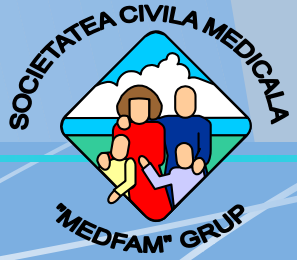
INNOVATING PRIMARY CARE DELIVERY IN ROMANIA

Group Practice Development and Clinical Practice Enhancement



July 2002

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This report was prepared for the U.S. Agency for International Development (USAID) in Romania under Interagency Agreement ENI-P-00-98-00009-00 between USAID and the U.S. Department of Health and Human Services

Introduction

The development and management of medical groups in Romania may appear to be a modern concept but it is rooted in the region's history. In the past, family physicians often practiced together, integrating their finances and operations to offer health care to the community. While many physicians today may practice in the same clinic facilities, they tend not to share finances, staff, supplies or equipment.

In 1998-1999, a group of general practice/primary care physicians sharing facilities began to discuss the potential of forming a group practice. Much of the early impetus related to issues concerning the centrally controlled health care system that emphasized the role of hospitals, but under-emphasized and under-funded primary care. Discussions among general practitioners about these issues began to take place seriously in the mid-1990s.

As a result of a number of meetings and, in particular, a meeting in Sibiu, Romania sponsored by the US Agency for International Development (USAID) and the US Department of Health and Human Services (DHHS), in February, 1999, a conceptual model of primary care was presented. This model (the flower garden) at the end of this section depicts the various services, which need to be provided by the primary care practice or other health agencies to ensure not only patient-centered care, but also continuity of care. Discussions at the Sibu meeting resulted in the preparation of a proposal to request funding for a primary care group practice demonstration program. This proposal was submitted to a Foundation but was not funded. The group of Romanian physicians who had a primary role in writing this proposal, along with substantial technical assistance provided by a US primary care health care team supported by DHHS/USAID, made a decision to use that proposal which included a timeline and budget as the framework for developing their own group practice in Cluj-Napoca, Romania. The US primary health care team provided technical assistance both on-site and through a series of workshops on management, clinical practice enhancement and quality of care activities.

On April 7, 2000, a little more than a year later, the MEDFAM Group held a grand opening ceremony to celebrate the formation of their new group practice. Six independent primary care physicians had signed an agreement to function as a formal, legal group practice. MEDFAM was the first legalized group practice in Romania to contract with the National Health Insurance House.

This Group Practice Manual was developed by the MEDFAM physicians and the US Primary Health Care Team. It is a joint effort to provide relevant information to other primary care physicians interested in developing their own group practices. Other physicians who may not be able to develop group practices will find sections of the manual helpful as they attempt to provide quality health care in an efficient and effective manner.

The manual is divided into five chapters. The first three chapters focus on the business and management of the group practice. Chapter 1 discusses reasons for forming a group practice, while Chapter 2 focuses on the steps to begin the formation. Developing a group practice

culture and management of the group practice are the topics of Chapter 3. Chapter 4 begins the discussion on creating a practice that delivers quality health care. Chapter 5 makes the case for building quality into the care process. Measurement, analysis, and improvement are essential factors in creating a group practice that delivers quality health care to all patients.

The development of this manual was a team effort with contributions from many individuals. We are grateful and express our thanks to the following teams and individuals:

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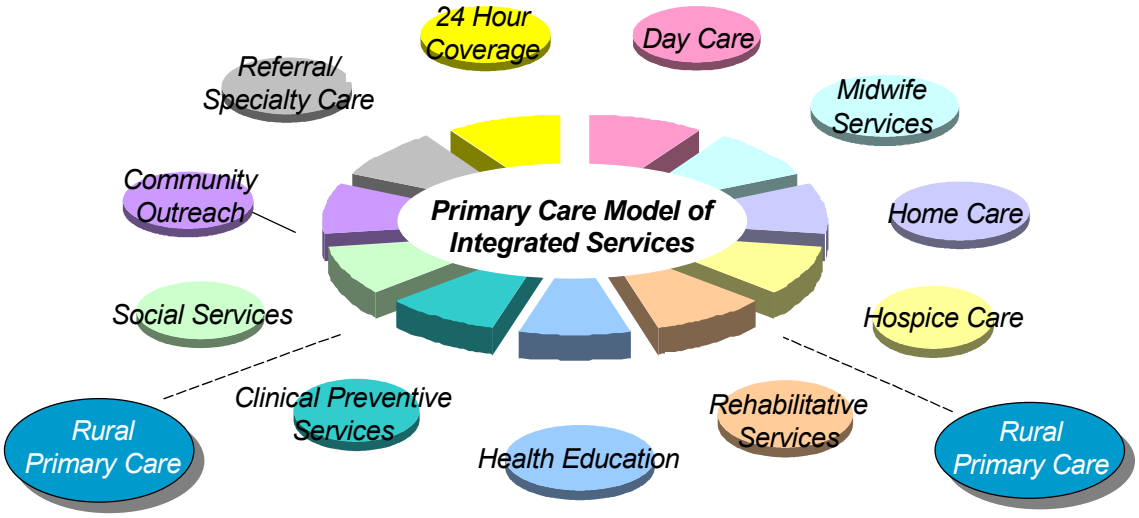
Partial support for this Primary Care Manual was provided by the US Department of Health and Human Services, Office of Global Health Affairs, the US Agency for International Development, the MEDFAM Group Practice, and the voluntary efforts of all involved. Mary Cummings and Mayur Patel were responsible for integrating the material from a variety of sources and editing the manual.

Primary Care Group Practice Model



Clinical Preventive Services
Breast Ca Screening
Cervical Ca Screening
Pre & Post-natal Care
Family Planning
Cardiac Disease
Diabetes

Rehabilitative Services
Alcohol & Drug
Physical Therapy
Cardiac

Chapter

1

The Business Case for Medical Groups

Give me a lever long enough and I will move the Earth - Archimedes

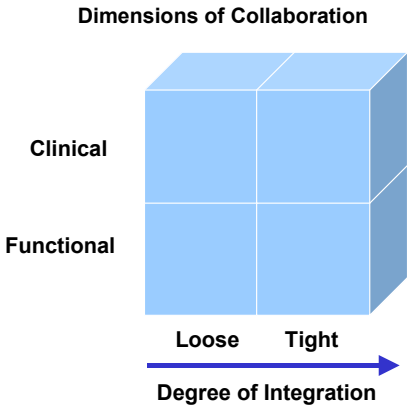
Increased quality of life, professional enrichment, decreased administrative burdens, and economies of scale are some of the reasons why many physicians in Western countries favor practicing in medical groups. In Romania, however, medical group formation is a recent phenomenon. Excepting a few group practices in urban centers, solo practice is almost the rule. Even physicians practicing in the same premises have almost no collaborative contacts. In rural areas, the professional isolation of the primary care provider is almost guaranteed. Both rural and urban physicians manifest weariness that is characteristic of their location and work habits, working long hours, taking little time off, and facing the challenges of health care reform. These physicians are precisely the ones who can benefit most from a group practice environment.

In Romania, the changes and challenges of the new health care reform laws are beginning to encourage physicians to change the ways they practice, specifically working in collaborative modes. These collaborative models range from loose arrangements between physicians to civil medical societies that bring together the finances and operations of individual physician practices. With the business of healthcare becoming more complex, many physicians are looking to create tighter linkages with their colleagues for relief and support while trying to deliver more efficient health care to their patients.

Little information is currently available in Romania on the potential rewards and pitfalls of practicing as a medical group. As physicians consider transitioning from solo practice to group practice, it is reassuring to know that others have gone down this path and are now enjoying tremendous success. The real life experiences of physicians, nurses, and consultants in developing and managing a medical group are summarized on the following pages. MEDFAM, a two-year old group practice in Cluj-Napoca, will frequently be mentioned in this guide to provide illustrations of activities, successes, and challenges experienced thus far. It is hoped that their experiences will help future medical group leaders achieve the rewards that this organizational structure can offer.

Definition of a Medical Group

What is driving the formation of medical groups? Before we get to that question, we need to answer a more basic question: "What is a medical group?" Physician collaboration can take many forms, depending upon the needs and circumstances of interested physicians. As shown in the figure below, physicians can create linkages by considering two dimensions: type of collaboration (clinical or functional) and level of integration desired (loose or tight).



There is virtually no aspect within family medicine's scope of practice that would not benefit from some form of collaboration. It can be informal, with the sole purpose of solving issues such as diffusion of information, planning of mutual coverage for vacations, sharing the services of an accountant or other staff, sharing building utilities or providing access to a particular piece of equipment. This form of collaboration is usually attained by ad hoc participation. Agreements are typically implicit and can be a good starting point for a more structured collaboration.

Formal collaboration requires the existence of written agreements and implies adherence to a set of commonly agreed upon rules and procedures. Membership is defined and there is a plan in place to solve short- and long-term problems. Full partnership implies tight integration. The partnership is a legal entity and is registered as a profit- or non-profit organization. It has a mission statement and a statute that defines participation, structure, and decision-making.

When opting for different forms of collaboration, several organizational and legal considerations must be carefully weighed. Some of these pertain to issues of authority, potential development, expansion of scope, legal aspects, and fiscal issues.

While there are several ways physicians can work together and collaborate, for the purposes of our discussion, a ***medical group refers to three or more physicians who are formally organized as a legal entity in which business and clinical facilities, patient records, and personnel are shared.*** The essential distinction between true medical groups and other physician organizations is that the economics of the individual practices are completely integrated.

A successful medical group, however, is more than just an economic device. Properly conceived and properly practiced, a medical group provides a means of bringing the diverse skills of a group of physicians together to achieve better and more efficient patient care. It also provides a climate to develop professional relationships, foster an atmosphere of mutual trust and helpfulness, and create a sense of security and support between the group members.

Forces Driving Medical Group Formation

In Romania, the strongest force driving physicians to consider creating medical groups has been the challenges of operating under the new health care reform laws. In this new health care environment, primary care physicians are responsible for the care of their patient population on a 24-hour basis. A benefit of group practice is the sharing of this 24-hour coverage among all of

the physicians in the practice. Physicians are also responsible for managing the finances and operations of their practice, skills never previously developed or practiced by most physicians.

Old Health Care Environment	"New" Health Care Environment
▪ No choice as to how to organize medical practice – solo physician practices. ▪ Salaried physicians. ▪ Care provided during office hours. ▪ Hospitals employed nurses and other staff. ▪ Hospitals supplied necessary medical supplies. ▪ Medical equipment generally unavailable to primary care physicians.	▪ Opportunity to organize into various structures, e.g. civil medical societies. ▪ Pay determined by capitation and fee-for-service components. ▪ Care must be available 24/7. ▪ Physician employs nurses and other staff through practice budget. ▪ Physician responsible for purchasing necessary medical supplies. ▪ Opportunity to develop other fee-for-service (FFS) medical services.

Another major force driving solo physicians to join medical groups is the ability to improve practice economics. The ability to thrive financially, while providing quality care, will become increasingly difficult for solo practice physicians. The health reform laws now allow the creation of "civil medical societies", which if properly implemented, can represent significant advantages to physicians practicing in those environments. We will explore the benefits of medical groups in the next section.

Benefits of Medical Groups

Group practice formation offers many benefits to its members as well as the population that it serves. For physicians, a group practice creates a sharing environment – the ability to share call coverage, have access to a ready source of patients, and participate in continuous education by being in close proximity to other physicians. The table on the next page displays the various benefits that can be accrued by working with other physicians in a medical group environment.

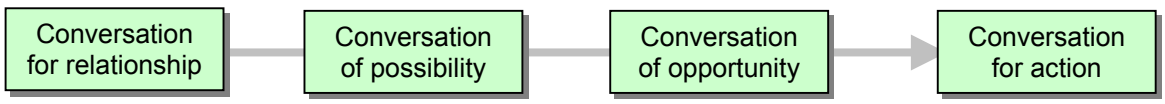
Shared governance, clinical protocols, and shared office space and staff can help physicians better coordinate clinical care in an efficient manner. The pooling of revenues between physicians is the key enabler that allows many of these benefits to be realized.

There are other benefits of medical groups that are not as easy to measure. Working collaboratively with a team of professionals, pride in the improved quality of care and service provided, a steady and diverse patient base, and an environment that fosters social and professional interaction are just some of the benefits for physicians that are only possible in a medical group environment.

Benefits of Medical Groups	
Clinical	▪ Opportunity to share medical knowledge and ideas between partners. ▪ Ability to focus on key areas of professional interest such as prevention or women's health. ▪ Ability to create practice guidelines and peer review structures to improve clinical quality. ▪ Share and jointly use equipment and personnel. ▪ Sharpen diagnostic and treatment acumen.
Financial	▪ Ability to make higher salaries by broadening the array of fee-for-service services and expanding the patient list. ▪ Reduce the costs of operation by sharing expenses for personnel, supplies, space, utilities, and other practice expenses. ▪ Ability to invest in introducing new technology and improving current physical facilities. ▪ Create effective practice management structures to increase physician productivity and improve operational efficiency.
Social	▪ Ability to work in a team-oriented environment. ▪ Security and lifestyle advantages by sharing administrative tasks and call coverage. ▪ Ability to take holidays knowing that patients will have adequate care.

Making the Transition

Physician interest is, of course, a prerequisite to forming a medical group. Enumerating and clarifying the advantages is often useful. Even though the benefits are clear, the transition from solo practice to full integration with fellow physicians in the form of a group practice is a process involving tremendous change and is not without its pitfalls. A trainer in organizational development once said that building effective collaboration is a process of sequential interactions driven by the nature of conversations between the people who set out to work together (Koster, 1997).



Relationships are shaped and deepened as colleagues start talking about their problems and ways to solve them. It's in this stage that collaboration often arises as a potential solution. Open communication is vital to allow this process to flourish and for the next steps to be accomplished. By the end of these conversations, the physicians most committed to cooperation form the nucleus of the future group.

As conversations continue between potential group members, aims and objectives become explicit. The feasibility of the desired change comes into focus. Gradually, options are taken, informed by opportunities, legislative aspects, and a more in-depth consideration of administrative and financial implications. Activities and accountabilities become structured into a plan. Finally the action of forming the group is undertaken; legal aspects are completed; and time frames are set for each activity. ***Change is implemented.***

Chapter

2

Forming the Medical Group

Assuming you have gotten this far in reading this manual, you may be seriously considering the possibility of creating a group practice. The objective of this chapter is to provide you with the tools to actually do it. It covers the steps you need to complete with your potential partners, from exploring various possibilities of collaboration, to creating and implementing a business plan.

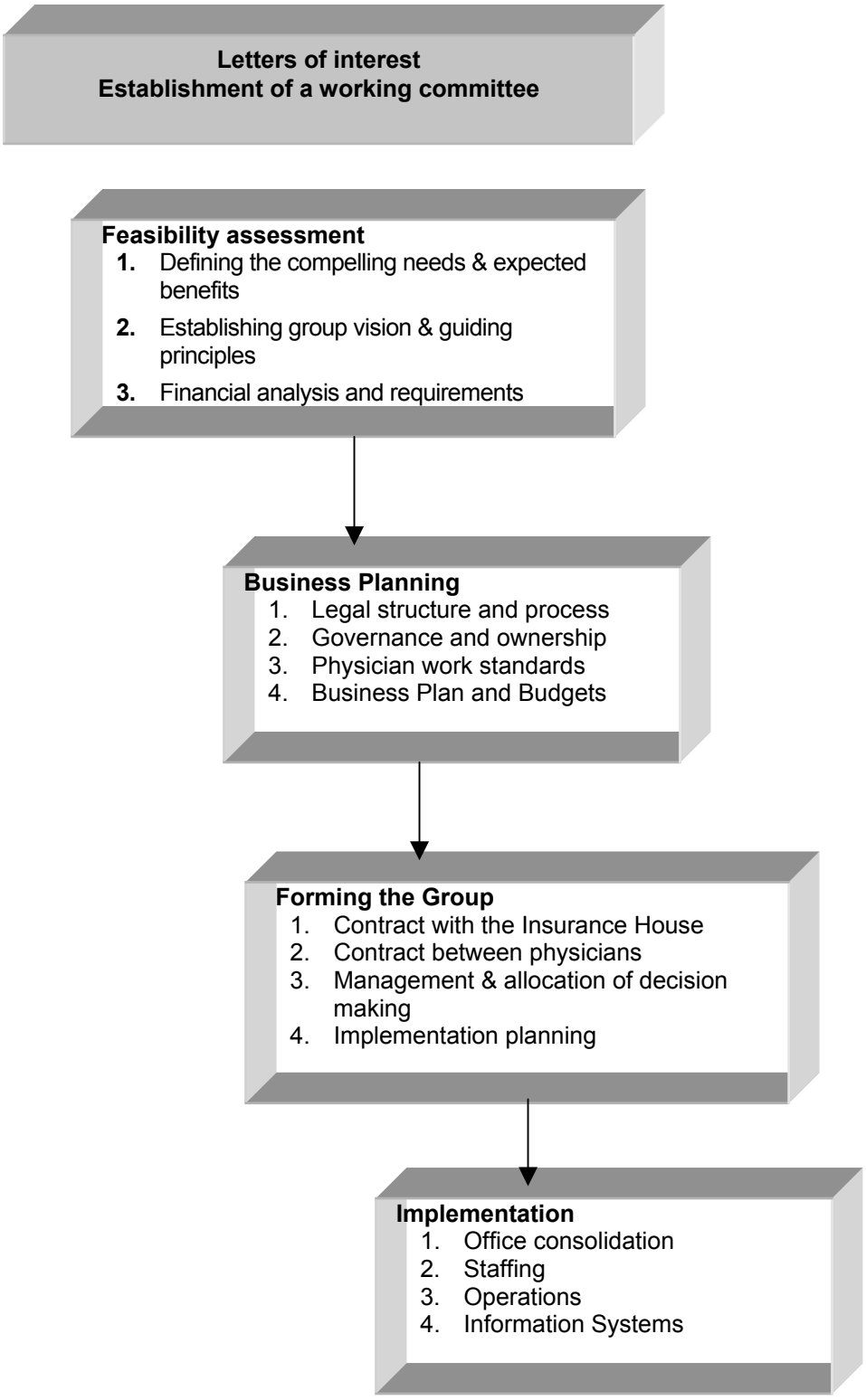
Forming the medical group is not a complicated endeavor and requires little capital to get started. As physicians begin to organize, it is important to follow several important steps to ensure long-term success. The diagram on the following page provides a roadmap to create the foundation of a successful group practice. If you are committed to forming a group, this chapter will provide you with some useful steps on how to construct and maintain a climate of open communication with your colleagues that will build trust and stimulate participation. The following discussion highlights the process and lessons learned by other physicians in starting a group practice.

Letters of Interest

This is the phase of exploration of the collaboration potential and of the attitudes of potential partners. This stage sets the tone for successful group formation. It enables potential partners to distinguish their own positions; become aware of others' talents and expertise; clarify differences; and address concerns.

