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WHAT'S NEWS

Diagnostic promise for Alzheimer's? In a small study, PET plus a radiolabeled imaging agent detected beta-amyloid plaques with 93% sensitivity. **6**

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And a biomarker shall lead them: Using N-terminal prohormone brain natriuretic peptide levels to guide therapy in patients with systolic heart failure proved superior to standard approaches. **23**

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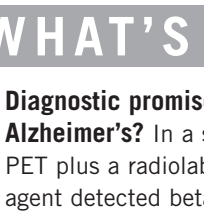

Tips for reaching the PCMH top: An expert offers primary care practices her advice for achieving patient-centered medical home recognition from NCQA. **58**

Osteoporosis Screening Guidelines Get an Update

There was insufficient evidence to form any recommendation about screening in men.

BY SHERRY BOSCHERT

FROM ANNALS OF INTERNAL MEDICINE

New federal recommendations on screening for osteoporosis provide more detail on when to screen women younger than age 65 years and – for the first time – point to a lack of data for screening decisions in men.

The U.S. Preventive Services Task Force updated its 2002 recommendations on osteoporosis screening to call for routine screening in all women aged 65 years or older and in any younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors (equivalent to a 9.3% or greater risk of fracture within 10 years). Previously, women younger than 65 years would be screened if they were at least 60 years old with risk factors for fracture.

The new recommendations were posted on the USPSTF Web site and published online by the Annals of Internal Medicine.

For the first time, the USPSTF evaluated the evidence for osteoporosis screening in men and found insufficient evidence to form any recommendation, Dr. Ned Colange, chair of the USPSTF, said in an interview. There's not enough evidence to recommend osteoporosis screening or treatment in men with no prior osteoporotic fractures, and "there's certainly not enough evidence to say, 'Don't' do it,' " he said.

"While there's not a call to action, that's an important call for research," added Dr. Colange, who is president and CEO of the Colorado Trust Foundation, Denver.

In women, the recommendations do not say to stop osteoporosis screening at any specific age, because the risk of fractures continues to increase with advancing age, and the minimal potential harms of treatment remain small.

Clinicians who are considering treating older patients with significant morbidity should take into account data showing that the benefits of osteoporosis treatment emerge 18-24 months after starting treatment.

To predict an individual's risk for osteoporotic fracture, the USPSTF used the online FRAX tool, developed by the World Health Organization and the

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Primary Care Group Visits Cut Readmissions

BY M. ALEXANDER OTTO

FROM A CONFERENCE ON PRACTICE IMPROVEMENT SPONSORED BY THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

SAN ANTONIO – Group visits aren't just for diabetes patients.

At the Maine Medical Center in Portland, they also help – along with other measures – to keep recently discharged patients from being readmitted, according to Dr. Ann Skelton, chief of the center's department of family medicine, who presented the findings at a conference on practice improvement sponsored by the Society of Teachers of Family Medicine.

Upon discharge from the Family Medicine Inpatient Service (FMIS) to the outpatient Family Medicine Center (FMC), patients are given the option of having their first follow-up visit with their primary care doctor, or in a group with other patients led by a team that includes an attending physician, a nurse, a social worker, a pharmacist, and a care manager, among others.

COURTESY HALLIE BIBEAU

The use of post-discharge group visits cut hospital readmissions, explained Mary McDonough, R.N., (in red) and Dr. Ann Skelton (second from the right).

The slightly more than half who opt for the group find all of their hospital-to-home issues addressed at one time, in one place, and without delay, explained Mary McDonough, R.N., FMC practice administrator, who also presented the findings.

If a patient has trouble getting through to a specialist, for instance, the

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IMPLEMENTING HEALTH REFORM

Medical Malpractice

Physicians have long sought an overhaul of the nation's tort system in the hope of reducing the financial and emotional costs involved with medical malpractice. The Affordable Care Act took a small step by funding demonstration projects to develop litigation alternatives. The law provides $50 million to states for 5-year grants in fiscal year 2011, which began on Oct. 1, 2010. The Obama administration said it will give preference to states that develop programs that improve access to liability insurance and improve patient safety by reducing medical errors.

Dr. Albert L. Strunk, deputy executive vice president of the American College of Obstetricians and Gynecologists, discusses the current malpractice environment and the impact of health reform.

FAMILY PRACTICE NEWS: Does ACOG consider this proposal a step in the right direction?

Dr. Strunk: Any step that is undertaken to reduce the cost of litigation and improve determinations of good vs. bad medical care is a very good idea. Whether you think medically related litigation costs $11 billion or $22 billion or $60 billion a year, the figures are substantial, so we're very anxious to have trial or pilot programs go forward.

We are grateful for any impact from the Affordable Care Act, but I think that real innovation also is occurring apart from the grants. There is an increasing institutional and practitioner awareness that the way in which less-than-optimal outcomes occur requires attention to a constellation of factors. Personnel is only one element.

More and more, we accept the notion that we have to, in a way, pull ourselves

The cap on noneconomic damages in Texas has resulted in a huge influx of doctors.

DR. STRUNK

up by our own bootstraps. While the 112th Congress may be more receptive to tort reform, primarily, we have to look to the states for legislative solutions.

FPN: Some studies have suggested that the cost of medical malpractice is a fraction of overall health spending, and that tort reform would do little to bring down total health care spending. How does the cost of medical malpractice impact the practice of obstetrics and gynecology?

Dr. Strunk: The ob.gyn. specialty is somewhat unique within the context of the current tort system, in part because of the size of awards attached to neurologically impaired or neonatal encephalopathy types of cases. Because those cases allege primarily economic damages based on the life-care of an impaired infant, traditional tort reform involving caps on noneconomic damages are of little assistance.

