Bundling prescription refills

The article "A Streamlined Approach to Prescription Management" [November/December 2012, http://www.aafp.org/fpm/2012/1100/p11.html] was well done! As with most process ideas, one size may not fit all. However, if I can become more mindful of this notion of synchronizing prescriptions throughout my day, I'll see opportunities to get more of my eligible chronic patients into this model and I will certainly save time overall.

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One issue with the authors' system of bundling a patient's prescriptions and handling them all at the annual visit is that prescription refills often assist with appointment compliance. If a patient with diabetes must come into the office quarterly for refills, he is more likely to keep his appointments than if he were given a year's worth of refills.

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Authors' response: In our practice, we do not use prescriptions as a hook, enforcer, or reminder for appointments. Rather, we promote adherence by scheduling each patient's next appointment at the conclusion of the current visit and then subsequently obtaining preappointment lab work. We aim to make the visit more meaningful than just a means to obtain a prescription renewal. Our approach includes an automatic preappointment reminder call, and for the 4 percent of our patients who no-show, we make a follow-up phone call to reschedule their appointment.

Consider the example of a patient with type 2 diabetes, hypertension, hyperlipidemia, chronic sinusitis, and depression. He is taking metformin, hydrochlorothiazide, lisinopril, atorvastatin, fluticasone, and citalopram at the time of the annual comprehensive care visit. Vitals and labs for this patient are as follows: A1C is 6.2, LDL is 90, and blood pressure is 160/80. Sinus and depression symptoms are well controlled. At the annual visit, we will increase the lisinopril dose and then resynchronize and renew all medications for 15 months. If the patient's blood pressure is not well controlled at the three-week follow-up visit, then the lisinopril will be further adjusted. When medications are changed, our nurses send a note to the pharmacist to discontinue the previous prescription.

If the rest of the patient's conditions remain stable, then the other five prescriptions need only be processed once per year. However, if a practice were to renew each of these medications quarterly, it would mean 15 more prescription renewals to address by phone/fax/email or at interval visits throughout the year. Multiply this work by, say, 1,000 patients who have multiple chronic disease medications, and you have just added 15,000 prescription renewals to your workload for the year.

Holding your entire patient population hostage with the threat of expired prescriptions adds unnecessary work to your practice and contributes to medication nonadherence. If there are specific patients for whom expired prescriptions are the only way to ensure continued compliance with follow-up visits, then limit refills for that small population only. It is not necessary to place the burden of this work on the practice for all patients. Remember to design your workflow to be efficient for 90 percent of patients and deal with the outliers separately rather than abandoning an efficient process because it is not applicable to a small minority of patients.

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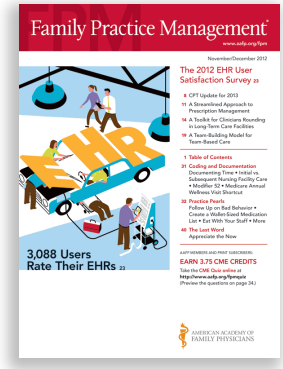
The overwhelming EHR marketplace

The implementation of electronic health records (EHRs) has been a huge burden for physicians. "The 2012 EHR User Satisfaction Survey: Responses From 3,088 Family Physicians" [November/December 2012, http://www.aafp.org/fpm/2012/1100/p23.html] is a helpful resource for physicians. However, the process of sorting through hundreds of different systems in order to find the best one is overwhelming. I suspect that most of us have purchased



2012 PRACTICE IMPROVEMENT AWARD

FPM is pleased to announce Terry Reilly Health Services of Nampa, Idaho, as the winner of this year's *Family Practice Management* Practice Improvement Award, a competition cosponsored by the Society of Teachers of Family Medicine (STFM). Bethany Gadzinski, medical operations manager and leader of the group's patient-centered medical home initiative, and Donald Morrison, RN, nursing manager, were presented with the award at the STFM/AAFP Conference on Practice Improvement in Greenville, S.C., last month. For more about the award winner see *FPM*'s Noteworthy blog at http://bit.ly/WJNVKX.

systems that will be extinct within the next five years. Since the government wants to mandate EHR use, perhaps they should develop a quality system and provide it to us. The current process of having hundreds of different systems and then trying to get them to communicate with one another will never work well, if it works at all, and will cost billions of dollars more than setting up a single unified system.

Gary Korff, MD
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Ask the nursing home to provide the toolkit

I work full time in a nursing home with patients who need both skilled and nonskilled care. Asking the nursing home to provide some of the medical equipment suggested in the article "A Toolkit for Clinicians Rounding in Long-Term Care Facilities" [November/December 2012, http://www.aafp.org/fpm/2012/1100/p14.html] would decrease the physician's cost of assembling the toolkit. The following items can be found in any nursing home and can be kept at the nursing station for physicians' visits: gastric and fecal occult blood tests, flashlight, oximeter, sphygmomanometer, toenail and fingernail cutters, all types of bandages, several sizes of syringes, straight needles, collection tubes for pathology (they come free from the labs), cultures, alcohol swabs, antibiotic ointment, Betadine swabs, lubricating jelly, tape measure, and tongue blades. I have convinced three facilities to purchase otoscopes, and one facility purchased a microscope for me. Also, some pharmacies will provide lidocaine and epinephrine injections and bill the patient for you. Save your money for the expensive items you might want, such as an external hearing aid, Doppler, cautery device, Dremel, etc.

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