At MEDFAM, the six physicians forming the partnership started their exploratory conversations in March 1999 and they continued on a weekly basis until the end of September. At that time, a Partnership agreement was signed to form the basis of the group practice.

Figure 1: Roadmap to forming a medical group



Physician interest is a prerequisite to forming a medical group. Therefore, the first step in developing a new medical group is to identify interested physicians. The benefits and challenges of medical groups should be articulated and potential physician leaders identified. Those physicians interested in joining should sign a "letter of interest" to affirm their willingness to participate and support the efforts of the medical group planning committee.

Phase I: Feasibility Assessment

Defining compelling needs and expected benefits

Desired change must be carefully defined and all involved should be in agreement in order for the partnership to be successful and sustainable. It is important that the proposed partnership be an adequate response to relevant needs and expected benefits, both for the community as well as for the healthcare providers.

Community Benefits

Recent trends in mortality and morbidity in Romania suggest a critical need for change in the health care system. Life expectancy at birth is 5 years less than in Western Europe and actually declined between 1980 and 1996, a period in which preventive efforts took hold across much of the rest of the continent. During that period, average life expectancy for males declined from 66.5 years to 65.3 years. Mortality rates from diseases that are non-fatal if detected early (e.g., breast and cervical cancer), and diseases that are partially preventable (e.g., stroke and cardiovascular disease) have risen or stabilized over the last 20 years in Romania, while they have declined in many other countries. Infant mortality is 3 times higher than in the European Community. Infectious diseases maintain a relatively high incidence with a rising trend for tuberculosis. Beginning in the 1980s, the elderly dependency rate has increased from 21.4% to 23.7%. The need for a shift from hospital-based care to primary care is clear in light of statistics showing a hospital average length of stay of 10.6 days.

Although the number of practicing family physicians in Romania ensures a national ratio of 1 GP to 580 inhabitants, the geographical distribution of these physicians engenders great disparities among regions as well as between urban and rural areas. Access to essential services such as emergency care, women's health services and monitoring of chronic diseases varies and is often inadequate in many rural communities.

All of these issues suggest unmet health needs throughout Romanian communities that call for changes in the delivery of primary health care. Evidence supports an increasing global recognition of the value of a health care system that balances general practice/family practice with specialty and hospital-based care. Studies have shown that a strong primary care component in a national health care system is associated with reduced hospitalizations, shorter lengths of stay in the hospital, and decreased costs (Starfield 1994). A country's level of primary care is closely related to improved national health indicators including a reduction in infant mortality, increased life expectancy, improved health outcomes and a focus on prevention of illness and disease. The central role of the family doctor in the achievement of quality, cost-effectiveness, and equity in health care systems was affirmed by the WHO and the World Organization of Family Doctors (WHO/WONCA) in 1994.

Ultimately, all of the primary care initiatives resulting in improved health outcomes and patient satisfaction enhance community support for the profession, contribute to an improved status for

primary care providers, and lead to increased recognition by other specialties and by policy makers.

Physician Benefits

Hardships confronting primary care providers have long been acknowledged by all of the stakeholders of the health care system. Insufficient and inadequate resources in terms of staff and equipment, practicing in isolation as well as inexperience in management skills have been discussed since the introduction of the health insurance system. Despite the obvious advantages of pooling resources, reducing administrative costs and workload relief that physician partnerships can provide, group practice remains a rarity in Romania.

However, the terms of the 2002 Framework Contract are likely to bring a new sense of urgency for collaboration among family physicians. New tasks will be added to the already large workload of the family physician. These tasks include the expansion of preventive activities with the requirement to run distinctive prevention clinics and mandatory annual coverage of the entire practice population; the new public health obligations to non-capitated vulnerable groups; and the increasing pressure to provide 24 hour access to care.

These features are not unique to the Romanian primary care system. General Practitioners (GPs) in many western health care systems have been coping with the same issues for many years. In all of these countries, workload volume, income and the correlate between the two are the most important determinants of job satisfaction among healthcare providers. Group practice appears to be the most satisfactory solution to this equation, according to evidence gathered by British, Dutch and American primary care researchers.

Managing workload

Workload is usually defined in terms of the number of hours worked (divided in time spent on different practice tasks), rates of patient contact (office consultation and home visit rates) and length of consultations. The total workload of GPs is generated from two sources: the demand for care by patients (demand-related) and other practice activities (supply-related). Demand-related influences refer to the list sizes of GP's and the composition of the practice population. Supply-related activities refer to the way GP's manage their workload.

Discussions concerning the workload of GPs are motivated by the debate about the payment/ reimbursement system and the implications of workload variations on the content and quality of care. It is argued that a fair remuneration system must reflect differences in workload. GPs with higher workloads should have higher incomes. Moreover, workload is assumed to influence performance. The diagram on the next page depicts the relationships between these factors.

Job satisfaction is another part of the equation. The extent to which GPs find their work to be rewarding, is complex and goes beyond the amount of money generated by their efforts. Much of the research is focused on factors that reduce GP satisfaction. Makin et al. (1988) found that the most important sources of stress for British GPs are interruptions in their daily routines, emotional involvement, administrative workload, and routine work. According to McCranie et al (1982), problems related to workload, such as time pressures and the amount of paperwork are most often mentioned by American solo-practice family physicians. Mawardi (1979), also in a US study, states that time pressures and the lack of leisure time present the largest sources of stress in medical practices.

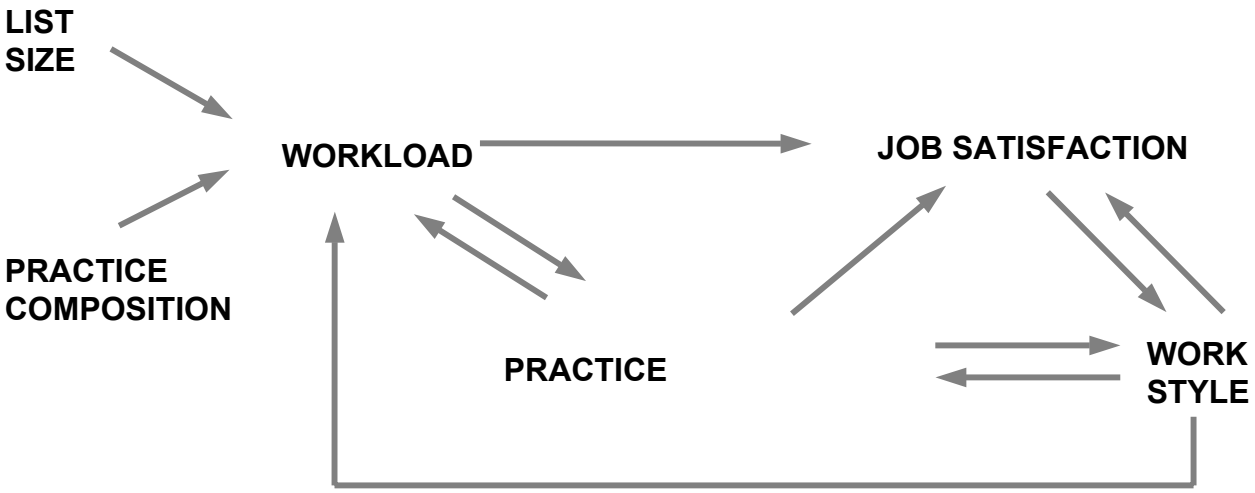


Figure 2: Workload and job satisfaction among general practitioners: a review of literature, Groenewegen PP, Hutten JBF, 1992

The relationships between demand-related workload, management of workload, and job satisfaction have not been studied systematically. Practice organization (such as partnerships, appointment systems, task delegation, and repeat prescribing systems) was emphasized by most studies to be a way to manage workload. It was hypothesized also to influence the relationship between workload and job satisfaction.

According to literature reviews, appointment systems and 24-hour coverage services were more likely to be found in practices with larger lists. In group practices, the appointment system can help level out differences in demand-related workload between partners. Bridgstock (1976) also found that appointment systems make it possible to spend more time per consultation without increasing the total number of hours worked. The research of Breslau and others (1978) indicates that the extent of task delegation (patient care tasks, e.g., history taking, physical exams and technical tasks, e.g., measuring height and weight) is greater for technical, routinized tasks.

In conclusion, there is a fair amount of evidence showing that practice organization in the form of partnerships makes it possible to structure the workload. Moreover, GPs who have opportunities to manage demand for care have a lower workload than would be expected based on their list size and composition.

Beginning the conversations

It is critical that physicians planning to form a group practice begin to address consider their motives and priorities. Following are some approaches recommended by Pringle (1991) in his book, ***Managing Change in Primary Care***, which can be helpful in initiating these conversations and the process of collaboration.

Examining personal positions

First, you need to understand your own motivations and priorities. The factors that you will need to examine include:

- Motives and priorities
- Time allocation
- Talents

Understanding your own motives and those of your colleagues is key when choosing which changes to pursue and planning for those changes. What are your prime needs? If, for example you are primarily concerned with your financial position, any change that increases your income will be attractive to you. If you are eager to be an innovator, then you are likely to be attracted to higher risk and possibly more expensive options.

The factors that motivate you and your colleagues are likely to be included in this list:

- Personal achievement
- Stability (financial and psychological)
- Relationships and emotional appreciation
- Self-image
- Status and reputation
- Creativity

We propose an exercise. Examine the list of motives and reflect on their relative importance in your life at this moment. Than give each one a score (1=low priority and 10= high priority). Ask someone you know and trust to rank these motives in relation to you. Others do not necessarily see us as we see ourselves. This has implications in your assessment of colleagues and their assessments of you.

Take yourself back a decade. Try to remember what you were doing and to recall your aspirations. For each of the motives score and order them according to how you remember them to be ten years ago. Notice how motives change. It is important to recognize this evolution of motives.

It is equally important to know and understand the motives of those who will be part of the new practice. Just as you have your motives, priorities, time conflicts and talents, so do the other members of the team. If everyone shared similar motives and priorities, then establishing the need for change and implementing it would be relatively straightforward.

Many practices fail to manage change because there is a fundamental mismatch between the motives and priorities of members of the team.

Understanding the goals of others

Failure to recognize differences in goals between members of the practice can lead to unhappy and frustrating work situations. These can occur even in long-established partnerships. As an example, disparities in workload are a common cause of partnership tension. Often partners with surgeries of equal lengths have different consultation durations. This means that some partners

see more patients. Those with shorter consultations tend to finish first and have time for other practice-based activities.

Some physicians may have commitments outside the practice, such as training appointments or may be involved in additional services. High workload partners may resent pooling their income in the practice. In such situations, open discussions usually disclose that workload is the tip of the iceberg. While completing consultations is a shared goal, teaching and other external activities may not be. Other issues are likely to surface during these discussions.

To manage change requires an awareness of what others think and feel. It is necessary to understand the goals of others. To reveal those goals requires a level of trust that may be difficult and will require continual effort.

" Are you listening or waiting to speak?"

Talking and listening are essential skills in medicine and management. Many of the principles of good general practice consulting (open-ended questions, non-directive counseling, empathy, reflection, etc) have the same relevance and validity when communicating with colleagues. Assessing underlying motives is in many ways analogous to the diagnostic process. Similarly, there are parallels between anticipatory care and the need to keep one step ahead in assessing others and predicting their future reactions.

However, it is often difficult to transfer communication skills from the consultation situation to the management situation. This is usually due to two obvious differences – management tends to be done with people we know are already well informed; and the relationship is perceived as being more equal and adult.

Seeking a consensus on goals

The better your understanding of those you work with, the greater your chance of correctly assessing their motives and goals. Some structured thinking may reveal the most obvious of your colleagues' goals. In the area of work, it will be critical to make goal-setting a group exercise.

Change may fail because people do not share a similar vision, or because they appear to agree with it and then obstruct it. At this time, it will be necessary to re-assess each person's goals to attempt to discover the problem. A re-examination of goals also may be helpful prior to a new and different change at any time along the way.

When everybody in an organization shares the same goals, matters are greatly simplified. What remains is to decide how and at what pace each goal is to be achieved. Unfortunately, this is seldom the case. It is necessary therefore to identify those goals that are shared and those that might become shared with increased understanding. In this process of seeking consensus, thought must be given to those who appear relatively neutral and undemanding. Unspoken frustrations can simmer and have a more disruptive effect on the process than overtly expressed antagonism.

When presenting ideas and seeking consensus, the leader will need to use the following skills.

- Seek opinions and feelings beforehand.
- Emphasize areas of common interest.

- Provide attractive offers for others.
- Plan for trade-offs.
- Maintain a sound, negotiating stance.
- Bear in mind the anxieties of others.
- Present a package which people cannot refuse.
- Acknowledge drawbacks honestly.
- Allow time for discussion.
- Allow time for a consensus to develop.
- Back-off and re-think rather than force a losing issue.

Never forget that success is most likely if the change solves a problem for all the participants. If this is not the case, consensus will be more difficult to achieve. Additionally, while a solution may not always be found, understanding is increased, making future cooperation more likely.

Assessing Readiness for Change

After individual and group motivations and goals have been examined, it may be useful to further examine both physician and staff readiness for change. This can be done by assessing staff values and attitudes about becoming part of a group practice, determining how the staff views their current practices, and establishing goals for the change initiative. If change is to be successful, each staff member should be included in the decision-making process.

Understanding the values, attitudes, and beliefs of the staff can contribute to establishing support for the group practice prior to implementation. Staff members are more likely to put energy into a program they helped to create, than one that is imposed upon them.

Acknowledging the value of those staff members who openly resist change is very important. Often, those who resist see barriers to change that need to be addressed. If the opinions of all staff members are valued, and if all staff members are enlisted to solve problems, then barriers can be overcome. In the future, those who initially resist may become champions of change and innovators in implementation.

Eliciting patients' ideas and concerns about the formation of a group practice may provide valuable insights in how to market the group practice to patients. This is important when patients will be required to change their habits in seeking health care.

Assessing Staff Values and Beliefs. One of the first steps in assessing staff readiness to change and to ultimately participate in that change is to determine how staff currently view their present situation. A readiness for change survey (Appendix A) can be administered. Anonymous responses should be acceptable. The survey can be analyzed with a view toward assessing variability of opinions and salient issues. This, in turn, will help in assessing the organizational climate.

Conduct Group or Individual Discussions. Through group and individual discussions, use the Readiness Survey to probe staff values and beliefs. A cohesive working team will begin to emerge from these discussions. Gather information concerning the following questions:

- How does communication flow among staff?
- What roles does staff play in the communication process?
- Who initiates communication?
- How do staff members work together?
- Who is task-oriented?
- Who is a natural leader?

Answers to these questions may provide valuable information concerning staff roles and will assist in the development of a cohesive team.

Establishing a Group Formation Committee

As the process evolves, it becomes apparent that some physicians are more attracted to the prospect of partnership than others. They are excited about the idea of change and promote them to others. This is the moment when an informal team begins to emerge. Conversations become more structured, people start assuming different roles and leadership begins to crystallize.

This is a crucial stage to formal partnership development, and it requires that the physicians commit themselves to continuing the process. Following are some insights into concepts such as "*leadership"* and "*ownership of ideas*" which may help you get through this delicate phase.

People who appear to be most efficient at managing change tend to be leaders. They tend to be regarded as sales executives, but no sales executive can be successful in the long term if the product is not right. So, behind every leader there are those who refine the product (the change that is to occur), and those who implement the agreed-upon changes. At varying times one individual may play all three roles (generating ideas, selling them and sustaining them), occasionally all at the same time. However, individual talents may lie more in one direction than another. There is nothing superior about any of these roles, since each is an essential part of the process of change. There are three other roles. There is the consumer of the change, who accepts it and will even support it in a passive way. Secondly, there is the person who obstructs change, overtly or covertly, actively or passively. The third role is assumed by the person who ignores the change. It seems peripheral to their priorities, too distant to be of concern. This can occur when the change is too small (it is delegated) or too distant (there is nothing to be done). Therefore, six potential roles can emerge before and during change:

- Generating ideas for change
- Selling ideas for change
- Sustaining the change
- Consuming the change
- Obstructing the change
- Ignoring the change

The first three roles all embody a personal commitment to the change, a concept called "ownership". The last three roles are essentially negative and infer no ownership of the change. A successful team needs members to have a range of talents for the first three roles. A team of totally like minds can be a recipe for stagnation. While virtually every change has passive consumers, all team members should be involved in the active roles for some changes while passively consuming others. Those who are always left to be passive consumers, quickly turn into obstructers and ignorers. Therefore, a successful team is one that has a variety of strengths, which are used appropriately.

Ownership of ideas

As a rule, one person or a small group of people is perceived as having more ownership of an idea than others. While it is important to credit the person with the idea, it is crucial that ***someone with authority*** be seen to own that idea. Where an idea comes from is usually assumed to be obvious, although the truth may be very different. There are many reasons why it is often useful and sometimes essential for the innovator or prime mover behind an idea to sacrifice ownership as a price for effective implementation. Among these are:

- **Pride**. People and organizations often act badly when presented with ideas which they feel they should have thought of first.

- **Fear of the unknown.** Common enough, but people or organizations tend to cope with innovation far better if they feel it *belongs* to them.

- **Competition.** For various reasons, people are often in competition with one another, possibly for status or promotion. To turn competition into cooperation often requires sharing ownership of ideas.

For these reasons, you may well find yourself passing on the ownership of some ideas to others in order to increase their chances of success. You may alternatively wish to retain prime ownership while spreading the ownership of smaller ideas to other members of the team. When people are speaking for or voting for an idea, ownership is, in part, transferred.

If an idea is to be successfully implemented, those involved need to feel part of the idea. The acid test of ownership is to determine how you would feel if the idea failed. If you own a part of it, you care about its success or failure. If you do not own it, you will probably not mourn its passing.

Eventually, the wider the ownership the better, and consensus starts with mutual ownership. However selling the idea may be difficult, and it is imperative that the stakes do not become so small that nobody cares enough to invest in making it work. So how can you sell ownership of ideas? Following are some strategies:

- Seek and acknowledge views before formulating the idea.
- Allow others to change the idea, so that part of it becomes theirs.
- Seek help in presenting and carrying forward the idea .
- Allow others to espouse the idea.
- Resist the temptation to be possessive about ideas.

- Share ideas and goals rather than solutions.
- Consider where incentives are aligned or conflicting.

An essential issue is the extent to which an idea will continue to be identified with one specific individual. Sometimes it is best to surrender the trappings of ownership, while remaining vigilant in the background. In this type of background leadership, another person is given the idea to present and develop.

Leading from behind is a high-risk strategy. However, it may offer the best chance of success in some situations. The issue with yielding ownership is that your own contribution and value may not be recognized, but this may be the necessary price for success.