In addition, there has been a good deal of judicial nullification of statutes of limitations in cases involving infants. So obstetricians today face a practice environment whereby simply being at the wrong place at the wrong time can literally cause economic ruin.

We know from survey results that the anxiety associated with this risk greatly influences the behavior of obstetricians and gynecologists, as does the cost and availability of liability insurance. The anxiety causes our physicians to leave obstetrics in their 40s, so there is a significant impact on the workforce. So we believe that defensive medicine and fear of litigation does add to our total health bill.

FPN: Is ACOG working to reform tort laws at the state level?

Dr. Strunk: We are, and it's quite a different approach that one takes. Most of the state initiatives tend to relate to traditional California MICRA (Medical Injury Compensation Reform Act)–style tort reform, addressing noneconomic damages through caps, as well as limiting contingency fees, for instance. The most successful initiative has been in Texas. The impact of the state cap on noneconomic damages – coupled with a constitutional amendment that prevented the courts from overturning the legislation – has resulted in a huge influx of doctors. Access to care, particularly in low-income populations, has been dramatically increased.

In the short term, caps on noneconomic damages are helpful in selected state environments. Some states are also exploring contractual arrangements between patients and physicians to provide for predispute voluntary binding arbitration. Another long-term goal would be the implementation of health courts.

FPN: What would ACOG ideally like to see happen with the malpractice reform demonstration projects?

Dr. Strunk: In terms of the grants that have been made, we are very supportive of a project in Missouri, which is going to focus on the quality of perinatal care and the way adverse perinatal events are managed in five Missouri hospitals. They are going to establish an evidence-based obstetrics practice model. We believe that the use of evidence-based guidelines and checklists increases patient safety and reduces risk.

The Carilion Roanoke Memorial Hospital Center has a planning grant to enhance teamwork and systems management, the goal being to improve the quality of obstetrical care and patient care, and reduce risk and liability. Team-based care, systems analysis, and systems solutions are essential. Most of the mishaps that occur in the delivery of care don't really relate to the negligence of a single person, notwithstanding what the tort system would have us believe. It is generally a constellation of factors.

So these are things we are not merely supportive of, but enthusiastic about. ■

DR. STRUNK is also vice president for fellowship activities at ACOG.

Posthospital Care Effective

Readmissions *from page 1*

social worker is there to help. If a patient needs home care, the care manager can set up an appointment, maybe for the same day.

And there's no need to go elsewhere for the physical exam – a physician does them during the meeting.

Patients also bring in their medications for the pharmacist to review. Sometimes the dosages are wrong; other times patients are taking the brand and generic versions of the same drug, or taking drugs that should have been discontinued at discharge – omeprazole and hydroxyzine, for example. COPD inhalers, warfarin, and allopurinol, among other drugs, have had to be added to some patients' regimens, too, said Ms. McDonough, who led efforts to start the groups.

The 30-day readmission rate among those who opted for t he group was 2.4%. For those patients who opted for office follow-up, the readmission rate was 9.4%.

Overall, group visits are "a very effective way to do posthospital care. Bringing that team together makes it flow smoothly," Dr. Skelton said following the presentation.

In a pilot project from June 2009 – shortly after the groups started – to November 2009, Dr. Skelton and her colleagues tracked outcomes for 175 patients admitted from the outpatient FMC to the inpatient FMIS, and then discharged back to the outpatient center.

The 30-day readmission rate among those who opted for the group was 2.4%; for those who opted for office follow-up, 9.4%. Overall, the 30-day readmission rate dropped from 14.2% to 12.6%, saving an estimated $158,884 on an annualized basis.

More recent data support the trend. From June 2009 to September 2010, the 30-day readmission rate for those who opted for the group was 6.7%. Among all FMC patients, those who attended the group following discharge and those who did not, the 30-day readmissions rate was 8.9%.

It is not known whether the patients who opted for the group had lower readmission rates because they were less sick to begin with, or if other confounding variables contributed to the results; that analysis has not been done, Dr. Skelton said.

However, patients polled said that they understood their medications and care plans better after the group visit; virtually all said they'd recommend the group to recently discharged patients.

The 2-hour group visits are offered at the FMC every Wednesday morning, so patients who opt for them can attend within 7 days of discharge. Usually about four, but sometimes up to seven, patients attend.

The team knows who is coming and can prepare for the visits because the FMIS and FMC have improved how they track recently discharged patients.

They share a common electronic registry of hospitalized patients; the system alerts staff on the outpatient side when a patient is admitted and discharged. Discharge summaries are almost always available within 24 hours. Nurses also call patients within 48 hours of discharge, making a note in the system of any issues.

The group visits and tracking upgrades are "catching things that used to fall through the cracks," one physician said in a poll.

The annual cost of the efforts, due mostly to the care team's group visit time, is $30,212. That's offset by an annual gross revenue from the group visits of $30,368, billed under CPT code 99214, Dr. Skelton said.

"As long as you have more than a couple patients in any week" so discharge group visits recoup their costs, they "make sense," she said.

There was no outside funding for the efforts, "just creative reallocation of human resources," said Dr. Skelton. ■

VITALS

Major Finding: Patients who had their first postdischarge follow-up visit in a group setting had a 30-day readmission rate of 2.4% versus 9.4% among those who opted for a standard office follow-up visit.

Data Source: A 6-month pilot project involving 175 recently discharged patients at the Maine Medical Center in Portland.

Disclosures: Dr. Skelton and Ms. McDonough reported having no relevant financial disclosures.