[3] Although electronic health records and disease registries hold promise for more sophisticated quality improvement programs, they are currently employed in a minority of practices. How can the rest incorporate this costly technology? What is a practice to do in the face of multiple health plans that have disparate frameworks for P4P? As Dr Roland asked, what if physicians focus on the prescribed set of measures but end up ignoring other important items that may affect patient outcomes? What if physicians stop seeing sicker, more complex, or less "compliant" patients because of the potential for financial penalties under P4P? What of those practices that by choice or location serve large numbers of such patients? What is the performance target based on—an agreed- upon standard or benchmark, or improvement from 1 year to the next (which, ironically, may be hard to achieve for practices already performing well)? Finally, do these payments represent new money, or usual reimbursement and a higher bar?[4]

The National Academy of Sciences Institute of Medicine, tasked with advising the US Congress on how to get P4P off the ground, recommended establishing a new federal office within the Department of Health and Human Services to coordinate the development and implementation of quality measures needed for P4P. This would provide guidance for federal payers in the United States and presumably would have an impact on how private insurers roll out their programs.[5] If this accomplished a uniform set of standards for US physicians, it would be an enormous achievement. But the other issues of case mix adjustment and financing the needed investment in IT infrastructure remain to be solved. NAPCRG has an opportunity to provide some insight on these questions, both by means of original health services research and by sharing lessons from many countries. Although the US health care system might be unique in its ability to spend so much on so few to achieve so little (Larry Green, MD, personal communication, October 26, 2004), the need for quality improvement, including efficient use of scarce resources, is felt by numerous countries. NAPCRG would do well to make fostering this work and dialogue a priority in the next decade.

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NETWORK EXPANDS; RESEARCH BOOSTS QI

AAFP's National Research Network Adds Members

New members are making the American Academy of Family Physicians' National Research Network hum.

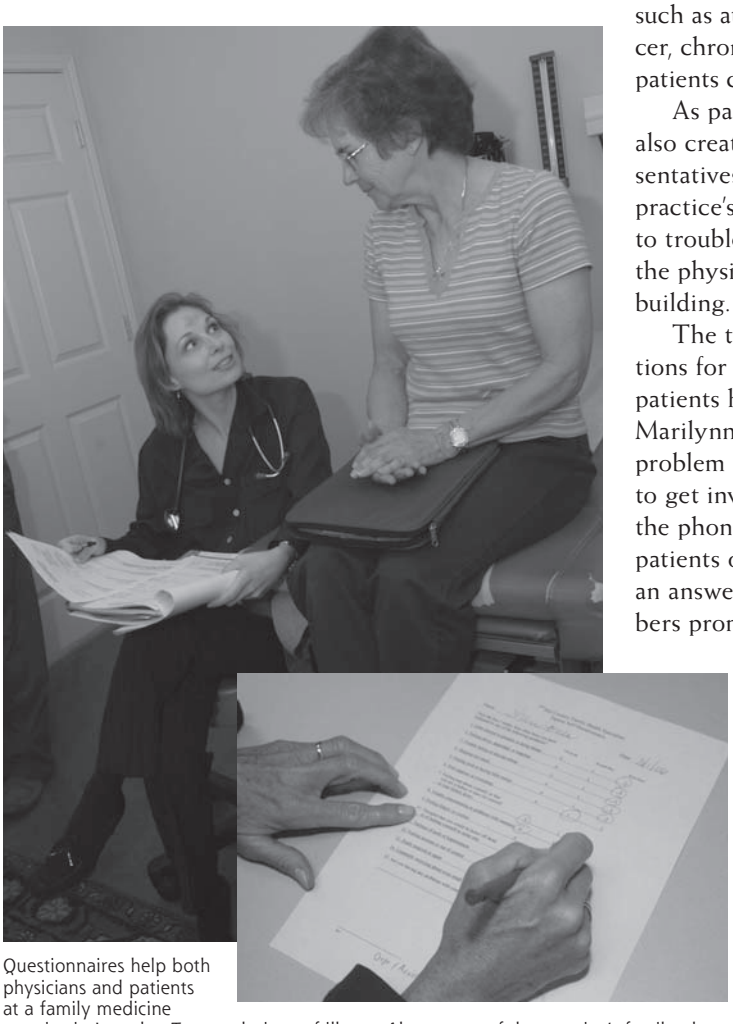
The network, which began in 1999 with 117 physicians from the former Ambulatory Sentinel Practice Network, now has 345 researchers, including 323 AAFP members. It also has established a residency branch, which now includes 69 family medicine residencies.

For more information on the National Research Network, including details on joining, visit http://www.aafp.org/x3201.xml or call Tom Stewart at (800) 274-2237, Ext. 3172.

AAFP Members Put Research Into Practice, Stimulate QI Efforts

Academy members doing practice-based research are finding that it is a 2-way street. As they and their staff members conduct research, they reap the rewards of providing better patient care; improving their office systems; and, sometimes, obtaining new equipment and expanded reimbursement.