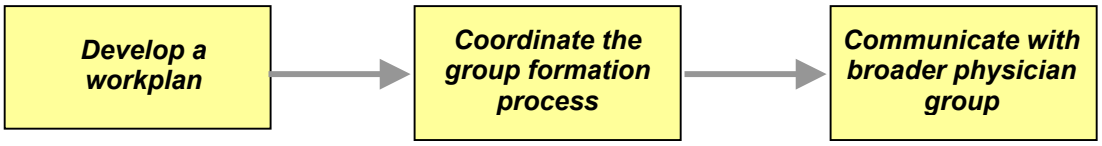
Being a chairman, although often equated with leadership, is a circumstance in which delegated ownership is often necessary. The chair can be a difficult position from which to innovate. Ideas generated from other members of the team may have a better chance of success. Thus, sacrificing the role of chairman might be the most effective way to attain power to advance new ideas.

Initiating the momentum for change is sometimes the hardest part and often physicians in the group may perceive other issues as having greater priority. Sometimes an idea may be presented but fail to gain acceptance for a variety of reasons. If an idea is good, it may work its way into the culture of the organization until its adoption seems a natural process. Initial rejection is not necessarily a disaster. It may be the precursor to a wider ownership and sponsorship within the practice.

Phase II: Business Planning

Committee Responsibilities

Identifying who will be responsible and accountable for forming the new medical group is the next step in the group formation process. The committee is usually composed of physician leaders who are willing to expend the time and energy necessary to facilitate group formation. It also may be helpful to have a staff nurse/midwife as a member of the committee to allow for staff perspectives. This committee will typically go through a three-phased process:



Developing a Work Plan

An effective work plan is key to the successful formation of a medical group. Work plans should have clearly assigned tasks and persons responsible and should be monitored on an ongoing basis. Work plans should be dynamic and flexible documents as situations can change. Following is an example of a medical group formation work plan.

Group Formation Work Plan

Activity	Person(s)	Timeframe		
		Month 1	Month 2	Month 3
Phase I: Feasibility Assessment / Business Planning				
1. Establish group vision and goals				
2. Determine legal structure and ownership				
3. Identify governance structure				
4. Complete legal documents				
5. Obtain necessary licenses				
6. Establish contract with Health Insurance House				
7. Communicate progress with other group members				
Phase II: Pre-Implementation Planning				
Phase III: Implementation				

Group Vision and Guiding Principles

As noted earlier, the most important step in forming a successful medical group is establishing a group vision and guiding principles. If the potential group is unwilling to follow the group vision and guiding principles, the long-term sustainability of the group will be in question. The process of developing a group vision and guiding principles establishes the foundation for future decision-making. It also begins to establish a culture for the group – one where the physicians begin to think collectively instead of individually. The process of going through and establishing a group vision helps to create a powerful bond between group members. It also provides a direction that can guide groups as they navigate through the formation and implementation process. It is important that the potential group identify what it hopes to accomplish before establishing a structural model. Following is an example of a group vision and guiding principles:

Group Vision and Guiding Principles

The group will:

- Deliver high quality, cost-effective health care.
- Offer an attractive, collegial, professionally and economically rewarding practice environment.
- Balance the needs of the group and its physician partners.
- Be focused on serving community health needs.
- Support continuing education and innovation in health care delivery.

Phase III: Forming the Group

Physician Selection Criteria and Mix

Successful medical groups are usually made up of physicians who share common values and who understand the need for balancing physician autonomy with group goals and objectives. Criteria

should be developed to help identify the compatibility of physicians within a group. Sample group physician selection criteria include:

- Professional competence:
  - Professional knowledge, expertise, and credentials.
  - Good professional judgment and diagnostic ability.
  - Expertise consistent with needs of group.
  - Respected medical professional.
- Group relations and participation:
  - Share vision/goals/values of the group.
  - Interest in group practice.
  - Willingness to follow the group's business decisions and clinical care guidelines.
- Financial performance
  - Evidence of financial stability in past practice.
  - Demonstration of productivity and efficiency.
- Other
  - Appropriate experience level.
  - Group practice commitment.
  - Flexibility and adaptability to change.
  - Ability to work in a shared revenue/cost environment.

Another important consideration is the proper mix of physicians (number and expertise). Many groups find it easier to begin operations as a smaller group. By establishing the initial infrastructure, the group can then continue to add physicians using lessons learned as a guide.

Determine Legal Structure and Ownership

The next step in forming a group practice is to determine the legal structure of the group. The physicians interested in forming a medical group should only get to this stage after first deciding on their mutual goals and objectives. They should then tailor a structural model to support those goals and objectives. The considerations for selection of a legal structure include:

- Analysis of the needs of physician participants.
- Physician considerations/sensitivity to merging practice operations.
- Legal and regulatory issues.
- Funding source/compensation issues.
- Comparative advantages and disadvantages of available structures.

The willingness of physicians to accept a legal structure is a key consideration in its selection. In Romania, there are a number of group practice options as noted on the following table.

Legal Framework for Group Practice - Options

- Ministry of Health (MOH) Ordinance No. 124/1998, 29 August, regarding the organizing and functioning of medical practices.
- Urgency Ordinance No.116/1999 modifying and completing MOH Ordinance No. 124/1998.
- Bill of Norms No. 786/1998 regarding the norms for practicing the medical profession.
- MOH Order No. 84/1998 regarding the license for independent medical practice in Romania; methodological norms for its application.
- MOH Order dated 19 July 1999, regarding the free-of-charge assignment of necessary floor spaces and related equipment for setting up medical practices.
- MOH Order No. 70/1999, 3 February, regarding approval for legal documentation for registering the medical practice, the registration certificate, General/Unique Register for medical practices, and the methodology.
- Pros and cons regarding the physicians associating in a group practice vs. individual grouped or associated medical practices.

Identify Governance Structure

A medical group without proper and effective governance is a group that will fail. Strong governance requires that a medical group form a board to take an oversight and policy role with respect to the functioning of the group practice. The size of the board will depend upon the size of the group. For smaller groups, decisions may be made by the entire physician membership. For larger groups (six or more), governance should consist of an executive committee or a board of directors. This helps to avoid being bogged down by slow decision-making processes or micro-management.

The process of selecting a board as well as the board's responsibilities should be clearly articulated. Those on the board should possess a core set of skills including the ability to appropriately delegate to management and staff, excellent oral and written communication skills, and the ability to engage in collaborative decision-making. Terms of board members should be structured to provide for continuity yet allow for eventual rotation of all physicians over time.

Complete Legal Documents and Obtain Necessary Licenses

Before a medical group can become official, several legal documents should be prepared and executed. The types of documents depend on the legal structure selected for the medical group. One of the key legal documents will be the physician agreement (or partnership agreement). This represents the terms and contract between the physicians in the group. The documents required for signing the contract include:

- Constitution Authorization and Registration Certificate issued by the Public Health Authority.
- Sanitary License.
- Bank account.

- Fiscal code.
- Physician's personal seal ID code.
- Independent medical practice authorization from the Public Health Authority.
- The initial list of registered patients.

Steps in Developing the Physician/Partnership Agreement

- All physician group members sign the contract for developing the Civil Medical Society (CMS).
- Development of the statutes of the CMS.
- Obtain the approval of the Board of Physicians for establishing the CMS.
- Setup a contract for physician office space with the Public Health Directorate.
- Obtain a sanitary license.
- Register the CMS in the General Register for GPs of the Health Authority.
- Obtain the Fiscal code from the Public finance Directorate.
- Obtain a bank account.

Legal documents should ***reflect*** the principles and values of the physicians forming the medical group, not ***determine*** them. Competent, experienced professional/legal advice should be sought in developing group practice legal documents.

Phase IV: Implementation

Implementation Planning

The final step in forming a medical group is to develop an implementation plan. At this point, the group vision and guiding principles should have been articulated, the physicians who will be joining the group identified, the initial investment agreed to, the governance and management identified, and all legal documents completed and executed. The implementation plan now builds on all of these steps and establishes the timeline and responsible parties to make the medical group operational. Each medical group will have a unique implementation plan depending upon local market conditions and the group's specific objectives. An example of an implementation plan created by the MEDFAM Group Practice is provided in Appendix B.

Chapter

3

Managing the Medical Group

Now comes the hard part – integrating and managing the medical group. Perhaps the most difficult aspect of integrating the group and ensuring its success is keeping everyone committed to realizing the goals and objectives the group set out to achieve. Change is a very difficult concept for many people, especially for physicians who are accustomed to practicing independently. Change management, as discussed in the previous chapter, becomes a critical component of the implementation process. Collaborative decision-making becomes an important tool in maintaining the trust of fellow physicians and staff while making practice changes.

There are a number of practice changes that will need to take place based on the objectives set forth by the group. If one of the objectives is improving practice efficiency, then the actions may consist of developing job descriptions, putting together an organizational chart, creating an appointment scheduling system, establishing practice guidelines, and other assorted activities. Similarly, if the objective is better market positioning, then the activities may consist of developing a marketing plan, offering new products and services, growing the group practice, etc. Regardless of the objectives, creating a medical group ***culture*** (a team-oriented environment) becomes paramount to the success of the group. This chapter begins with a discussion on creating a medical group culture and then offers practical tips and tools related to realizing a group practice environment.

Medical Group Culture

An important ingredient in successful medical groups is the development of a group culture. Group culture is defined in a variety of ways, but its most useful definition is "the way we collectively do things and conduct ourselves." It has also been described as a system of shared beliefs, values, and behaviors within an organization. Others suggest that group culture consists of the norms, values and unwritten rules of conduct.

The essential objective of a new group practice is the creation of a cohesive group culture. The reason for the failure of many groups is that they are just a formal collection of independent solo practitioners agreeing to theoretically share personnel and expenses. They do not realize the benefits of a real group practice. Specifically, they do not have the cohesiveness to bind them together, especially when situations get tough.

Indications that a group culture does not exist are fairly easy to determine. They include physicians or staff who display the following characteristics:

- Unwilling to delegate authority or give up individual autonomy.
- Unable to work collaboratively to solve problems.
- Not committed to or willing to follow overall group goals and directives.
- Refusing to move toward consolidation of staff and economies of scale.
- Unwilling to share revenue, expenses, or governance.
- Focused on the short-term rather than the long-term.
- Unwilling to make individual sacrifices for the good of the larger group.

Creation of a group culture is something that requires considerable time and effort. The ease with which a cohesive culture is created is very dependent upon the makeup of the physician and staff members and their receptivity to change. Different personalities require different strategies. However, by following the general rules listed below, creation of a cohesive group culture can take place over time more easily and with less effort.

1. Bring together the "right" physicians and staff with the "right" shared values. The shared vision should be group-oriented, not individual-oriented. Group goals and objectives should be developed based on this vision. Those who do not agree with these ideals or who show resistance may need to be counseled out of the group practice structure. Otherwise, successfully realizing the vision and objectives may be difficult if not impossible.

2. Place a strong and respected person in the role of group practice leader and/or manager. Strong leadership (both physician and administrative) must be in place for success. This leadership must be given appropriate authority and accountability.

3. Develop an effective governance structure (see next section for more detail). An executive committee should be formally nominated and elected to help guide the role of policy-making and management (policy-implementation). For small groups, consisting of six or fewer members, all physicians should be on this executive committee. For larger groups, a Board should be nominated and elected to represent the views of all physicians.

4. Promote team building. A team consists of a group of people working towards a common goal. *Team building* is the process of enabling the team to achieve that goal. In its simplest terms, the stages of team building include 1) clarifying the goals; 2) identifying those issues which may inhibit the team from realizing its goals; and 3) addressing the issues and removing the inhibitors to enable the goals to be achieved. Team building should be done consistently to ensure that the group realizes their goals and objectives.

5. Communicate thoroughly and regularly. The importance of communication and setting of expectations cannot be overstated. Effective communication is a prerequisite to building commitment for change and behavior modification. In addition, transparency with respect to business and financial matters helps gain the trust of fellow physicians especially during the critical initial stages of group formation.

The Importance of Governance and Physician Leadership

Governance refers to the exercise of authority and control over an organization. Without effective governance, newly formed medical groups can begin to decay and suffer eventual breakup. The need for effective governance is a function of historical physician behavior – independent solo practice. In a group setting, this independent mindset can continue unless a strong physician leader can focus the members of the group on the objectives at hand. The presence of a strong physician leader who embodies the characteristics displayed in the right hand column below will contribute to the success of the group.

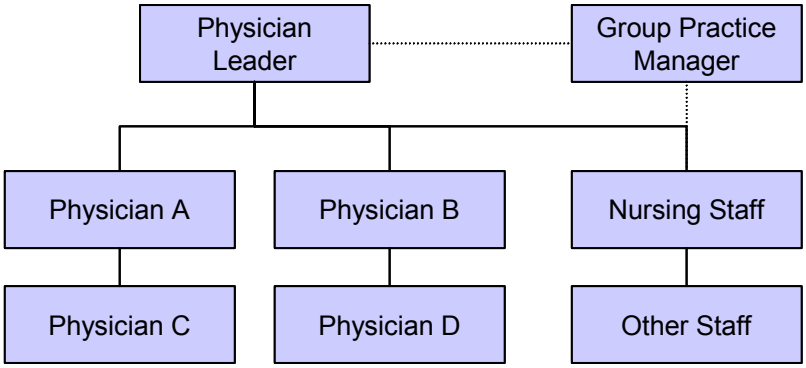
Evidence of *Poor* Medical Group Governance	Evidence of *Strong* Medical Group Governance
▪ Physicians act as part-time, untrained micro-managers. ▪ Individual physicians are valued more than the group. ▪ Unacceptable individual physician behavior is tolerated over a period of time. ▪ Decision-making is poor and delayed. ▪ The most popular, not the most competent, people are selected. ▪ Physician leader self-interest (not group-interest) dictates decisions. ▪ Management delegation is difficult or non-existent. ▪ There is little transparency of practice finances and performance. ▪ Decision-making process is idiosyncratic.	▪ Shared vision of group goals and objectives. ▪ Established and followed group principles. ▪ Effective and competent physician and administrative leadership. ▪ Appropriate delegation of authority to management. ▪ Group orientation, not individual orientation. ▪ Business and strategic plans with follow-up. ▪ Policy-making at the medical group board level.

A physician leader should possess certain competencies. As physicians are not typically trained in management, the group may need to commit some resources to help develop the skill set of the designated physician leader or consider hiring a group practice manager.

Leadership Competency	Description
Mission / Vision Articulation and Focus	▪ Acts as a champion to define and promote the organization's mission and vision.
Business Orientation	▪ Effectively positions the group within the market.
Group Leadership	▪ Promotes collaborative decision-making.
Negotiation Skills	▪ Demonstrates ability to forge relationships and agreements to further the organization's mission.
Relationship-building	▪ Develops close relationships and linkages with fellow physician colleagues and external parties.
Organizational Awareness	▪ Maintains an active understanding of the group practice operations without micro-managing.
Empowering Others	▪ Empowers others to accomplish the goals and objectives.

Practice Organization

Physicians and trained managers have very different experience levels, characteristics, and perspectives. Managers typically relate to other individuals with an understanding of the functions of management (see next section). Physicians, on the other hand, are usually individualists and have no prior experience with managing people, processes or finances. These conflicting characteristics make it difficult for the physician leader and group practice manager to appreciate each other's worlds. If your group practice is in a position to hire a trained manager or promote a capable employee, then you will benefit from the experience this individual can offer in managing day-to-day operations and helping realize the group's objectives. If your group practice is not in a position to hire a dedicated manager, then the physician leader will have to assume the responsibility of coordinating the management of administrative activities. These responsibilities can be divided among the physician members, but a physician leader should still be designated to help guide and set the development of the group practice.

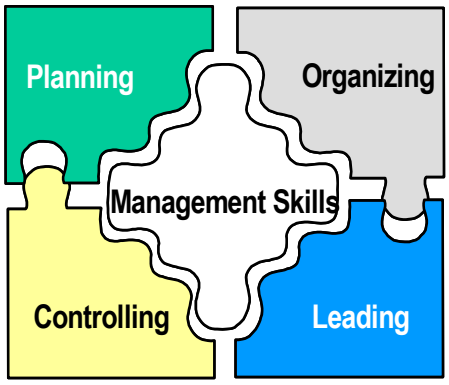


Functions of Management

Classical management theory states that there are four functions of management – planning, leading, organizing, and controlling – that must take place for any organization to operate successfully. These management functions can be thought of as pieces of a larger puzzle. All of the pieces have to fit together properly in order to have an effective operation.

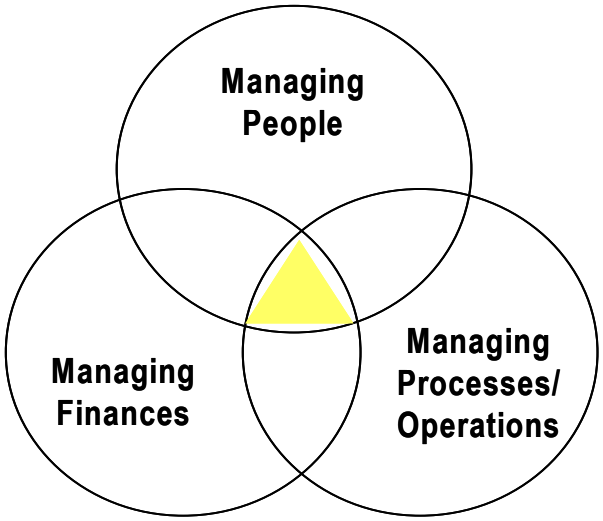
Planning is the act of defining where the organization wants to be in the future and how to get there. It requires identifying goals and the methods and resources needed to achieve them. For a newly formed medical group, planning is a critical element to keep the group focused on what it needs to do to be successful.

Organizing follows planning and focuses on how to get things done. This includes developing processes and assigning responsibility for task accomplishment.



Leading is the use of influence to motivate and direct employees towards achieving organizational goals. In a group practice, there is usually a lead physician and/or a practice manager leading the management and development of the group.

Controlling consists of monitoring processes and activities and making corrections as necessary. This includes activities such as managing finances and evaluating quality of patient care. At the center of this puzzle are **management skills**, which embody the conceptual, technical, and interpersonal skills necessary to run a medical group.



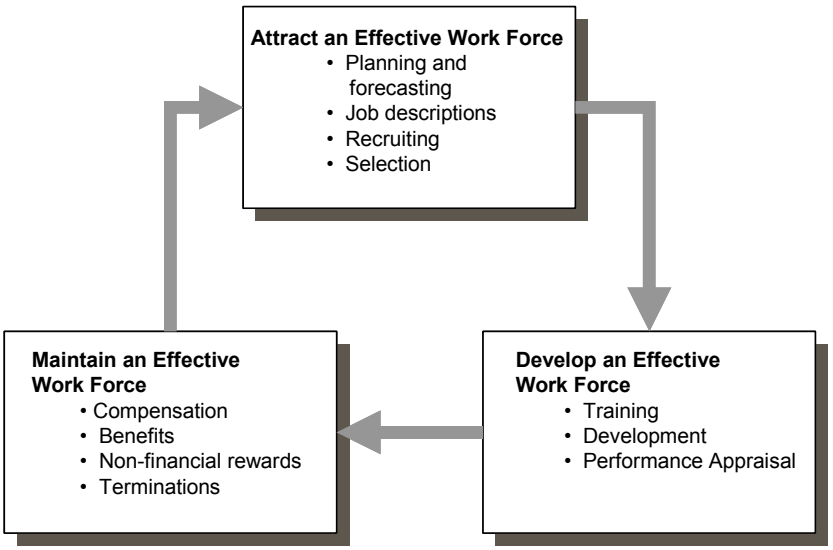
The next few sections aim to be practical and focus on the basics of what needs to be done in order to develop and manage an efficient and effective medical group practice. The model to the right displays the key activities that must take place in running any type of organization.

