ON TRACK

Transformation and Renewal

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The September/October issue of *Annals*[1] stimulated a wide range of reflections, kudos, and critiques. Despite their diversity, many comments shared a focus on innovation and change, the same focus that pervades family medicine as it attempts to "transform and renew the discipline…to meet the needs of patients in a changing health care environment."[2]

TRANSFORMING PATIENT CARE AND PRACTICE

A number of readers expressed enthusiasm for a study evaluating the ongoing effectiveness of a depression care management program in the primary care setting.[3] In particular, they noted the importance of the study's unselected patient population,[4] reflecting the diversity of complex patients with depression seen in primary care, and the use of components associated with the patient-centered medical home (PCMH), such as a team-based approach, to address these complexities.[5] The study methods hold promise not only for depression care but also for evaluating management of other chronic conditions.[6] Why, then, is this model not in widespread use? According to one comment,

> …the primary barriers are lack of resources and financing…making this model the predominant model in primary care will require a change in reimbursement structures to pay for the resources that are necessary to improve care. This is true for depression care management as it is for most aspects of the PCMH.[5]

The authors see reason for optimism, however, noting that new care management demonstration projects are being supported by a health system–insurance coalition:

> We are now seeing things open up…the community program is seen as a cornerstone of a more comprehensive approach to build a community-based accountable care organization. So, for us at least, there may be a tipping-point coming soon.[7]

In the previous issue we summarized comments[8] from readers of a supplement on the "Evaluation of the American Academy of Family Physicians' Patient-Centered Medical Home National Demonstration Project."[9] Since then, the authors of the supplement have responded to these readers.[10] These discussions highlight several of the struggles and strengths of primary care. Multiple readers had been dismayed by the lack of financial data from the TransforMED project. The authors of the supplement shared the readers' dismay and described the inability to collect consistent financial information across practices as indicative of the complex and dysfunctional nature of current primary care reimbursement practices. Authors and readers were in agreement that the PCMH is a process as much as a product, with a need for a broad, systematic perspective for transformation—and that the role of a personal physician is central to effective primary care. They differed as to whether any PCMH must be exclusively physician-led, with the authors suggesting that nonphysicians may have important roles to play in practice transformation and maintenance. Finally, the authors discussed the importance of rigorous evaluation of practice change to inform the translation of new knowledge across primary care systems. They agree with readers that such evaluation may require new and/or different measurement tools and higher response rates than were they were able to obtain in the National Demonstration Project (NDP) evaluation, and they point out that longer-term follow-up will be necessary to truly assess the effects of such practice change efforts.

In addition to the response from the supplement authors, we call your attention to the detailed and instructive TRACK commentary by Newton et al.[11] Dr Newton and his coauthors provide the perspective of participants in a series of large-scale interventions to develop new models of practice with the goal of improving the quality of care in all 2000 primary care practices in North Carolina. From this perspective, they point out several issues that should be discussed

when reading and interpreting the results of the NDP. For example, the characteristics of the 36 NDP practices may differ substantially relative to many other practices involved in practice transformation in that they self-selected to participate in the program. Other practices with different characteristics may require a broader range of facilitation and intervention strategies for successful transformation. Finally, such a range of practice improvements and transformation will require a range of measurement tools (some not yet developed) and quality improvement approaches. Dr Newton and colleagues applaud the NDP efforts while illustrating additional challenges that will be faced in expanding primary care practice change.

MOTIVATING PATIENTS, UNDERSTANDING RELATIONSHIPS

A study of patients with type 2 diabetes[12] generated new questions and areas for exploration. The study's findings—that participatory decision making results in improved outcomes by improving patient activation, which in turn improves medication adherence—are only a first step:

> While already-activated patients clearly do well, we don't know yet how to transform "unactivated" patients into activated ones.[13]

> Are physicians with greater participatory decision making (PDM) really activating their patients? Or are more activated patients (who are also more likely to adhere) prompting more PDM among their physicians?[14]

According to one reader, implementation of patient activation techniques both requires and engenders transformation:

> If we are to have truly effective primary care the fundamental ways of practicing medicine must change. This does not mean more burden on physicians. In fact, if done well, practice change can lead to more satisfied physicians and healthier patients.[15]

A number of readers believed that a study of the relationship between continuity of care and patient trust, viewed through the lens of game theory,[16] adds "an important piece to the difficult puzzle called trust."[17] Although measures of trust are already in existence, this study adds "the issue of personal knowledge"[18] as well as a theoretical base, which could have important implications for future research[18-20] and health policy:

> Here in London we are currently working with negotiators and policymakers to try and introduce worthwhile incentives for Family Practitioners/General Practitioners to prioritise continuity of care, rather than merely quick access to any available clinician. Game theory as described here enables us to argue our case more strongly![20]

ETHICAL ISSUES IN PRACTICE AND RESEARCH

A recent study evaluated the effects of a practice's internal transformation, as it implemented a policy prohibiting prescription drug samples and visits from pharmaceutical representatives.[21] The article spurred a number of thoughtful comments addressing the study's limitations,[22-24] promising areas for further inquiry in this underresearched topic,[22,24,25] and personal reflections[22,26]:

> I no longer meet with pharmaceutical reps in my office. I feel I can judge the data on drugs better without being presented with biased marketing information [sic]…. My practice has improved now that I've removed myself (and my partners) from the sample closet, and we can all practice medicine in the exam room.[27]

Do existing ethical guidelines provide adequate protection for community-based research? According to a recent study of ethnic minority communities,[28] more is needed, including expansion of the Belmont Report (the ethical foundation for human subjects research).[29] A commenter agreed, calling for new language and a new research framework:

> …engaging communities require[s] researchers to reframe their research as research "with" and not "in," "on" or "about" communities…. A core value is that all partners participate in all phases of the research process.[30]

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