

## Primary Care/Family Medicine

Anonymous. (2005). Current systems for handling chronic diseases is crippling primary care, study finds. *Hospitals and Health Networks*, 79(7), 127-127-128.

Bodenheimer, T., Wagner, E. H., & Grumbach, K. (2002). Improving primary care for patients with chronic illness. *JAMA : The Journal of the American Medical Association*, 288(14), 1775-1779.

The chronic care model is a guide to higher-quality chronic illness management within primary care. The model predicts that improvement in its 6 interrelated components-self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources-can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. Case studies are provided describing how components of the chronic care model have been implemented in the primary care practices of 4 health care organizations.

Landers, S. H. (2006). Home care: A key to the future of family medicine? *Annals of Family Medicine*, 4(4), 366-368. doi:10.1370/afm.550

This essay is about my transition from family medicine residency into house call/home-based primary care practice. Though some aspects of making home visits have been difficult and uncomfortable, I have found a higher level of satisfaction and sense of purpose than I had as a resident in a traditional outpatient clinic. This enhanced satisfaction is, in part, due to my discovery that a lower-volume, time-intensive house call practice is a more appropriate way than the brief office visit to care for older patients who have multiple morbidities. In light of the aging population, advances in portable medical technology, and changes in Medicare reimbursement, home care could become a key to the future success and ongoing relevance of family medicine.

Leveille, S. G., Wagner, E. H., Davis, C., Grothaus, L., Wallace, J., LoGerfo, M., et al. (1998). Preventing disability and managing chronic illness in frail older adults: A randomized trial of a community-based partnership with primary care. *Journal of the American Geriatrics Society*, 46(10), 1191-1198.

This study was conducted to evaluate the impact of a 1-year, senior center-based chronic illness self-management and disability prevention program on health, functioning, and healthcare utilization in frail older adults. The trial was conducted at a large senior center in a Seattle suburb in collaboration with primary care providers of two large managed care organizations. A total of 201 chronically ill older adults, aged 70+, were recruited through medical practices. The intervention group received a targeted, multi-component disability prevention and disease self-management program led by a geriatric nurse practitioner (GNP). Results show that intervention participants showed less decline in function and lower scores on the Health Assessment Questionnaire. Other measures of function, such as the SF-36 and other physical performance tests, did not change with the intervention. In the intervention group, the number of hospitalizations decreased by 38%, while it rose by 69% among the controls. The intervention also led to significantly higher levels of physical activity and senior center participation and significant reductions in the use of psychoactive medications. The study concludes that "a community-based collaboration with primary care providers can improve function and reduce inpatient utilization in chronically ill older adults. Linking organized medical care with complementary community-based interventions may be a promising direction for research and practice."

Sepulveda, M. J., Bodenheimer, T., & Grundy, P. (2008). Primary care: Can it solve employers' health care dilemma? *Health Affairs (Project Hope)*, 27(1), 151-158. doi:10.1377/hlthaff.27.1.151

Employers are beginning to recognize that investing in the primary care foundation of the health care system may help address their problems of rising health care costs and uneven quality. Primary care faces a crisis as a growing number of U.S. medical graduates are avoiding primary care careers because of relatively low reimbursement and an unsatisfying work life. Yet a strong primary care sector has been associated with reduced health care costs and improved quality. Through the Patient-Centered Primary Care Collaborative and other efforts, some large employers are engaged in initiatives to strengthen primary care.

Starfield, B. (2007). Global health, equity, and primary care. *Journal of the American Board of Family Medicine : JABFM*, 20(6), 511-513. doi:10.3122/jabfm.2007.06.070176

Global health provides a special challenge for primary care and general practice, which will become increasingly important in the future as the prevalence of multimorbidity increases with increasing likelihood of survival from acute manifestations of illness, as populations age, and as costs of care increase with increasing availability of technologic interventions. World organizations of primary care physicians need to take up the challenge before it becomes a crisis.

Woolf, S. H. (2008). The power of prevention and what it requires. *JAMA : The Journal of the American Medical Association*, 299(20), 2437-2439. doi:10.1001/jama.299.20.2437

This article focuses on prevention as an effective way of reducing healthcare costs and burden of illness in the population related to chronic disease.

World Health Organization. (2008). *World health report 2008: Primary health care now more than ever*