The model consists of the three key elements of running an efficient group: managing people, managing finances, and managing processes/operations. Each of the circles is equally important with overlapping areas that are dependent upon, and reflect upon, each other.

The central, overlapping area is the pivot around which the practice operates. It represents the skills and functions of the group practice leader to accomplish each of these three areas successfully. The following sections will describe these three management skills and their application in a group practice setting in further detail.

Managing People

Management is often described as more art than science. This is clearly reflected in the task of managing people – the cross-functional team of physicians, nurses, and support staff that make up a medical group. Perhaps the greatest amount of time spent by the group practice leader will be on managing people. This includes activities such as recruitment, training, supporting, motivating, appraising, and most importantly, communicating. But at its core, managing people is the art of attracting, developing, and maintaining an effective team (work force).



Developing a Job Description

As physicians come together to form a group, each having his/her own staff, attracting employees will not necessarily be the first priority. The physician leader or group practice manager (hereafter referred to as the 'manager') will inherit employees (nurses and other staff). These employees may not be comfortable or accustomed to working together to accomplish the tasks that are relevant

to the new group practice. Therefore, one of the most important components of developing a successful group practice is to clearly define each person's role and job function. Creating a job description is a tool to help do just that.

At the outset, the group practice manager should evaluate each employee for basic job skills, the ability to get along well with others, and work ethic. Each employee will have varying levels of skills and aptitudes. While all can make valuable contributions to the success of the group practice depending upon his or her set of skills, it is up to the practice manager to encourage them to appropriately define their contributions and encourage them to realize their potential.

Job descriptions help define and focus the employee's role in the group practice. They also help to communicate job-related expectations. A comprehensive job description would include the following major components:

- Job title.
- Job summary (a few sentences).
- Supervisor (each employee should only have one supervisor).
- Qualifications: education, skills, required experience.
- Job duties - should be clearly stated and action-oriented. Note how often tasks must be done and the performance standards by which they'll be judged.

A sample job description is provided to the right and further examples can be found in Appendix C.

Job Title – Receptionist

Job Summary – Schedule appointments, answer telephone, receive patients, and address any questions the patient may have

Supervised by – Practice Manager

Qualifications

1. One year experience as a receptionist in a medical office
2. Ability to deal with people in person or on the telephone in a friendly, effective manner
3. Well-organized
4. High school graduate

Job Duties

1. Answer the telephone within three rings
2. Schedule patient appointments
3. Prepare appointment recall and reminder notice
4. Greet and check-in patients as they arrive
5. Obtain patient demographic information
6. Other duties as assigned

The number of employees in a group practice depends on the work to be done and the degree to which activities are delegated. The MEDFAM physicians realized they had too many employees when they merged their practices. While they were not able to let go of redundant or unnecessary staff, they redefined roles so that each person was a productive member of the team.

Managing Processes/Operations

For your new group practice to be successful, you need to understand that *work is a process*. In fact, work is a collection of a number of different processes that come together to produce different outputs. A process is a set of specific tasks or activities that are done to produce an output that is needed by a customer. In a physician's office, the output is typically a treated patient. The processes that go into treating a patient include ordering supplies, scheduling an appointment,

seeing a patient, etc. There are many processes that physicians, nurses, and others in the practice engage in to produce treated patients with effective outcomes.

A group practice environment will provide unique opportunities to go beyond traditional activities and implement new and creative ways to better satisfy patient and physician needs. In addition, these new and creative ways of doing things can also help improve efficiency and increase quality. The process of identifying problem areas of the practice and pursuing improvements is commonly called "process improvement" or "continuous quality improvement." Process improvement is about improving quality while reducing cost and eliminating waste.

Poor practice organization and insufficient resource utilization may be important challenges for solo practices. These issues may be reflected in poor patient flow, inadequate use of personnel, and lack of appropriate information when needed. These issues may ultimately translate into uninformed and dissatisfied patients and overworked and dissatisfied providers. This was the case at MEDFAM prior to group practice formation. Six physicians shared a contiguous space, each operating independently and maintaining their own employees. Since there was no appointment system, patients would gather anxiously at the door, waiting to be acknowledged by a nurse so that their place in the queue could be established. Analysis of visits showed that the majority of patients were coming for 'administrative' visits, such as having their prescriptions refilled or obtaining sick leave extensions. It became very clear that these administrative visits could be organized more efficiently.

In response, one of the important initiatives pursued by MEDFAM was to implement an appointment system. They created a receptionist position to receive patients, answer telephone calls and questions, and schedule patient appointments. In addition, this person was able to take care of some portion of the administrative visits to allow the physicians to focus more of their time on actual patient care. This system would have been difficult to implement in a solo practice. However, in a group practice environment, MEDFAM was able to reorganize staff functions to create this dedicated receptionist position. With the appointment system and a full-time receptionist, patients no longer have extensive waiting times to see their physicians or take care of administrative matters. This is a classic example of applying process improvement principles.

As you begin the task of managing processes and operations, it is important that you focus on the right problems, ones that are important to you, your organization, and your customers. Working on the wrong problems will only waste time and valuable resources.

The group practice environment provides a wonderful opportunity to develop innovative solutions that improve efficiency and effectiveness. So, how do you go about doing

Effectiveness – the degree to which an organization achieves a stated objective

Efficiency – the use of minimal resources to produce a desired volume of output

this? MEDFAM followed a process that included many of the steps listed in the table below. The table provides an approach to address process and operational issues.

Step	Key Questions
1. Describe the problem	▪ What is the problem that needs to be addressed? ▪ How bad is the problem? What is its history? ▪ How does the problem affect the current customers? ▪ What will success look like when the problem is solved?
2. Describe the current process	▪ What does the current process look like? ▪ Where in the process do the problems/symptoms occur? ▪ Who is involved in the process? Who is not involved but should be?
3. Identify the root cause(s)	▪ What are all the potential causes of the problem? ▪ Which causes can be verified with data? ▪ What is the root cause or causes of the problem?
4. Develop a solution and action plan	▪ What solutions can be developed? ▪ What process should we go through to select the best solution? ▪ How will we implement the selected solution? ▪ What are the necessary resources, time, and money? Are there any limitations? ▪ What is the timeframe?
5. Implement the solution	▪ Are we monitoring the key measures? ▪ Are we following the implementation plan as specified?
6. Review and evaluate	▪ How well is the solution addressing the problem? ▪ How well did we do in implementing the solution? ▪ What needs to be adjusted?
7. Reflect and act based on progress	▪ Does everyone know about the change? If not, how does it need to be communicated? ▪ What needs were not addressed? ▪ What have we learned? ▪ How will we celebrate our success? ▪ Who needs to be rewarded?

Setting Organizational Goals

A common characteristic of successful people is that they set goals for themselves. This also holds true for organizations. Goals are targets used to set direction and to evaluate progress and degree of success. Goal setting is a powerful management process for promoting the accountability of individuals, work groups, and organizations as a whole.

Goals are rooted in patient needs and the organization's overall business purpose. Managers sometimes delude themselves into thinking the organization is doing well, even though the customers (internal and external) may not be satisfied. Before MEDFAM even began to address specific process issues, they first identified core goals that the practice wanted to achieve. MEDFAM identified three core goals to developing their model group practice:

1) To enhance practice efficiency through improved management systems and facility reconfiguration. Greater practice efficiency will allow improvement in patient care in a

current environment of serious resource constraints, ineffective use of existing resources, and from a baseline of poor patient and provider satisfaction.

2) To enhance practice effectiveness by introducing health promotion and primary prevention practices such as screening for cervical, breast and colo-rectal cancer, STDs, hypertension and diabetes. Health promotion and the provision of effective screening tests are major primary care functions and currently under-utilized in Romania.

3) To enhance effectiveness by developing reciprocal relationships with specialists, hospitals and social services. Coordination and continuity of care are essential to quality care and effective use of limited resources.

It was the first goal that focused the organization on pursuing many of the process improvements that took place in the practice. This included creating a receptionist position, reconfiguring the physical layout of the practice, and improving the aesthetics of the dispensary to increase patient, physician and staff satisfaction. Much of the work to improve the aesthetics of the dispensary was done by the physicians, staff, and their families.

Goals are essential to managing a business and keeping the group focused on operating to defined standards of performance. You achieve these goals by managing processes efficiently and effectively through creative problem solving.

Set Operational Goals by Seeing Your Practice Through The Patient's Eyes

- What does the waiting area look like? Is it inviting, pleasing, 'healing'? Is there natural light in the waiting area?
- Is there a staff person waiting to greet the patient?
- Is traffic flow efficient for patients and employees?
- What do the patient exam rooms look like?
- Is there sufficient privacy for patients?
- Does the office space appear clean and free of clutter?
- Is equipment situated for easy access?
- Is there space for patient education?
- Are patient records in a secure location?
- Is the building or office accessible for disabled persons?

Managing Finances

There may be a lack of expertise in financial management within the physician group. In this case, it will be helpful and cost-effective to hire someone experienced in managing finances such as an accountant. The accountant can help set-up a bookkeeping system, generate financial statements, and basic financial analysis. But don't count on an accountant to completely take over your responsibility as a financial manager. The accountant can help you set up the initial financial structure of the group practice. The physician leader will still need to understand financial data in order to make sound management and budgetary decisions.

Ways in Which an Accountant Can Help Your Practice

- Prepare periodic financial statements and annual reports.
- Assist you in analyzing your financial statements, looking for problems and/or opportunities for improvement.
- Determine working capital and cash flow requirements.
- Conduct customer profitability and break-even analysis.
- Help you develop a budget and setup a system for your monthly review of budget as compared to actual results.
- Prepare tax returns and assist with tax planning.
- Help set up your accounting systems, including computer-based systems.
- Assist with determining loan or capital requirements.
- Act as an advisor in financial and administrative matters.
- Perform operational reviews and help you find ways to operate more efficiently

New business leaders and managers have to develop at least basic skills in financial management. Expecting others in the organization to manage finances or shifting it completely to the accountant is clearly asking for trouble. New leaders and managers should learn how to create financial statements and analyze those statements to really understand the financial condition of the business. Financial analysis shows the economic "reality" of the business in terms of revenue and expenses. This section is intended to help you understand the basic practices in financial management needed for a healthy business.

Basics of Financial Management

The following overview will give you some perspective on the basic processes involved in financial management for small, for-profit businesses. The following activities described below occur regularly as part of the yearly accounting cycle. The accounting cycle includes bookkeeping, generating financial statements, and analyzing information from these statements.

Bookkeeping – Bookkeeping (or record-keeping) is basically recording various financial transactions such as cash receipts (revenue) or cash disbursements (expenses) in a journal or ledger. Each posting should refer to accompanying documents that you keep on file such as receipts or checks. Unless you're experienced in accounting, you should let your accountant handle this activity.

Budgets – A budget is a very important financial statement and should be prepared by the practice leader or manager on a yearly basis and revised regularly. A budget shows planned revenue and expenses for the coming year. Budget amounts are usually divided into major categories, such as employee salaries, benefits, equipment, supplies, etc. It is advisable to review your budget against actual revenue and expenses on a monthly basis. This way you can compare

your planned revenue and expenses to actual revenue and expenses. This will give you a good idea of whether you are operating according to plan or whether you need to reduce expenses or increase revenue.

Financial Statements – In order to know how your business is doing, you will use your bookkeeping information to produce various financial statements, including a cash flow statement, an income statement (revenue & expenses), and a balance sheet. The ***cash flow*** statement depicts changes in your cash during the year. The ***income statement*** depicts the changes in your assets over the past year. This statement will tell you if you are operating with a profit or a loss. The ***balance sheet*** depicts the overall value of your business at any given time, by reporting the group's total assets, subtracting your total liabilities, and reporting the resulting net assets. The statement below is an example of an income statement.

Revenues reflect the income that comes into the practice .

Expenses define the cost of doing business by category.

Variable costs vary with the volume of patient activity.

Fixed costs remain constant regardless of patient activity.

The net income is calculated by taking revenue and subtracting expenses.

ABC Family Physicians
Income Statement
For the Year Ended 1998

Patient Revenue	
Capitation Revenue	867,313
Medical Fees - FFS	186,966
Medical Fees - Adjustments	(57,409)
Total Revenue	996,870
Expenses	
Physician Salaries	414,753
Non-physician Salaries	199,933
Benefits	118,471
Payroll Taxes	44,449
Total Salary and Benefits	777,606
Medical Supplies	33,681
Facility and Occupancy	97,716
Advertising/Promotion	5,827
Office Supplies	23,230
Telephone	10,121
Postage	4,043
Insurance	7,371
Travel	1,469
Miscellaneous	(155)
Total Other Expenses	183,303
Total Operating Expenses	960,909
Net Income (Loss)	35,961

Financial reporting – By themselves, numbers don't usually mean much. But when you compare them to certain other numbers, you can learn a lot about how your business is doing. For example, you can compare your planned revenue (based on your patient lists and expected points) and compare that to your actual revenue to see if the money is coming in as expected. Another key analysis is determining whether you are operating with a profit or a loss.

Working Towards Profitability

The independent contractor status of general practitioners means that they are self-employed, but contracted to provide for medical services. This does allow them the freedom to decide how they organize and run their practices. This also means that they have the responsibilities associated with running a business as well as the clinical services provided.

The fundamental equation of financial performance should be evident to every GP:

Profit = Revenue – Expenses

Profitability for a practice depends upon two management actions: optimizing revenue and minimizing expenses while providing quality patient care.

The introduction of global practice revenue, instead of the dual system separating practice budget from physician income, is likely to add extra pressure on financial management decisions, since the practice financial requirements compete with the physician's personal income. This constitutes a major challenge to practices in enhancing their capability to manage resources cost-effectively, i.e., the need for budgeting and resource control. As it will be shown below and in several other sections of this manual, one spin-off of this innovation is likely to be that partnerships/group practices, will gain the benefits of sound financial control of their business before conventional solo practices. Therefore, it is essential that any conversation around income and finance be based upon a clear understanding of budgets. An example of a budget analysis is provided in Appendix D.

Budgets are statements of anticipated performance expressed in financial terms and divided into revenue and expense categories. Revenues in Romanian family practice come from two possible sources. The most significant of them (if not almost exclusively for many practices) is the contract with the insurance house with its two payment types:

Capitated Revenue: given by panel size or number of capitated lives and the list composition, i.e., distribution by age.

Fee-for-service Revenue: expected number of items, estimated revenue per item.

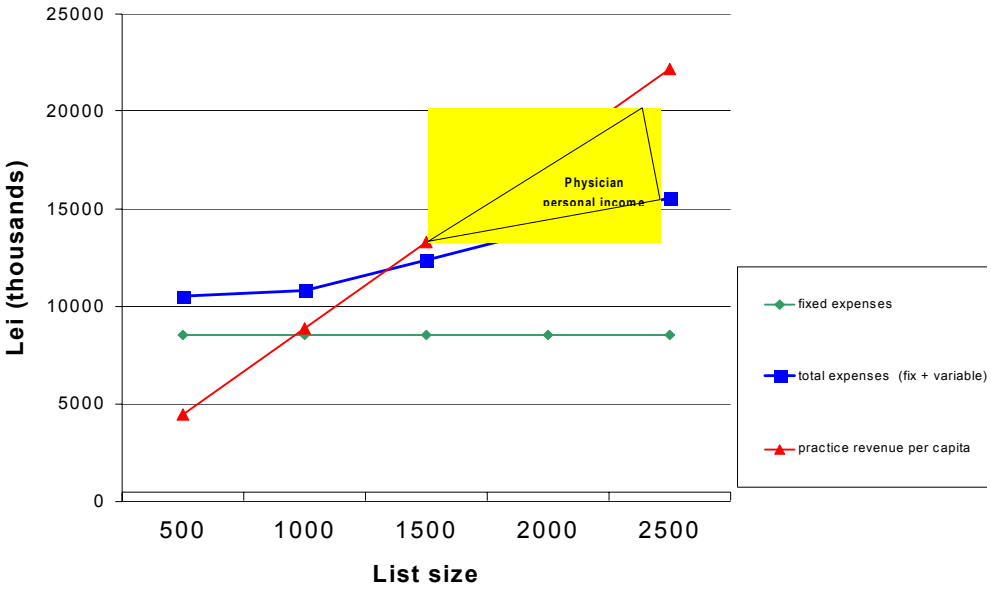
Client-fees: less significant in volume, but nevertheless important because of its entrepreneurial implications, is direct payment from the client for service items not included in the insurance benefits package. Besides health certificates of all kinds, developing other services like rehabilitation, lab tests etc., are potential alternative revenue generating activities.

Very critical to practice economics is the sound understanding and control of expenses. What contributes to the amount of expenses? What is the significance of each expense category? How is the volume of practice activity influencing them? These questions are vital for any entrepreneur in any domain.

Variable Expenses	*Semi-variable Expenses:*	*Fixed Expenses*
Covered services, expected number of visits (linear) - e.g. medical supplies, office supplies	Expected number of visits over relevant ranges (non-linear) – e.g. nursing salary costs	Estimated based upon historical use (overhead, staff)

Available data from the first two years of the new payment system (per capita, practice budget and fee for service) showed a marked dominance of fixed expenses in the total practice expenditure.

The impact of the introduction of the global practice revenue at the current per capita point value is illustrated below. It is easy to see that the physicians' personal income becomes a direct expression of practice profitability. The graph presents the relationship between revenues and expenditures on the one hand and volume of activity (i.e., list size) on the other. It clearly shows that expenses do not have a linear relationship since they are heavily dominated by fixed expenses – that is expenses any practice would incur no matter the size of the population.



Shared overhead and staffing costs are the classic examples of group practice benefits in reducing the pressure of fixed costs on the practice revenues. As mentioned in the previous section, group practice is also one effective way of maximizing volumes by increasing list size. If developing additional services is the focus, joint capitalization and increased patient lists as a result of partnerships make equipment purchases possible and maximize investments. Development of services such as laboratories or ultrasound requires a minimum population size in order for it to be profitable. In conclusion, a group practice is an effective way to increase profitability and deliver patient care in an effective and efficient manner.