During the past 5 years, FP researchers have learned how to blend quality improvement and research, said Wilson Pace, MD, director of the AAFP National Research Network. The network has collaborated with other groups in sponsoring depression-and-QI and spirometry studies. These 2 research projects, plus another not related to the AAFP network, are in the final report-writing phase. Taken together, the 3 studies show how research leaves its footprints in grass-roots practices; FPs learn through the projects, and the lessons stick long after their practices have completed the research work.



JANE STOEVER

Questionnaires help both physicians and patients at a family medicine practice in Leander, Tex, track signs of illness. Above, one of the practice's family physicians, Elizabeth Burnell-Mansolo, MD, discusses bone density test rsults with Harriet Aarestad of Lago Vista, Tex.

Study on Depression and QI

FPs Ron Mansolo, MD, and Elizabeth Burnell-Mansolo, MD, a husband-and-wife team in Leander, Texas, and nurse practitioner Megan Passe, RN, who works with them, took part in a 2004-2006 National Research Network study on depression and quality improvement. They tested the usefulness of a patient health questionnaire for determining whether patients are depressed, and they are finding the lessons learned from the research invaluable for enhancing their patient care.

"I knew one patient was depressed, but he wasn't real open about how he was feeling," said Burnell-Mansolo. She had him fill out the questionnaire, and his answers indicated a more serious degree of depression than she had suspected. "At that point, I increased the medication, and at the next visit, the patient was better," she said.

The practice found the questionnaire so valuable that Mansolo created similar tools on conditions such as attention-deficit/hyperactivity disorder, cancer, chronic illness and diabetes; another is issued to patients coming in for a general physical exam.

As part of the depression study, the practice also created a QI team that then multiplied. Representatives from billing and the front office and the practice's medical assistants now hold regular sessions to troubleshoot, and all staff members, including the physicians and Passe, meet each month for team building.

The team meetings help define problems and solutions for everyone in the office. "The biggest problem patients had was holding on the phone too long," said Marilynn McAlister, office manager. By looking at the problem in the team setting, everyone was encouraged to get involved in solving it. "Now whoever answers the phone tries to really listen instead of putting the patients on hold at first," said McAlister. When getting an answer to a question will take awhile, staff members promise to call the patient back within 2 hours.

"And we do," said McAlister.

Spirometry Research

Mansolo, Burnell-Mansolo and Passe also took part in a 2004-2005 spirometry study that tested whether FPs and their staff members could do accurate pulmonary function tests, or PFTs, and whether in-office spirometry would change FPs' assessment of the severity of patients' asthma or chronic obstructive pulmonary disease--thus, changing their care plan for the patient. Study FPs received spirometers to keep and use at their practices, and, during

the study, pulmonologists checked the FPs' spirometry interpretations.

The addition of this service again helped Burnell-Mansolo and Mansolo enhance their patient care. "A woman I saw recently was complaining of shortness of breath, but I didn't hear her wheezing when I examined her," said Burnell-Mansolo. She started the patient on medication and, within a few days, had Passe give the patient a PFT. The results indicated the patient needed more assistance, so Burnell-Mansolo ordered inhaled steroids. "The PFT helps with diagnosis and treatment," she said.

The addition also helped boost the practice's accounts receivable. Insurance companies pay for the PFTs, Mansolo said. "Being able to treat our patients in our office saves money" for the health care system as a whole, he added.

FP Raj Kachoria, MD, of Macedon, NY, chair of the family physicians' section of the 8-county Rochester (NY) Independent Physicians Association, or RIPA, was another participant in the spirometry study who discovered its financial benefits. Kachoria shared information about the spirometry study, as well as the manual for study participants, with RIPA members and then with an HMO that contracts with RIPA. "The study information and the manual backed us up on the value of doing spirometry in our offices," said Kachoria. "We now have a guideline from the HMO for primary care physicians to do spirometry, and we're not getting questions when we bill for it."

Diabetic Retinopathy Study

Agreeing to take part in a retinopathy study funded by the American Diabetes Association led to better patient care for the FPs at 15 clinics in the Salud Family Health Centers system in Colorado. They participated in a 2002-2004 study on diabetic retinopathy that examined primary care physicians' ability to read retinal photographs. The grant paid for 2 cameras for the clinics and a photographer to take pictures of about 2,500 patients with diabetes. For the study, the Salud FPs read the photographs, and an ophthalmologist "over-read" them to check the FPs' interpretation.

"We found out family docs can read retinal photographs, and we discovered about 8% of our diabetic patients had severe diabetic retinopathy and needed to see ophthalmologists for that," said FP Tillman Farley, MD. Farley, who practices in Fort Lupton, Colo., is the Salud clinics' medical director and is writing the research report discussing the study's findings.

He emphasized the retinopathy study's patient care benefits. "Instead of referring all our diabetic patients for screening and treatment, we are now referring only those patients with significant disease," he said. "The screening and treatment are now just part of our program. We've put the research into practice."

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