Chapter

4

Creating Excellence in Clinical Practice

Throughout the world, there is recognition that effective health care services depend, in large part, on the balance between primary and specialty care. It is clear in both developing and developed countries that primary care is the most efficient way to improve national health indicators. A well-accepted definition of primary care is as follows:

> PRIMARY CARE is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
>
> (1996 IOM Report on the Future of Primary Care)

The provision of primary care is carried out by clinicians who are appropriately and specifically trained to have the knowledge and skills needed to plan and implement community-based programs that address the definition of primary care. In most developed countries and increasingly in developing countries throughout the world, this task is carried out by family physicians (general practitioners) with specialty training in family medicine (general practice). The World Organization of Family Doctors has defined a family physician as follows:

> FAMILY PHYSICIAN is a licensed medical graduate who gives personal, primary and continuing care to individuals, families, and the practice population, irrespective of age, sex, and illness.

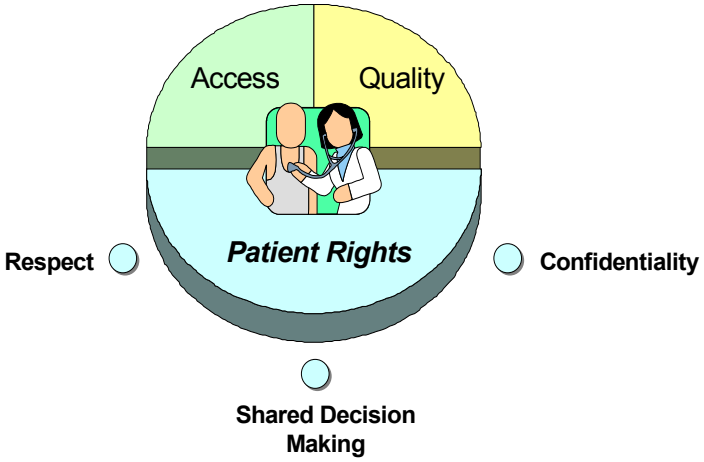
The MEDFAM group practice organized its practice according to internationally recognized principles of primary care. The following are the key elements of family medicine that have been incorporated into the MEDFAM practice:

- Patient Centered Care
- Continuity of Care
- Access to Care
- Coordination of Care
- Comprehensive Care
- Improving the Quality of Care
- Prevention and Health Maintenance
- Cost effective Care

This chapter will review each of these principles and discuss how they can be incorporated into Romanian family practice dispensaries, using MEDFAM as an example.

Patient-Centered Care

The patient must be seen as the center and the focal point of the health care system (refer to the following model). Those in need of care have certain rights that all practices should be designed to meet. Each person in need of care has the right to be seen by a physician and/or other health care provider, to receive quality care, be treated with respect, and share in treatment decisions. Further, they should be able to feel assured that their interactions with health care providers and their medical records will be kept confidential.



Patient Rights

Patients have certain rights according to Romanian Law No. 45:

- To freely choose his/her family physician (to register on a physician's list of their choice after providing proof of health insurance). If a patient is not able to find a family physician, the Health Insurance House must provide them with a list of accredited physicians who can register patients on their lists.
- To be examined by a physician (not necessarily his/her family physician) during the regular work schedule of the medical practice.
- To be informed about the services offered by the family physician.
- To request and receive consultations by telephone.
- To request medical home visits. The physician will decide if these are necessary and whether they are contracted with the Health Insurance House.
- To receive immediate treatment in case of emergency.
- To change their registrations to another physician's list.

- To enjoy confidentiality. Parents or legal tutors are entitled to be informed about their children under the age of 16.
- To receive appropriate treatment and medication according to their illness or condition.
- To receive referrals to specialists, if needed.

The list of patients' rights according to Law No 45 should be posted on the wall in the waiting room of every primary care practice.

Practice Brochure

The practice brochure is an important way of informing patients about their rights, the functioning of the group practice, and the benefits to the patient. It is worthwhile to spend time and money to produce an understandable and attractive leaflet. The brochure will be seen by many people and will serve as a valuable marketing tool in providing patients and families their first impressions of the practice. The brochure can also be used to establish procedures and minimize misunderstandings. It may be of value to add the group practice mission statement as well. Under the terms of service, certain information must be included in such a brochure as follows:

- Names, qualifications, and year of birth or first qualification of each physician
- Information about making appointments
- Arrangements for home visits
- Emergency call procedures
- Off-duty arrangements
- Prescription refills
- Clinic times
- Details of staff other than physicians
- Other services (types, charges, times available)
- Patient education activities including health education for disease prevention
- The geographical area covered by the practice
- Access for the disabled

It is very important to establish good and efficient communication between patients and members of the group practice. The group practice has a responsibility to inform patients about the medical services offered and the ways to obtain these services.

Continuity of Care

The family physician is involved in many of life's important events. Care is improved through knowing families and their medical history and developing trust over time. MEDFAM has improved continuity by developing an appointment system, and arrangements for care of unscheduled and after-hours patients.

Quality patient care includes timely access to care without great difficulty. Patients should be able to be seen by a physician without having to wait in the waiting room for an extensive amount of time. Barring an emergency, patients should not have to wait more than 30 minutes to see a physician. In the most efficient systems, patients should not have to wait

more than 15 minutes to see a provider. One important way to become more efficient and to reduce waiting time is to institute a patient appointment system.

Planning the appointment system

A patient appointment system will reduce the number of people waiting to see physicians in the waiting room, improve patient satisfaction and reduce staff stress. It can also be used to increase efficiency by facilitating triage and access to specialized services. All physicians and staff in the group practice must agree to the development of the patient appointment system. In order to provide baseline information for planning and evaluation, it is useful to monitor the waiting times of patients prior to implementing an appointment system. Additional elements for consideration in developing an appointment system are the size of the capitation list, the age range of patients, the disease burden and an understanding of the most common reasons for visits.

Monitoring Waiting Times

Certain interactions may adversely affect how patients feel about the kind of care that they receive, a critical element of patient satisfaction. The monitoring of patient waiting times can be particularly important in practices that have a significant number of elderly patients. Sufficient data should be collected to reflect the activities and types of patients seen in the group practice. Observations should be made both in the morning and the afternoon over at least one week's time to allow for measurement at "peak/busy" times and other times when it may not be as busy.

A staff member can monitor waiting times in the reception area. The observer can sit in the waiting room and measure the time spent by patients from the time they enter the practice until they exit the examination rooms. While observing, the person notes "what happens" in the waiting room and in the medical attendants' room. These observations will be useful to the practice in improving patient interactions with staff.

Following is an example of the type of information to be collected using a pre-developed form:

- The form should include the date, whether the visit has been scheduled, the patient's check-in time, the check-in time with the nurse, the check-in time with the physician, the nurse's check-out time, the patient's check-out time, and the primary reason for visit;
- Repeat the same procedure for the times spent in the treatment room.

Monitoring of patient waiting times should take place periodically after the appointment system is implemented to ensure that waiting times continue to be reasonable.

Implementing the Appointment System

To ensure the success of an appointment system, one staff person needs to be assigned as the receptionist. This individual will be responsible for maintaining the appointment schedule and making individual patient appointments. Patients should be informed and educated about the new appointment system. It is the responsibility of the receptionist to inform patients about the appointment system and to briefly discuss the benefits to the patient, the staff and the overall functioning of a more efficient health care delivery system.

Flyers, brochures, signs in the waiting areas and staff and provider discussion are other ways to provide information to patients.

Appendix E contains a scheduling template that can be used for each physician. It should include times in the office, home visits, and absences. Routine appointments can be scheduled in 15-minute increments while special examinations may require longer lengths of time. If the scheduling is done electronically, it is advisable to have a back-up paper system in case of a malfunction or electrical failure.

To help ensure that patients do not forget their appointments, the date and time of the appointment is noted either on the inner cover of the personal health card or on a separate appointment slip. In the event that a physician is not available for an appointment, due to an emergency or other reasons, the patient will need to be rescheduled. Alternatively, arrangements can be made for the patient to be seen by one of the other group practice physicians. Willingness to see patients for other physicians in the Group Practice is an integral part of the group practice ethic.

Planning ahead

In preparation for the next day, medical records can be taken from the files and placed on the physician's desk. This saves time and effort the following day and allows the receptionist time at the end of the shift to file the current day's records and to obtain patient medical records for the next day. This effort is more efficient and easier than accessing records as the patients arrive for their appointments. At the same time, this can be an opportunity to review charts to identify needed prevention services. The availability of patient charts is a critical element in both quality and continuity of care. In addition to the daily stack of patient records, the receptionist can also provide the physician with a list of the patients scheduled to be seen that day. This provides the physician with information about individual patients to be seen as well as workload. Nurses should also have copies of the appointment lists for each physician.

Implementing a new appointment system is not an easy task. Most importantly, establish policies and procedures and adhere to them. Changing the patients' perception and behavior may require patience and tenacity but the benefits outweigh the initial challenges!

Access to Care

Quality care assumes that the family doctor is accessible to the patients and families under his/her care. Providing patients with appropriate access requires thought and planning.

Emergency Patients

Every practice can expect to receive emergency patients. Emergency patients are of two types: true emergencies and urgent patients who present for care without an appointment. True emergencies are characterized by severe pain, unstable vital signs, symptoms suggestive of myocardial infarction or cerebrovascular accident, etc. Such patients are fortunately uncommon. These patients should be taken immediately to the treatment room, the

physician summoned and an ambulance summoned. The physician or an experienced staff member should stay with the unstable patient until transport to the hospital arrives. A protocol for the management of emergency patients should be developed to prevent misunderstandings about staff roles and responsibilities. This will ensure that the patient is cared for effectively until care is transferred to the emergency medical system (EMS).

Urgent patients

Even with a well-developed appointment system, patients will arrive each day with urgent problems such as streptococcal pharyngitis, cystitis, acute bronchitis, etc. A plan for caring for these patients must be developed. Otherwise they will be inserted into an already full schedule and cause scheduled patients to wait. This, in turn, will degrade the appointment system. An important first step is to determine how many urgent patients must be accommodated during an average day. In order to do this, the appointment system must be functioning. Then the practice manager can determine the numbers of such urgent patients (as opposed to non-urgent patients who just arrive at the clinic requesting a medication refill). If the numbers are modest, then the scheduling template should leave 2-3 15-minute spaces open for urgent patients during each half-day session. An alternative is to leave the last hour of each session for urgent visits, but that forces patients to wait up to 4 hours in the waiting room for their visit. In larger group practices, a third alternative is to designate a physician as the "urgent care MD" for each half-day session, with the majority of his/her time reserved for these urgent care visits. This may be especially advantageous in the winter influenza season.

Availability of Medications

Most primary care physician offices have a supply of drugs available for emergency care, immunizations and certain other drugs. Accountability, appropriate storage, and attention to expiration dates are all responsibilities of assigned staff. Appendix F contains further detail.

After-hours/emergency care policy

Emergency assistance is provided 12 hours per day at the practice by the medical team (physicians, nurses) during regular working hours (7:00 AM – 7:00 PM). Between 7:00 PM and 7:00 AM, emergency care is provided by the on-call physician. The on-call physician sees all patients, regardless of whether the patient is on the physician's list or not. Emergency assistance on Saturday and Sunday and during legal holidays is also part of the practice. These medical services must be negotiated with the Health Insurance House in order to be reimbursed.

Coordination of Care

Family physicians are advocates for their patients and help them negotiate the health care system no matter the location or the setting. They are responsible for helping their patients navigate the health care system. Concepts important to coordination of care include:

- Well-organized medical record system;
- Professional collegiality between primary health care and specialty personnel;
- Emphasis on teamwork among the office health care "team"; and
- Collaboration with ancillary services such as home health visitors, and health educators.

Patient Records

Patient records are key to delivering quality care. It is critically important to record content of care at each visit along with medications, treatments and laboratory tests ordered and referrals made. The following data are included in patient records: date of birth, sex, marital status, permanent address, phone, occupation including working conditions, employer, and personal and family medical history. An important component of the chart is the patient problem list. The problem list should identify serious problems that each physician caring for the patient should be able to identify at a glance. The list should be the first item one sees on looking at the chart, after the patient identifying information. The problem list should be regularly updated. For example, a problem of "weight loss," after investigation, may be updated to "diabetes type II."

Patients' records are maintained in envelopes and the physician-nurse team is responsible for allocating sufficient time to complete them during or directly after each visit. Records can be hand-written (as is the medical treatment record) or kept electronically in computer files. The existing norms stipulate that patient records must be kept for five years after the patient is removed from the GP's patient list. Patient records must also be kept in a secure location to maintain patient privacy.

Maintaining a patient database is important for effective and efficient management of patients. This information is also useful in planning patient education programs (e.g., identifying patients with diabetes or hypertension) and/or measuring quality of patient care. Another use of this information is in developing targeted prevention programs such as immunizations, cervical cancer screening, prenatal programs, etc.

Experience at the MEDFAM practice has shown that patient registration data are as important as clinical data in the diagnosis and treatment of patients. It is very important to have a standardized system of registration, information, and record keeping for the entire group practice. Since this information system is so useful and valuable to the practice, it is important to provide focused training for the practice staff concerning the input and maintenance of patient data. This is particularly important because MEDFAM surveys of staff attitudes have demonstrated that maintaining this registration data is considered by staff to be "the most tedious" of all practice activities.

Referral to specialty services

Referrals to specialists are recorded daily on a specially designed form (Refer to Appendix G for an example of a patient referral form). Referrals may be for tests or procedures (e.g., X-rays, EKG, clinical laboratory) or establishing and/or confirming a diagnosis by specialists. The Health Insurance House maintains a monthly record of the number of referrals to the hospital and to the medical centers for diagnosis and treatment. The volume of referrals is justified by the limitations of the technical equipment of the family physician's practice and by his/her medical competence.

Monitoring referrals to physician specialists, whether to outpatient facilities or hospitals is important. For a group practice this can be facilitated if the physicians collaborate with other physicians/specialists and receive feedback reports. Copies of treatments, medications, and procedures should be appended to the patient record.

Referral information is important to maintain continuity and quality of patient care. This information may also be useful in estimating the practice budget and in providing justification for adding other services to the practice. Feedback information from specialists can also be an opportunity for clinicians to enhance their knowledge and ability to manage various conditions and illnesses.

Data to be collected to monitor referrals are as follows:

- diagnosis
- name of specialist or referral clinic
- hospitalization including length of stay
- tests and/procedures done
- treatments and/or tests requiring further follow-up
- extension of sick leave
- evaluation of the working capacity of the patient

The Health Care Team and Teamwork

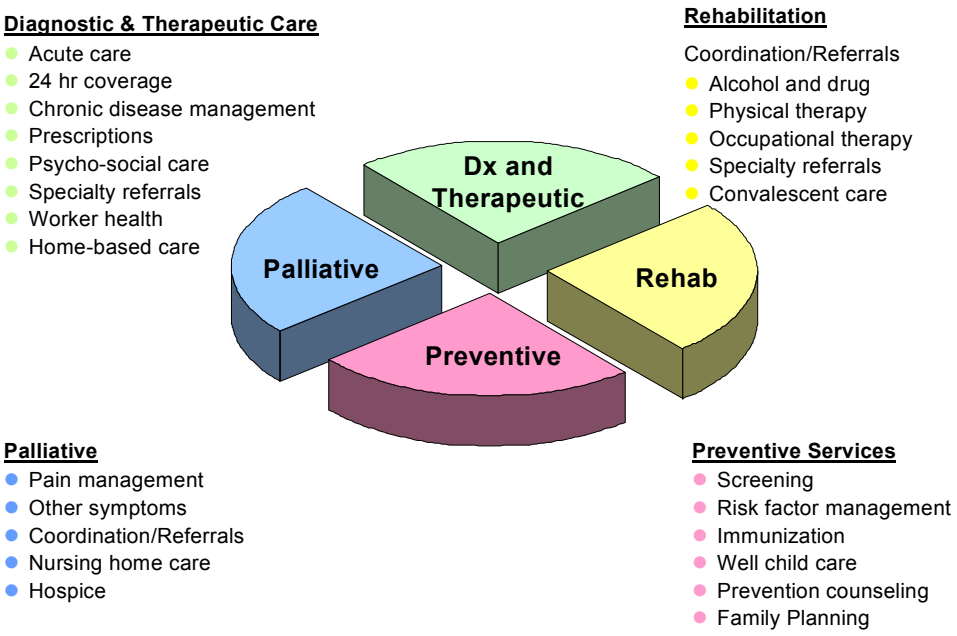
The emphasis has been on teamwork among the staff in the group practice. This is a critical component in the effort to provide effective and efficient care. Lets now take a step back and consider the larger health care team---the health educators, the home health visitors, specialists, community resources and hospital resources. All of these individuals and entities are critical to providing coordinated care for each patient. Some patients may never need much in the way of coordination, while other, particularly the elderly and those with chronic diseases may need intensive coordination of care. Primary care physicians and their staffs have the major responsibility for coordinating care for their patients. Quality patient care is coordinated and cost-effective care.

COMPREHENSIVE CARE

Family physicians are the physicians of first contact. Family physicians are specialists in caring for undifferentiated problems. International studies show that well-trained family doctors care for over 85 percent of all medical problems that present to them in their offices. Studies in many different countries show that about 19 diagnoses account for about 50 percent of visits.

Scope of Primary Care Service

Primary care consists of prevention, health education, diagnosis, treatment, rehabilitation, management of chronic disease, and terminal care. The model following this paragraph lists some of the services under each of the components. It is not expected that primary care physicians will provide all of these services. Referral mechanisms should be developed so that patients who need special services such as hospice care or physical therapy can be sent to appropriate providers. Further, primary care physicians have the responsibility to coordinate care across multiple referrals and services. Physicians in group practices may be able to provide more of the services listed because of the different interests and expertise of the individual physicians in the group.



Morbidity Surveys

In 1999, MEDFAM kept track of the kinds of diagnoses that were seen in the practice. The following table shows the distribution of diagnoses by patients seen in a one-month period. This kind of morbidity study can be done in any practice and is an important part of health reform efforts in many central and eastern European countries. It allows the practice to recognize the diagnoses that are seen frequently and to develop effective and efficient methods for treating these common problems. One way to do this is to develop practice-based guidelines. These are discussed in the next section.

CHRONIC DISEASES SEEN AT MEDFAM: DECEMBER 1999				
	CURRENT PATIENTS	NEW PATIENTS	OUT	TOTAL
TBC	108	1	20	89
TUMORI MALIGNE	245	6	47	204
GUSA NODULARA SIMPLA	21	1	0	22
DIABET ZAHARAT	313	3	37	279
CALCULOZA CAILOR URINARE	46	0	16	30
ANEMII	42	1	0	43
BOLI PSIHICE	151	0	71	80
EPILEPSIE	27	1	0	28

REUMATISM ARTICULAR	7	0	0	7
CARDIOPATIE ISCHEMICA	754	14	161	607
BOALA HIPERTENSIVA	1141	19	120	1040
CORD PULMONAR CRONIC	23	1	3	21
BOALA CEREBRO-VASCULARA	68	12	0	80
BOLI PULMONARE CR. OBSTRUCTIVE	119	3	30	92
BOALA ULCEROASA	196	13	0	209
CIROZA SI ALTE HEPATITE	114	0	12	102
INSUFICIENTA RENALA CR.	13	1	0	14
OPERATII PE CORD SI ARTERE	50	3	1	52
VETERANII DE RAZBOI	193	3	0	196
DETINUTI POLITICI	19	2	0	21
URMASI AI EROILOR MARTIRI	2	0	0	2
NEVAZATORI	17	1	0	18
GLAUCOM	55	2	0	57

Improving the Quality of Care

Practiced-Based Guidelines

The first step to improving quality is to recognize that there are always possibilities for continued improvement in clinical practice. How can family physicians continue to improve the care that they provide for the common clinical problems that they encounter?

One way to improve quality is to organize a system of Clinical Practice Guidelines (CPGs). CPGs are systematic, evidence-based recommendations which, when implemented, will result in improved health outcomes for patients. CPGs allow for dissemination of new, effective therapies and provide a mechanism for standardizing clinical systems so that therapy that is known to be effective is used. CPGs are not rules or orders and may not be applicable to all patients with the same condition. It is important to consider patient preference and local variation based on economic factors

You may want to query the group practice physicians concerning where to begin the clinical practice guideline process. For example, in 1999, a survey was done of family physicians in Cluj, Constanza, and Iasi asking them for which clinical conditions they would like to develop CPGs. The following table shows the results of this survey.

Priorities of Selected FPs in Romania When Asked What Practice-Based Guidelines Would be Most Helpful to Them

	Cluj	Constanza	Iasi	Average
Adult Prevention	1	1	1	2.1
Diabetes	3	3	5	3.2
Hypertension	5	4	3	3.7
Contraception	4	6	4	3.9
Geriatrics	2	7	8	3.9
Prenatal Care	6	5	6	4.2
Pediatric Prevention	10	2	7	4.2
Smoking Cessation	7	8	2	4.2
General Consultation	8	9	9	5.4
Orthopedics	9	10	10	6.2

Based upon the results of this and other surveys, hypertension and diabetes mellitus were chosen as the first two guidelines developed. Subsequently, several workshops were held between 1999 and 2002 to develop guidelines for those clinical conditions that would be useful to Romanian family physicians.

How to Develop a Practice Based Guideline

The following table shows the sequence of steps that a Group Practice can follow in order to develop a useful Clinical Guideline. These steps are briefly described below.

Guideline Development Sequence

Step I: Select Clinical Problem
Step II: Develop an Action Group
Step III: Write guidelines or obtain "seed"
Step IV: Obtain Consensus
Step V: Disseminate and Pilot
Step VI: Revise
Step VII: Implementation
Step VIII: Monitor and evaluate
Step IX: Revise and evaluate

The first step is to annually **select a clinical problem** for intensive effort. The condition chosen should be common in your practice and treated in your practice (not referred out on a routine basis). There should be consensus about the choice of topic among the members of the group practice. It is important to establish a sense of urgency for each topic chosen in order to motivate the practice to implement the results.

Second, a **guideline development team** should be formed for each new topic. The team can include senior leaders, content experts, physician change agents, clinical managers, clinical staff, data collectors and others within and external to the practice.

Third, find a **published "seed" guideline** that can be adapted to local needs. Clinical practice guidelines may be accessed at the following website: www.guideline.gov. This website, the National Guideline ClearingHouse, was developed by the Agency for Healthcare Research and Quality in partnership with American Medical Association and the American Association of Health Plans. It is an Internet based repository of guidelines containing structured abstracts, full text guidelines and comparisons among guidelines covering the same topic. These evidence-based guidelines have been submitted by many different groups of providers. By the end of the year, 2002, a website, the National Quality Measures ClearingHouse, will be online and will contain quality measures by disease or condition. These measures can be used to assess the quality of care for certain conditions and also to identify and monitor opportunities for improvement.

Fourth, it is important to **obtain consensus among the group practice.** Routine agreement of guidelines can be achieved and will facilitate the implementation phase. Collaborating and consensus speeds improvement. Guidelines modified from national or international experts may increase acceptance by practitioners. Consensus will be more easily reached if the following questions are addressed:

- Was a complete search of the literature performed?
- Was a formal process used to abstract, synthesize and assess the evidence?
- Was the process explicit?
- Does the sponsoring entity have a vested interest?
- Was the developer representative of those who will be using the guideline?
- Was the guideline peer reviewed?
- Is the guideline updated on a regular basis?
- Are practical, clinically important recommendations made?
- Will the guideline, if implemented, improve the health of the patients in your practice?

Fifth, the guideline should be **disseminated to the staff and pilot studies** initiated in the practice. Regular meetings should be scheduled that allow the staff the opportunity to provide feedback about the content or the process of implementation. The guideline should be adapted to local circumstances and easy for the staff to follow.

Sixth, the guideline should be **revised** based upon the feedback of the staff. This is an effective way to 'iron out the wrinkles' and to have the staff feel part of the process, thereby facilitating implementation. It is at this stage that any identified barriers are addressed and successes celebrated.

The seventh step, **implementation**, is the most difficult. Passive dissemination of guidelines is insufficient to produce sustained changes in patient care. Once completed and consensus reached, the guideline should be actively implemented in the group practice. Ways to do this are to place reminders in patient charts, bring in expert opinion leaders to emphasize

importance, provide organized lunch presentations, and make the guideline part of the routine duties of the support staff.

Eighth, the guideline should be **monitored and its impact evaluated.** The measurement of outcomes for improvement may be unfamiliar. The process of measurement should include audits and feedback to providers. Please see Chapter 5 for more detail.

Finally, there should be a schedule of guideline **revision**. Guidelines should be reviewed and updated regularly.

Barriers to Guideline Adherence

It will be difficult to implement the guideline if the clinical staff is not aware of a guideline's existence, cannot access the guideline at the time of need, or is not knowledgeable in the topic area. Implementation problems might also occur if the physician does not agree with the guideline (consensus was not developed early); does not feel comfortable with or think it will make a difference; or isn't motivated to change. Finally, the guideline must be easy to carry out by the staff.

Examples of Guideline Development in Romania

Appendix H contains two examples of guidelines for the treatment of hypertension and type II diabetes. These evidence-based guidelines were originally developed in the United States, but were modified by Romanian physicians for Romanian practice.

Incorporating guidelines into physician practice can lead to consistency in practice across physicians as well as improved quality of care at potentially reduced cost. For example, although physicians know how to treat hypertension, most physicians are not very aggressive in treating hypertension and tend to use medications that are too expensive as compared to other equally effective, less expensive agents. Similarly, guidelines can lead to agreed-upon goals of therapy for hypertension, which can lead to more intensive and effective treatment.

Examples of two other evidence-based guidelines on breast cancer and cervical cancer screening may be found in Appendix I. These two guidelines were introduced and used in a practicum at a Rural Health Workshop in Botasani, Romania, September 2001.

Prevention and Health Maintenance

Preventive health care services

According to Article Nine, Norms Section, of the Romanian Framework Contract, the family physician must submit a report each month to the Insurance House (through his/her legal representative). The report details medical services provided and the number of patients receiving these services. The Health Insurance House verifies this report.

The list of preventive medical services to be provided by the family physician include: immunizations, counseling on disease risk factors, prevention examinations, well baby, well child, and adult examinations, detecting transmissible/infectious diseases, monitoring pregnant women, family planning services, cervical and breast cancer screening, and child

health examinations for specific diseases or problems. Appendix J contains more detail concerning preventive services.

A medical practice should develop a systematic approach to the provision of preventive health care services. Depending on providers to remember and make the effort to provide these services for all appropriate patients has been shown to result in inadequate usage. Instead, reminder systems or other strategies should be employed.

Group practice also provides the opportunity to place a new emphasis on promoting healthy lifestyles. Doctors, nurses and health educators on the practice team can provide preventive health education as a part of daily routines. Patient education is a critical element of primary care practice. As providers are examining and listening to patients, they have a responsibility to discuss the patient's illness, treatment and the importance of compliance to a treatment regimen.

Additionally, every provider needs to take the opportunity to teach patients about disease prevention. There are many ways that physicians and nurses can educate and inform their patients, such as, brochures, individual/group counseling, by word of mouth from any member of the practice, posters, newsletters, banners, and videos. Additionally, support staff can develop expertise in patient education and counseling. This can serve as a valuable adjunct to the services provided by professional staff. A group practice provides opportunities to pool patient education resources and expertise enabling more efficient and effective education.

Cost Effective Patient Care

There are a number of definitions for cost-effectiveness based on who is asking the question---the patient, the provider, the insurance organization, society etc. In thinking about cost-effectiveness from the standpoint of the group practice and the patients, it may be wise to keep it simple. Cost-effective patient care is that care provided using the best treatment evidence, considering patient preferences, and provided in an efficient and quality-driven manner. Resource use should be directed toward maximizing patient outcomes.

An essential factor is the use of evidence-based medicine, which in today's world may be very different from what was originally learned in medical school. This is where the use of up-to-date clinical practice guidelines can be very helpful in both providing information on appropriate treatments and helping to ensure the delivery of quality care. Another factor is the consideration of patient preferences in the treatment of certain diseases and conditions. Many treatment decisions should be made jointly by the physician and the patient after the patient has been fully informed of choices and alternatives.

As the Group Practice becomes more experienced, it may be possible to offer additional patient services such as performing electrocardiograms, asthma inhalant treatment, laboratory tests etc. Three factors should be considered: the expertise of the physicians, patient need and the ability to provide a quality service.

SUMMARY

What we have attempted to do in this chapter is discuss some of the important issues related to the delivery of cost-effective, quality health care. Each of the eight elements discussed is critical to providing quality care. Further, each of the elements needs constant effort. For example, access to care and continuity of care apply to every patient that walks in the dispensary door and at every visit as do all of the other elements (patient centered care, coordination of care, comprehensive care, quality care, prevention and health maintenance, and cost-effective care). Each patient deserves the best care possible. While establishing a group practice is an important step, it is not in and of itself a sufficient indicator of high quality care.

Delivery of quality health care in any country is a challenge. The challenge is to provide health care that patients want and need. A recent report from the US Institute of Medicine entitled ***Crossing the Quality Chasm*** (page 71) provides some simple common sense rules for "thinking outside the box" in providing health care in the 21st century.

Simple Rules for the 21st-Century Health Care System

Current Approach	New Rule
Care is based primarily on visits.	Care is based on continuous healing relationships.
Professional autonomy drives variability.	Care is customized according to patient needs and values.
Professionals control care.	The patient is the source of control.
Information is a record.	Knowledge is shared and information flows freely.
Decision-making is based on training and experience.	Decision-making is evidence based.
Do no harm is an individual responsibility.	Safety is a system property.
Secrecy is necessary.	Transparency is necessary.
The system reacts to needs.	Needs are anticipated.
Cost reduction is sought.	Waste is continuously decreased.
Preference is given to professional roles over the system.	Cooperation among clinicians is a priority.

In reviewing these simple rules, it becomes clear that providing quality health care is more than just changing the system and increasing reimbursement and payment. It requires that providers, managers and staff change their way of thinking. This may be the greatest challenge of all, but increased satisfaction (providers, staff and patients) and quality of care will be the outcomes.

Chapter

5

Building Quality into the Care Process – Quality Improvement and Measurement

The provision of quality health care is the responsibility of every health care professional: physicians, nurses, pharmacists, therapists, administrators, and other staff. A group medical practice offers many opportunities and a few challenges in the provision of excellent patient care. The challenges are modest. The members of the practice need to reach consensus among themselves as to the aspects of quality that they wish to emphasize in the practice. This requires both leadership and collaboration. Most practices appoint a leader in quality improvement activities, just as practices usually have a member with a special interest in business activities. The practice leader is responsible for keeping up-to-date regarding new evidence-based practice guidelines as they are promulgated by national and international organizations. The practice quality leader will examine such guidelines, making sure that they are based on empirical clinical evidence, not just opinion. Most guidelines will also need to be adapted to local practice circumstances. The practice leader will be responsible for making initial recommendations to the practice regarding changes in procedures to improve the quality of care and patient outcomes.

While all aspects of clinical care can be improved, not all aspects of clinical practice can be improved simultaneously. Each practice should choose several aspects of the practice for targeted quality improvement each year. Over time, a large number of clinical components of the practice can be addressed. Topics for quality improvement should be chosen based on several criteria:

- The problem should be important to the clinicians and to the patients they serve. That is, it should be important in terms of mortality or morbidity, and relatively common in the population served.

- Quality can be assessed through inexpensive measurement tools such as chart abstraction, patient interview, or other means. Quality must be measured in order for improvement to occur.

- There should be sufficient evidence-based consensus as to the appropriate interventions that will lead to improved quality of patient care. Such consensus does not always need to result from randomized controlled trials, but should certainly be based on the best available clinical evidence.

- Measurement must be built into the practice so that it becomes routine. If it is viewed as an addition to an already busy practice, it will not be done on a routine basis.

Measurement in Group Practice

Measurement is critically important in estimating and improving quality. Measurement activities can address a number of needs in group practice including developing baseline information so that changes over time can be monitored. Certain data elements collected at intervals may also be used for reporting requirements, resource allocation decisions and determination of individual physician workload. Other data collection forms may be developed to collect information about a certain segment of the patient population. For example, Appendix K contains a form that can be used to monitor pregnant women in the practice. Patient referral forms (Appendix G) can be used to measure numbers and types of referrals and possibly appropriateness as well. Standard forms are regularly used for monitoring the monthly flow of patients registered on the physician's list including: practice activity summary, medical services, numbers of chronic care patients, number of listed patients by age group, monthly, trimester, number of pregnant women etc. In addition, the number of infectious-transmissible diseases must be reported annually. These standard forms are completed by the physician or nurse and are submitted to the Health Insurance House and Public Health Directorate to document physician practice. These required reporting forms can be supplemented by additional information for use by the practice physicians and staff to improve care for their patients.

Measurement in the practice is accomplished at a cost but pays off in dividends such as increased patient satisfaction and increased abilities to provide quality care. The practice manager or a member of the nursing staff must dedicate time to develop and test the data collection forms. Time must be allocated each month to collect the data necessary for assessing the quality and efficiency of the practice. All of these activities must be an explicit part of one or more staff job descriptions.

Within a group practice, measurement projects should be initiated after consensus among the members of the practice regarding what is to be measured, who is going to do the measuring, and, most importantly, what is going to be done with the information. The effort involved in measurement of the practice activity and quality is only worthwhile if it is used to change practice and improve the quality of care for the practice, and/or improve the financial position of the practice. Since only a limited number of measurement activities can be undertaken at any given time, several criteria should be used to determine priorities:

- The benefit from the measurement activity should assessed prior to undertaking;
- Measures should be defined to reduce subjectivity and enhance objectivity and consistency;
- To the extent possible, the information should be collected during the course of care. For example, nursing personnel routinely take blood pressures on hypertensive patients. This information can be recorded on the patient chart and on a special data collection form, if hypertension is the disease/condition under study;
- Short, relatively intense periods of measurement are generally preferable to continuous measurement;
- The physicians and staff should be enthusiastic regarding the measurement activity.

The measurement issues in practice change are important. The measures used should be easy to implement, inexpensive, reliable and not detract from the daily operation of the practice. One does not need to measure every clinical episode in order to determine whether change is occurring. For example, if one is assessing the level of hypertension control in the practice, one could audit the first 20 hypertensive patients seen in a month. Such sampling, while not the ideal of random sampling, is often sufficient to track the quality of care of selected conditions. No single monthly sample will be large enough to gain an accurate estimate of the level of hypertension control in the practice, but over time, the total number of patients in the database will be substantial (over 200 by the end of the year). This tracking, when presented in a graphical format, is a powerful tool that can easily demonstrate trends in practice to both health professionals and the lay public. The tools used are important. A monthly worksheet can be used to document the results of the brief audit. The results should be plotted on a line or bar graph to track results over time. These graphs can be developed using simple ratios and without the use of a computer. What is needed are the numbers of patients seen at risk for the condition under evaluation, and the proportion of patients in whom the desired intervention took place. For example, in the case of hypertension, the denominator is the number of patients with hypertension seen in a week, and the numerator is the number of hypertensive patients with blood pressures below the goal of 140/90 mm./Hg. Posting the results in a site where all members of the practice can see the results will allow all to feel that they have participated in the work. Appendix L contains a data collection form and a table for use in reporting results of measuring hypertension.

Patient satisfaction is part of overall quality assessment and improvement. Patients often have perspectives of the practice that clinicians may not perceive, and their perspectives are important. Patient satisfaction can usually be assessed with brief written surveys. These surveys can be distributed by practice administrative personnel as the patient is leaving the examination room, and filled out in the waiting area just prior to leaving the practice. The surveys should be anonymous, so that patients will have no inhibitions about providing a frank assessment of the care received.

Surveys should be designed to solicit a range of opinions. Relatively specific questions are usually best. Broad questions such as were you satisfied with your visit today might lead to either happiness or distress on the part of the physician (depending on the answer). If the answer is no, the provider is not sure how to remedy the situation. More specific questions such as how long did you wait for your visit today or were all of your questions about your health condition answered today can yield much more useful information for practice improvement.

Staff satisfaction is another element in the improvement of patient care. Staff needs to feel they are important and integral members of the health care team. They also need to know that some of their suggestions will be put into practice. Staff surveys should be completed anonymously. Appendix M contains an example of a staff survey.

Quality Improvement

The practice quality leader should work in tandem with one of the nursing staff. While some practice quality improvements are completely within the control of the physician staff (such as change in preferred medication for hypertension), most practice changes are collaborative activities among physicians, nurses, and administration. The lead physician and

nurse should communicate regularly, monitoring interventions as they take place and modifying them so as to lead to rapid, effective practice change.

The time frame for clinical practice improvement should be relatively rapid. One can often identify improvements in the process of care within 3 months after an intervention is initiated. Such rapid change allows the practice personnel to keep up their enthusiasm. It also permits strengthening the intervention if it appears to be only minimally effective after the first 3 months. Quality improvement is, therefore, a cycle of change. The team conducts baseline measurement; initiates change; and then assesses whether the desired change has actually occurred. If the desired improvement has not occurred, then a different intervention is needed.

Quality improvement efforts should have a measurable goal. Everyone enjoys successes, and it's important to set goals that are achievable. For example, a goal such as Pap smears on every female patient, who is sexually active, every year, is the ideal, but not an achievable goal. Not all female patients are appropriate for Pap smear (hysterectomy) and a few patients may unfortunately refuse or not return for appointments. However, practices have found that 80-90% rates are possible. Similarly, a practice goal of improved children's health is a laudable overall goal. However, if everyone has a different definition of improvement or of health, then little true progress is possible. A better goal might be 100% DPT immunization rates or a 20% reduction in hospitalization for children 2-12 years of age.

Similar to other areas of quality improvement, focusing on specific aspects of patient satisfaction yields the quickest and most measurable results. Once improvement has been achieved, one can then address other issues. A very efficient way to obtain ideas for practice quality or satisfaction improvement is to have a small advisory group of patients who meet periodically and assist the clinicians in setting the agenda for practice improvement.

As group practices measure their care and work to improve it, assessment of the rates at which preventive interventions are offered to patients, and the quality of the implementation are ideal activities for quality measurement and improvement activities. Practices can choose several activities for focused scrutiny for a period of several months. An initial activity, for example, would be an audit of medical records of women over age 40 to determine the proportion who have had clinical breast exams in the previous year. If the proportion is below the practice's pre-set goal, then the low rate of clinical breast examinations represents an opportunity to improve care.

The process of care improvement might begin at a practice meeting at which the physicians are shown the low rate of breast examinations. Then together they would discuss the barriers to performing clinical breast exams, and potential interventions to improve the performance of the screening activity. Simply agreeing that the activity is important is unlikely to change physician or nurse behavior.

As an example, barriers to breast cancer screening, with potential activities to remedy them, might include:

Barrier	Possible solution
Physicians may feel unsure of their skills in performing the examinations.	Practice-based continuing education.
Patients may be reluctant to accept the examination.	Posters in the waiting room, patient education brochures, radio and television education etc.
Patients not appropriately disrobed for the examination.	Nurses explain the examination to the patient and arrange patient gown to preserve modesty.
Time constraints during the day.	Trial of a women's health day for such screening activities.
Women reluctant to be referred for further testing or to a specialist once a mass is discovered.	Communication with surgical consultants. Improve public education.

A given practice may identify only one of these barriers, or other barriers not listed above. These issues vary from practice to practice. However, the process of audit, identification of barriers, implementation of an action plan to overcome these barriers to practice improvement, and then re-audit to determine whether the desired change has taken place can be consistent across many practices.

Physician and Staff Qualifications

Practices often assume that staff qualifications are a given. It is still important to make sure that all providers have up-to-date licenses. Copies of these documents should be available at the request of patients, or displayed in the waiting room. Similarly, the qualifications of physicians and staff (when appropriate) should be mentioned in practice brochures.

Continuing Education

A core value of professionals is the obligation to continue to educate ourselves throughout our professional careers. Training learned in medical school and residency all too quickly becomes outdated and must be renewed. This is usually called "continuing medical education" (CME). This type of education occurs in many ways: through attendance at local clinical conferences, journal reading, consultation with colleagues, and formal courses. Professional education is an individual obligation, but the practice group can and should encourage such activities. Several options have been found useful:

- Use a portion of practice group meetings for mutual education. Each member of the group may take responsibility for a certain topic, prepare a brief presentation and then tell his/her colleagues about recent innovations in a given area.

- The practice should support colleagues in taking time away from the practice to attend continuing education meetings. Some practices require that members attend a minimum number of hours of education each year.

- The practice may subscribe to journals as a group, or pay for an Internet-service provider account so that members may log onto Internet web sites that provide a rich source of information, such as that of the US Agency for Healthcare Research and Quality (http://www.ahrq.gov) or the Cochrane Collaboration (http://www.cochrane.org).

Learn From Your Mistakes

All physicians make mistakes. The practice of medicine is complex, our knowledge of diagnosis and treatment is imperfect, and variation among patients is extensive. In addition, physicians are fallible. We get tired, we may become distracted by the pressures of the day, and we sometimes make poor judgments. The important issue is to acknowledge these errors when they occur and endeavor to reduce their number. Some mistakes are knowledge-based. The professional may not have known (for example) about a drug interaction between administration of aspirin and warfarin in the same patient, leading to increased risk of bleeding. Professional education can address these issues. However, large numbers of mistakes occur as a result of problems with systems of care in offices and hospitals. For example, allergic reactions can be reduced, not just through asking patients about medication sensitivity, but also clearly marking and updating charts regarding drug allergies. These issues represent opportunities for improvement in the quality of care.

The practice as a group should commit to the reduction of preventable errors both through continuing education and making practice system changes. Selected errors should be reviewed at practice meetings on a regular basis. Especially important is the need to address errors in a supportive and non-punitive way, with the emphasis on avoidance of recurrence. The recent US Institute of Medicine (IOM) publications on errors (*To Err is Human* and *Crossing the Quality Chasm*) illustrate these issues in great detail.

In summary, maintenance of enthusiasm for quality improvement efforts is an ongoing challenge. Keep in mind that the objective of the effort is to improve the care and outcomes of your patients. Sharing of results, discussion of goals, and infusion of a sense of excitement in clinical care improvement are all important. Several new quality initiatives should be started each year. Similarly, once initiatives have reached the pre-established goal, they should stop being the result of intensive audit and feedback. Returning to such successful projects for a repeat audit in 1-2 years is important and advisable in order to maintain the gains/improvement. And, always, celebrate successes!

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Appendices

Appendix A: Readiness for Change Survey

The following questions are for the purpose of assessing organizational climate and readiness for change. They should be completed by each physician and staff member. An alternative is to use them to elicit opinions and discussion about the proposed changes from solo practice to group practice. These questions may also be useful for rural physicians as they seek physician partners in a less formal way.

1. What are our values, attitudes and beliefs in planning to become a group practice?

2. What are the values, attitudes, and beliefs of our staff about becoming members of a group practice team?

3. What kinds of benefits will there be for our patients if we become a group practice? Enumerate the benefits.

4. What will be the differences between what we do now as solo practitioners and what we will be doing in a group practice? Enumerate the differences.

5. Do we see a need to change?

6. Are we ready to make a change?

Appendix B: MEDFAM Implementation Workplan

Primary Care Demonstration Project
Cluj Workplan

		1999		2000			
Activity	**Person(s)**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Objective: Establish Legal Framework for Practice							
1. Obtain buy-in from all physicians/staff	Cornel/Dana						
2. Seek approval from District Health Authority	Cornel						
3. Establish partnership agreement between physicians	Mihaela						
Objective: Improve Management Systems							
1. Hire and train practice manager	**Complete**						
2. Establish baseline practice performance measures	Doina/Tanya						
3. Collect practice performance measures on regular basis	Doina						
4. Restructure job tasks	Cornel/Dana/Doina						
-- Develop job descriptions	Doina						
5. Establish practice policies and procedures	Doina/Phys. Lead						
6. Create patient survey tool and conduct survey	Doina/Phys. Lead						
7. Conduct patient satisfaction survey on regular basis	Doina						
8. Establish patient scheduling/appointment system (trial run)	Doina/Mihaela						
9. Evaluate trial run of patient scheduling system	Doina/Mihaela						
10. Make necessary changes to scheduling system	Doina/Mihaela						
11. Establish patient database for demographic information *	Doina/Mihaela						
12. Establish info. system for registration and scheduling	Cornel/Doina/Lucian Pop						
13. Place computer at reception desk for scheduling/registration	Cornel/Doina						
14. Evaluate clinical information systems **							
-- Start collecting utilization data							
-- Start collecting clinical data							
15. Develop space plan	Doina/Cornel						
-- Seek necessary approvals and funding							
16. Renovate space	Doina/Cornel						
-- Solicit potential donors							
-- Establish personal contributions/commitments							
-- Make physical improvements to waiting area	Dana/Doina						
-- Make physical improvements to other areas of the practice	Dana/Doina						
17. Establish Advisory Board	Dana/Mihaela						

18. Understand practice costs / Establish budgets and forecasts	Doina/Cornel/Mayur						
19. Educate patients regarding changes in practice	Doina						
-- Place placards/leaflets in waiting area							
-- Create master physician schedule							
-- Place practice mission/values statement in waiting area							
Objective: Improve Clinical Systems							
1. Develop plan for physician team building	Mihaela						
-- Develop mission statement and practice values statement	Mihaela						
2. Identify target conditions for improvement	Physician Staff						
3. Establish and implement practice guidelines	Physician Staff						
-- Evaluate guidelines	Physician Staff						
4. Implement nurse telephone triage							
Objective: Develop Relationships with Providers							
1. Informal communication with specialists							
2. Develop and test patient referral forms							
3. Nurse to nurse communication							
Objective: Expand Health Promotion and Disease Prevention Services							
1. Adapt USPSTF guidelines							
2. Patient education regarding health promotion/disease prevention							
3. Expand screening program							
4. Collaboration with specialized centers							
5. Office systems for prevention information							

Activity complete

* Patient database development will consist of three phases of data collection: 1. Demographic data; 2. Utilization data; and 3. Clinical data. Patient lists are now being received on diskettes from the Health Insurance House. The diskettes reflect the demographic data for the practice.

** Utilization data is currently being collected manually for certain procedures and disease categories.

*** As no money will be coming from external donors at this time, the practice will be creating an Advisory Board and soliciting potential donors.

1. Demographic data includes patient age, sex, address, phone, unique patient identifier, nearest relative/contact, physician code, and other relevant socioeconomic data.
2. Utilization data includes visit data, visit code, and physician code
3. Clinical data includes problem list and other relevant clinical indicators

Appendix C: Job Description Examples

JOB DESCRIPTION: Medical Attendant in Consulting Room

First name:
Last name:
Studies:
Job:
Main responsibilities:
- To prepare patients for examination and treatment;
- To fill in data in the patient's record
- To help the physician while making consultations (height, weight, blood pressure; help the patient take off his / her clothes in the patients' preparation room)
- To prepare and supervise the supply of necessary equipment in the consulting rooms (clean bed sheets, forms, stamp, stethoscope, etc.).

Duties and responsibilities
- To put patients in examining rooms and prepare necessary information for the consultation
- To fill in correctly prescription headings, notes, medical receipts and other documents as the physician requires
- To prepare the patient for the consultation
- To weigh patients
- To organize health educational meetings in writing or by teaching to small groups and when making home visits
- To help transport patients from the consulting room to the ambulance
- To fulfill administrative and medical tasks
- To help program tests and treatments
- To answer the phone as necessary
- To offer general information concerning the practice group procedures
- To take out and put into order the patients' records
- To program patients for return visits
- To combine and synthesize the technical data and the statistics every month in order to prepare reports and medical records
- To take part in practice group meetings as appropriate
- To take part in continuing education courses and stay in contact with professional associations
- To keep patients' data confidential
- To specialize in other activities depending on preferences and practice needs (pain treatment, home care, etc.)
- To inform the physician of special clinical problems of patients
- To provide a secure and pleasant atmosphere for patients
- To estimate needs, depending on the health problems of the client and to develop a care plan together with the client, family and friends

- To review the care plan results (home care, palliative care) and inform the family physician of the results
- To update the consulting room record forms
- To fill in record forms every month

1) The medical attendant pays special attention to the following population categories that have social and health problems:
    a) New-born children
    b) Premature babies
    c) One-year old children
    d) Children aged between 1 and 6 years
    e) Children with chronic diseases
    f) School children and teenagers
    g) Young adults
    h) Pregnant women
    i) Elderly
    j) People with special needs
    k) Risk groups
2) Offers palliative care and trains the patient's family or friends to help provide patient care
3) Takes part in the organization of psycho-therapeutic activities meant to reduce stress and overcome crisis situations
4) Cooperates with non-governmental organizations to achieve programs that address target population groups (e.g. mentally ill, elderly, alcoholics, drug addicts, etc.) according to the national health strategy
5) Takes part and/or initiates quality measurement and improvement activities in the medical practice
6) Respects the medical attendants' professional ethical code
7) Respects and defends patient rights
8) Respects internal rules
9) Uses and maintains equipment in good condition
10) Supervises the collection of used materials and equipment and assures their appropriate disposal and destruction
11) Fulfills other tasks as assigned

Professional training
- High school diploma or an equivalent
- Medical certificate, preferably in an accredited institution
- Minimum of one year experience
- Efficiency in using medical terms and the computer

Knowledge and Skills
- To be familiar with medical attendant techniques in order to help with patient examinations

- To be familiar with the medical equipment necessary for patient care
- To be familiar with regulations
- To be skillful when taking part in different treatment techniques and medicine administration
- To have skills in measuring vital signs
- To have skills in the preservation of medical records and files, as well as in the registration of test results
- To have skills in the development and maintenance of the safety and quality level of the department
- To have skills in maintaining efficient work relations with patients, medical staff and the public
- To be able to maintain standards of quality control
- To be able to react calmly and efficiently in emergency situations
- To be able to interpret, adapt and apply medical procedures
- To be able to communicate and work in a team

Equipment

-Stethoscope, ECG, needles, analysis apparatus, glucometer, Pupinel, computer, copy machine, phone, fax.

JOB DESCRIPTION: Receptionist

First name:
Last name:
Studies:
Function:
The person who welcomes patients must have good manners, check patients' insurance and be efficient.

Main responsibilities:
- to welcome patients
- to create a pleasant & professional atmosphere
- to obtain additional patient information as necessary
- to answer the phone
- to welcome visitors and make appointments for drug and equipment representatives
- to schedule patient appointments by phone or personally at the end of a visit
- to provide information by phone

Other duties and responsibilities
- To organize and maintain a welcoming environment for patients
- To provide information on the way the group practice works
- To check patient insurance and inclusion on physician list
- To record the mail in the Entries Journal and distribute it to the physicians
- To inform staff of acute patients' problems
- To inform staff of long waiting times of patients
- To administer forms used by the practice group as appropriate
- To maintain up-to-date patient lists for each physician
- To take part in practice group meetings
- To become involved in professional development activities
- To keep patient information confidential
- To fulfill other duties established by the coordinating physician
- To prepare for other activities according to need
- To organize her / his activity effectively
- To record all information correctly

Skills
- High school diploma
- Minimum 6 months experience in the medical field
- Minimum 6 months experience in the medical insurance field
- Computer skills

Other skills
- Communication skills
- Teamwork

- To follow rules established by the group practice concerning relationships with patients
- The ability to read, understand and follow written communication
- The ability to express clearly and concisely
- The ability to cope with stress and solve problems
- The ability to establish and maintain good working relationships with the group practice team and the public

Necessary equipment
- Computer, printer, copy machine, telephone, fax

JOB DESCRIPTION: Medical Attendant Obstetrics-Gynecology - Treatment Room

Last name:
First name:
Studies:

Responsibilities:
1) To organize activities effectively;
2) To adhere to rules concerning the disposal of contaminated materials
3) Responsible for correct data in the pregnant register, patient files, screening register immunization register, treatment register, home visit register
4) Responsible for actions and decisions in conformity with qualifications and professional competence
5) Provide treatments, immunizations and biological tests according to the doctor's orders;
6) Obey regulations regarding the prevention and control of infections
7) Take part in activities for patients (immunization, population screening, epidemiological activities etc.)
8) Organize and run programs for health education, counseling, and instruction and practice demonstration for pregnant women and other patients as necessary
9) Intervene in emergencies as appropriate
10) Pay special attention to the following population categories that have social and health problems:
    a) New-born children
    b) Premature babies
    c) One-year old children
    d) Pregnant women
    e) Confined women
11) To be up-to-date with the professional knowledge through individual study and continuing education
12) Carry out lab exams at physician's request (urine tests, etc.)
13) Prepare patients for Pap smears and assure the safe transport of the tests to the lab
14) To keep medicines in stock for the group practice and store appropriately
15) To count existing medicines and record every month
16) To respect the professional ethical code of the medical attendant
17) To respect and defend patient's rights
18) To respect internal regulations
19) To keep equipment in good condition and assure appropriate disposal of one-use materials

The Competences of the Medical Attendant in the Treatment Room
- To measure vital functions
- To provide first-aid

- To assist the physician with cardio-respiratory resuscitation
- To provide parenteral treatments according to training and experience
- To provide immunizations
- To dress wounds
- To collect biological products
- To educate family members to assist patients in becoming independent

Appendix D: MEDFAM Budget Analysis

MEDFAM Group Practice Budget									
	Budget Scenarios (based on no. of patients)			**As Percent of Total**			**Per Physician**		
Assumptions:									
Patients per Physician	**2,000**	**2,200**	**2,400**						
Number of Physicians	6	6	6						
Total Patients	12,000	13,200	14,400						
Est. Points per Patient	11	11	11						
Total Estimated Points per Year	132,000	145,200	158,400						
Est. Lei per Point	4,387	4,387	4,387						
Total Estimated Practice Revenue	**579,084,000**	**636,992,400**	**694,900,800**	100%	100%	100%	96,514,000	106,165,400	115,816,800
Fixed Expenses									
- Assistant Salaries (a)	360,000,000	360,000,000	360,000,000	62%	57%	52%	60,000,000	60,000,000	60,000,000
- Cleaning Person (1/2 time)	10,800,000	10,800,000	10,800,000	2%	2%	2%	1,800,000	1,800,000	1,800,000
- Cleaning Supplies	6,000,000	6,000,000	6,000,000	1%	1%	1%	1,000,000	1,000,000	1,000,000
- Utilities (electricity/heating/water)	25,000,000	25,000,000	25,000,000	4%	4%	4%	4,166,667	4,166,667	4,166,667
- Telephone	14,400,000	14,400,000	14,400,000	2%	2%	2%	2,400,000	2,400,000	2,400,000
- Continuing Medical Education	9,000,000	9,000,000	9,000,000	2%	1%	1%	1,500,000	1,500,000	1,500,000
- Miscellaneous	6,000,000	6,000,000	6,000,000	1%	1%	1%	1,000,000	1,000,000	1,000,000
Variable Expenses									
- Medical Supplies (b)	180,000,000	198,000,000	216,000,000	31%	31%	31%	30,000,000	33,000,000	36,000,000
- Syringes									
- Gauze									
- Gloves									
- Medications									
- Other									
- Printing/Stationary	21,600,000	23,760,000	28,512,000	4%	4%	4%	3,600,000	3,960,000	4,752,000
Total Expenses	**632,800,000**	**652,960,000**	**675,712,000**	109%	103%	97%	105,466,667	108,826,667	112,618,667
Net Profit (Loss)	(53,716,000)	(15,967,600)	19,188,800	-9%	-3%	3%	(8,952,667)	(2,661,267)	3,198,133
Notes:									
(a) Assumes 10 assistants at 3 million Lei per month; amount includes taxes and benefits .									
(b) Assumes 2.5 million Lei per month per physician for the base scenario									

Appendix E: Appointment Scheduling Template

	**PROGRAMARI CONSULTAȚII** **PROGRAMARI DOMICILIU** _____/_____/1999 08:00 - 12:00 Cluj-Napoca

Consultatii:	**Curative:**	**Profilactice:**	**Gravide:**
Tratamente:		**Decese:**	
----- Agenda Programări-----			
1.			8:00-8:15
2.			8:15-8:30
3.			8:30-8:45
4.			8:45-9:00
5.			9:00-9:15
6.			9:15-9:30
7.			9:30-9:45
8.			9:45-10:00
9.			10:00-10:15
10.			10:15-10:30
11.			10:30-10:45
12.			10:45-11:00
13.			11:00-11:15
14.			11:15-11:30
15.			11:30-11:45
16.			11:45-12:00
17.			12:00-12:15

OBSERVATII:

Dr. Mihaela Beuran medic primar tel.: 132197 medic de familie	**PROGRAMĂRI CONSULTAȚII** **PROGRAMĂRI DOMICILIU** _____/_____/1999 14:00 - 18:00 Cluj-Napoca

Consultatii:	**Curative:**	**Profilactice:**	**Gravide**:
Tratamente:		**Decese:**	

----- Agenda Programări-----

PROGRAMĂRI		
1.		14:00-14:15
2.		14:15-14:30
3.		14:30-14:45
4.		14:45-15:00
5.		15:00-15:15
6.		15:15-15:30
7.		15:30-15:45
8.		15:45-16:00
9.		16:00-16:15
10.		16:15-16:30
11.		16:30-16:45
12.		16:45-17:00
13.		17:00-17:15
14.		17:15-17:30
15.		17:30-17:45
16.		17:45-18:00

OBSERVATII:

Appendix F: Medication Accountability and Storage

MEDICATION ACCOUNTABILITY AND STORAGE

Emergency drugs are usually stored in the physician's office or the treatment room and are kept in a locked cabinet. Strict accountability is required. Drugs are delivered to physicians with inventory lists and their use is closely monitored. Access to the drug cabinet is limited to persons who are responsible for treating medical emergencies (nurses in the treatment rooms and physicians). Drug consumption is registered daily and the total monthly consumption is maintained in the inventory record.

The major requirements that should be observed with drug storage are:

- Each drug properly labeled
- Expiration date of each drug
- Drugs arranged in alphabetical order
- Monitoring available daily stock
- Knowledge of drug contraindications and interactions
- GP monitoring system for repeat prescriptions
- Stock control system
- Easy identification of patients on a specific therapy

Record of medication expiration dates
The nurses in the treatment room check the drug expiration dates monthly when the monthly use is recorded in the storage files. Purchasing medicines with no expiration dates (or validity period) is not permitted. When purchasing drugs, the manufacturing and expiration dates are noted in the drug entry register. When supplementing a stock of medicines, the previously purchased medicines are used first. The use of medicines that have deteriorated (are friable, sticky, have a broken package, or have changed color) is not permitted. If medicines become outdated, the person responsible for drug inventory will need to provide the documentation to support the need to purchase new drugs.

Outdated drugs should be destroyed in accordance with government regulations. Outdated drugs should be put in special plastic bags burned together with other waste products from the medical practice by the contracted waste removal company.

Narcotics control plan
Strict regulations (Law No. 73/1969) control the circulation and use of narcotic substances and products. It is strictly forbidden for anyone to administer narcotics without a physician's prescription. Special forms are used for prescribing these controlled medications. Medical staff who have a history of drug addiction are precluded from prescribing and handling narcotics for their patients.

The list of narcotic products and substances is established by the Ministry of Health and is published in the "Monitorul Oficial". Storing narcotics as components of first aid kits is permitted if the following conditions are observed:

- Narcotics are locked in a sealed box or cabinet, without any exterior inscription.
- One individual is responsible for the contents of the box.
- a nominal and quantitative list of the narcotics is placed inside the box.
- Administration of narcotics must be recorded in a separate register. Information to include: location of treatment, the name of the treated person, the ID card serial number, and the reason for administering the medication.
- Identification information, manufacturing and expiration dates must be visible.
- Storing medications should facilitate administration according to the principle "the closer to expiration, the closer to utilization."

It is recommended that the storing and inactivating directions of the manufacturer and confirmed by the Ministry of Health be observed. The narcotics used in the MEDFAM medical practice are codeine, fortral, and all forms of morphine. For the safety of patients, it is recommended that Pentazocine be eliminated as a narcotics stock item and that it no longer be used.

Refrigeration of drugs

Medical practices where immunization activities are carried out (vaccination of children, immunizations of pregnant women, ATPA in case of accidents or trauma) should be equipped with refrigerators for storage of vaccines. Storage of food or other objects in these refrigerators is not allowed. Vaccines are stored according to the specifications included in their product prospectus. The freezer door must close tightly.

The physician who manages the group practice or the practice manager must designate a person who will be responsible for recording the temperature of the interior of the refrigerator daily in order to prove to any control authority that the biological products are stored at optimal temperature which is +4 degree Celsius. For an accurate reading, the thermometer must be held at a right angle for viewing. Any problems with the refrigerator must be reported to the physician who manages the group practice or the practice manager.

Emergency Drug Storage

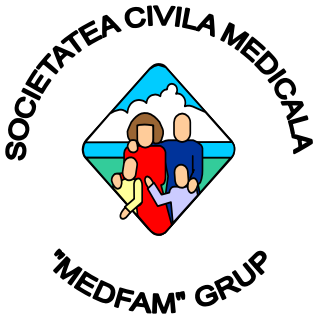
Storage of drugs in the treatment room is based on the list of major medical emergencies:

- Cardiac arrest
- Ventricular fibrillation
- Ventricular tachycardia
- Paroxysmal supraventricular tachycardia
- Atrial fibrillation
- Myocardial Infarction
- Hypertensive emergencies
- Pulmonary edema
- Anaphylactic shock
- Asthma attack

- Status asthmaticus
- Abdominal pain
- Arterial peripheral occlusion
- Stroke
- Seizure
- Eclampsia
- Bleeding during pregnancy
- Drug abuse, intoxication
- Coma
- Trauma

Emergency drugs, excepting narcotics, should be available for immediate use.

Appendix G: Patient Referral Form



Cluj Napoca Str. Constanța nr. 5
el. 132137, 132197
E-mail: medfam@mail.dntcj.ro

Dr. _____

To (clinic):
……

Address:
……...
……

Dear Dr. .....

I introduce..... age ..... years old, Address City: ..... street: .....no.: ..... sc.: ..... apt.: ..... phone: ..... Occupation .....

Diagnosis:

_____
_____
_____

Reason for referral:

_____
_____

Other diseases /allergies:

Previous examinations and treatments:

_____
_____
_____
_____
_____
_____
_____
_____

Cluj-Napoca, Date:_____ **Dr. _____**

Appendix H: Guidelines for Hypertension and Type II Diabetes

Clinical Practice Guideline for the Detection and Treatment of Hypertension
Adapted by: Romanian General Practice Physicians
Iasi – March 2000

Proper BP Screening
- Patient seated: back supported; arm supported at heart level

Appropriately-sized cuffs (S, M, L)
Placement of cuffs and stethoscope
If test of BP indicates high BP
1. Make sure to test again: more than one reading; measure after 5 minutes of rest
2. Average of 2 readings, 2 mins. apart
3. Ask about family history

Initial Evaluation

I. History	**II. Physical Exam**	**III. Labs *(perform once within 6 months)***	**Optional**
Gender (If F, then menopausal or not? Use of contraceptives? Hypertension Cardiovascular disease/symptoms Renal Diabetes Dyslipidemia Smoking Alcohol + Caffeine Fat/Salt + Medications (OTC and Herbal remedies) Illicit Drugs Other: gout, sexual dysfunction, etc. Social History (*type of job, risk)* Family History ROS (weight changes, activity level)	Vital Signs *(BP on both arms)* HT WT Waist/Hip Fundoscopy *(generally not done in primary care office – have it done by referral; or, if trained, in office)* Neck (thyroid) CV (arteries, bruits, heart, edema) Respiratory GI (kidneys, masses) Neuro	Routine: *(used mostly for checking for complications and risk factors)* UA *(if possible, in office)* Creatinine NA+ *(if able to treat within 6 months, not important)* K+ *(if able to treat within 6 months, not imp.)* Glucose Cholesterol HDL *(? – move to optional test)* ECG	CR clearance 24 urine protein Calcium Triglycerides *(suggestion for this to be routine)* LDL HgbA1c TSH Limited Echo Screen for pheochromocytoma

Category	Systolic	Diastolic	Follow-up Recommended
Optimal	<120	<80	*(Normal, healthy adults)* Recheck in 2 years
Normal	<130	<85	Recheck in 2 years
High-normal	130-139	85-89	Recheck in 1 year and discuss lifestyle modifications
Hypertension			
Stage 1	140-159	90-99	Confirm within 2 months and lifestyle modifications
Stage 2	160-180	100-109	Evaluate within 1 month
Stage 3	>180	>110	Evaluate within 0-7 days

For Stage 1 and 2, waiting 1 month might be too long

Technical Assistance provided by the DHHS Primary Health Care Team with support from USAID.

Risk Stratification

Major Risk Factors (aggressiveness of treatment is driven by risk factors)	Target Organ Damage/Clinical Cardiovascular Disease
Smoking Dylipidemia Age > 60 Sex (male or postmenopausal) Family History of cardiovascular disease (women <65 or men<55) Diabetes	Heart Disease – LVH – Angina or MI – Revascularization – Heart Failure Stroke or TIA Nephropathy Peripheral Artery Disease Retinopathy Obesity

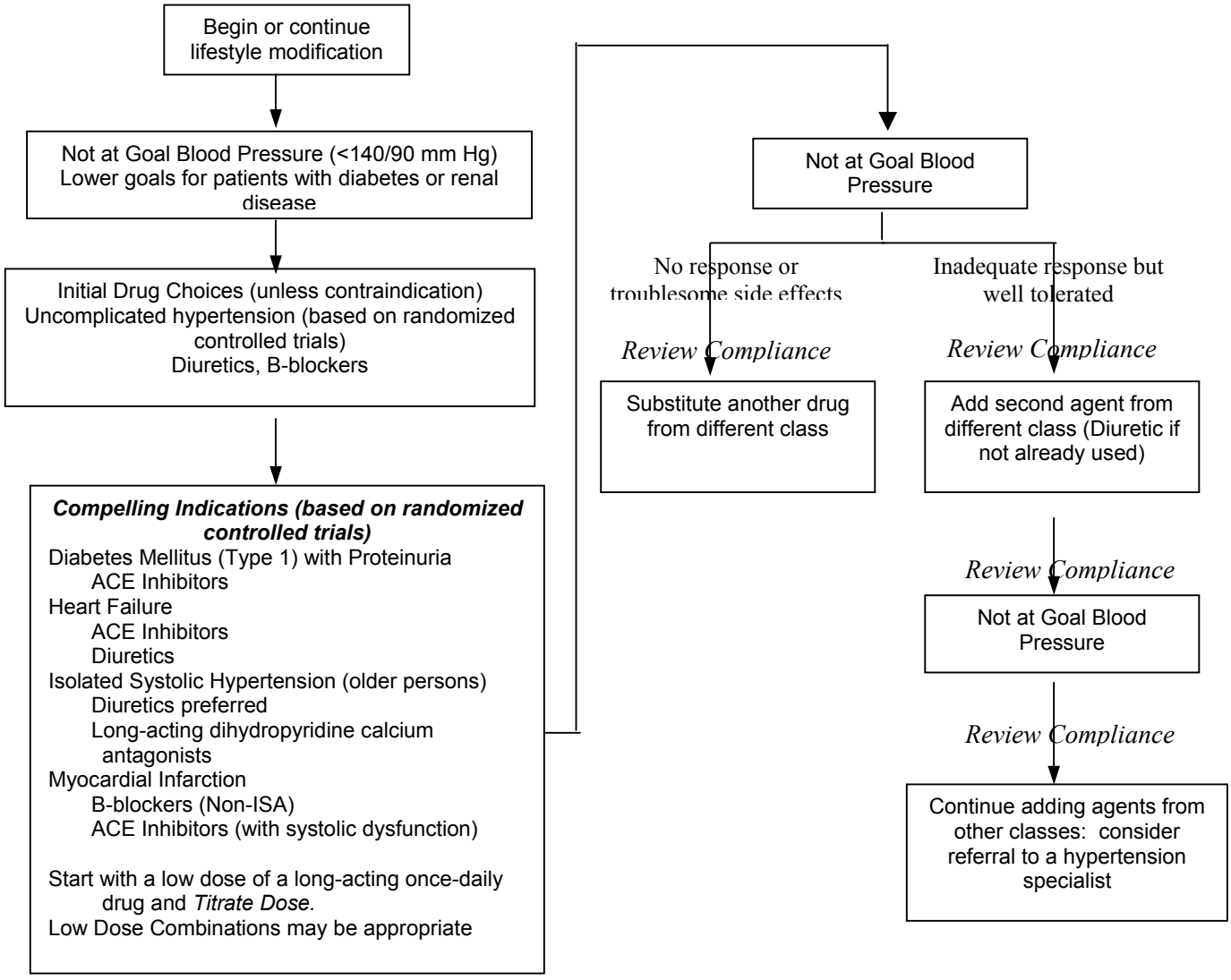
Treatment Guidelines

Stage (BP)	Group A	Group B	Group C
Risk Factors	No	+RF except DM	DM +/- other RF
TOD/CCD	No	No	Yes
High Normal	Lifestyle Modifications	*Lifestyle Modifications ?*	Drug Therapy (if DM, CHF, Renal Failure)
Stage 1	Lifestyle Modifications	Lifestyle Modification (upto 6 months)	Drug Therapy
Stage 2 and 3	Drug Therapy	Drug Therapy	Drug Therapy

Lifestyle Modifications:

1. Lose weight, if overweight
2. Limit alcohol to no more than 30ml/day (24 oz beer, 10 oz wine, 2 oz 100 proof whiskey) or 15 ml if small person
3. Increase activity to 30-45 min 4-7 days per week
4. Reduce sodium (<6 g NaCl)
5. Maintain adequate potassium (bananas)
6. Maintain adequate calcium and magnesium
7. Stop smoking
8. Reduce dietary saturated fat and cholesterol
9. *Reduce coffee*
10. *Avoid exposure to psychological stress – consciously relax (meditation)*
11. *Good nights sleep*

Therapeutic Algorithm



Indication	Drug Therapy
Compelling Indications Unless Contraindicated	
Diabetes mellitus (type 1) with proteinuria	ACE 1
Heart failure	ACE 1, Diuretics
Isolated systolic hypertension (older patients)	Diuretics (preferred), CA (long-acting)
Myocardial infarction	B-blockers (non-ISA), ACE 1 (with systolic dysfunction)
May Have Favorable Effects on Comorbid Conditions	
Angina	B-blockers, CA
Atrial tachycardia and fibrillation	B-blockers, CA (non DHP)
Cyclosporine-induced hypertension CA (caution with the dose of cyclosporina)	
Diabetes mellitus (types 1 and 2) with proteinuria	ACE 1 (preferred), CA
Diabetes mellitus (type 2)	Low-dose diuretics
Dyslipidemia	a-blockers
Essential tremor	B-blockers (non-CS)
Heart failure	Carvedilol, losartan potassium
Hyperthyroidism	B-blockers
Migraine	B-blockers (non-CS), CA (non-DHP)
Myocardial infarction	Diltiazem hydrochloride, verapamil hydrocholoride
Osteoporosis	Thiazides
Preoperative hypertension	B-blockers
Prostatism (BPH)	a-blockers
Renal insufficiency (caution in renovascular Hypertension and creatinine level >= 265.2 Umol/L (>= mg/dL)	ACE 1
May Have Unfavorable Effects on Comorbid Conditions	
Bronchospastic disease	B-blockers (contra-indicated)
Depression	B-blockers, central α-antagonists, reserpine (CI)
Diabetes mellitus (types 1 and 2)	B-blockers, high-dose diuretics
Dyslipidemia	B-blockers (non-ISA), diuretics (high dose)
Gout	Diuretics
2 or 3 heart block	B-blockers (CI) non DHP (CI)
Heart failure	B-blockers (except carvedilol), CA (except amiodipine besylate, felodipine)
Liver disease	Labetalol hydrochloride, methyldopa (CI)
Peripheral vascular disease	B-blockers
Pregnancy	ACE 1; angiotensin II receptor blockers (CI)
Renal insufficiency	Potassium-sparing agents
Renovascular disease	ACE 1, angiotensin II receptor blockers

Ghid de practica pentru tratamentul Hipertensiunii arteriale
Adaptat de medici romani de medicina de familie
Iasi- Martie 2000

Dupa 5 min de repaus

La > 30 min de cafea si fumat

Pacient in pozitie sezanda: spatele sprijinit; bratul sustinut la nivelul inimii

Mansete de dimensiune adecvata (Mare, Medie, Mica)

Pozitionarea mansetei cu 2 cm deasupra plicii cotului, direct* pe piele si a stetoscopului pe artera brahiala

In cazul masurarii unei TA cu valori mari

Repetarea masurarii:

1. Ultima din 3 masurari succesive

Evaluarea initiala

I. Anamneza	II. Examen Fizic	III. Explorari laborator (min. o data in primele 6 luni)	Explorari optionale
Sex *(daca F, statutul privind menopauza/ utilizare CO)* HTA Afectiuni/ simptome CV renale diabet zaharat dislipidemie endocrine, fumat alcool +/- cofeina Sare/Grasime Medicamente (OTC si remedii naturiste) Consum de droguri ilicite Alte: guta, disfunctii sexuale, etc. Anamneza sociala (*conditii de munca, risc, stress, sedentarism)* A H C	Semnele Vitale *(TA la ambele brate)* T G R. talie/ sold F.O. *(trimitere ofta/ cabinet* tiroida CV (artere, sufluri, aria cardiaca, edeme) Respirator Z. Abdom. (rinichi,) Neurol Tegumente (xantelasme, lipoame, etc)	De rutina: Analiza urinii Creatinina serica Na+ K+ Glicemia Colesterol ECG	Clearance creatinina Proteinurie pe 24 h Calciu Trigliceride LDL/ HDL HgbA1c TSH Echografie AVM Acid uric

* Cu asistenta tehnica oferita de o echipa a DHHS , cu sprijinul USAID.

Simptome altele (pe ap. si sisteme)(de ex. variatii de greutate, nivel de activitate)			

Categorie	**Sistolica**	**Diastolica**	**Urmarire recomandata**
Optimala	<120	<80	*(Adulti sanatosi cu risc normal)* Reverificati peste 2 ani
Normala	<130	<85	Reverificati peste 2 ani
Normal crescuta	130-139	85-89	Reverificati peste 1 an si discutati modificarea stilului de viata
HTA			
Stadiu 1	140-159	90-99	Confirmati in max. 2 luni si schimbati stilul de viata
Stadiu 2	160-180	100-109	Evaluati in 1 luna
Stadiu 3	>180	>110	Evaluate in 0-7 zile

Stratificarea Riscului

Factori de risc majori (*agresivitatea tratmentului depinde de factorii de risc*)	Afectare organe tinta(AOT)/ Afectiune Clinica Cardiovasculara (ACC)
Fumatul Dilipidemia Varsta > 60 Sex (M sau F postmenopauza) AHC cardiovasculare (F <65 or B<55) Diabet Zaharat	Boala cardiaca: HVS; Angina P sau IMA; Revascularizare; ICC AVC sau AIT Nefropatie Arteriopatie periferica Retinopatie

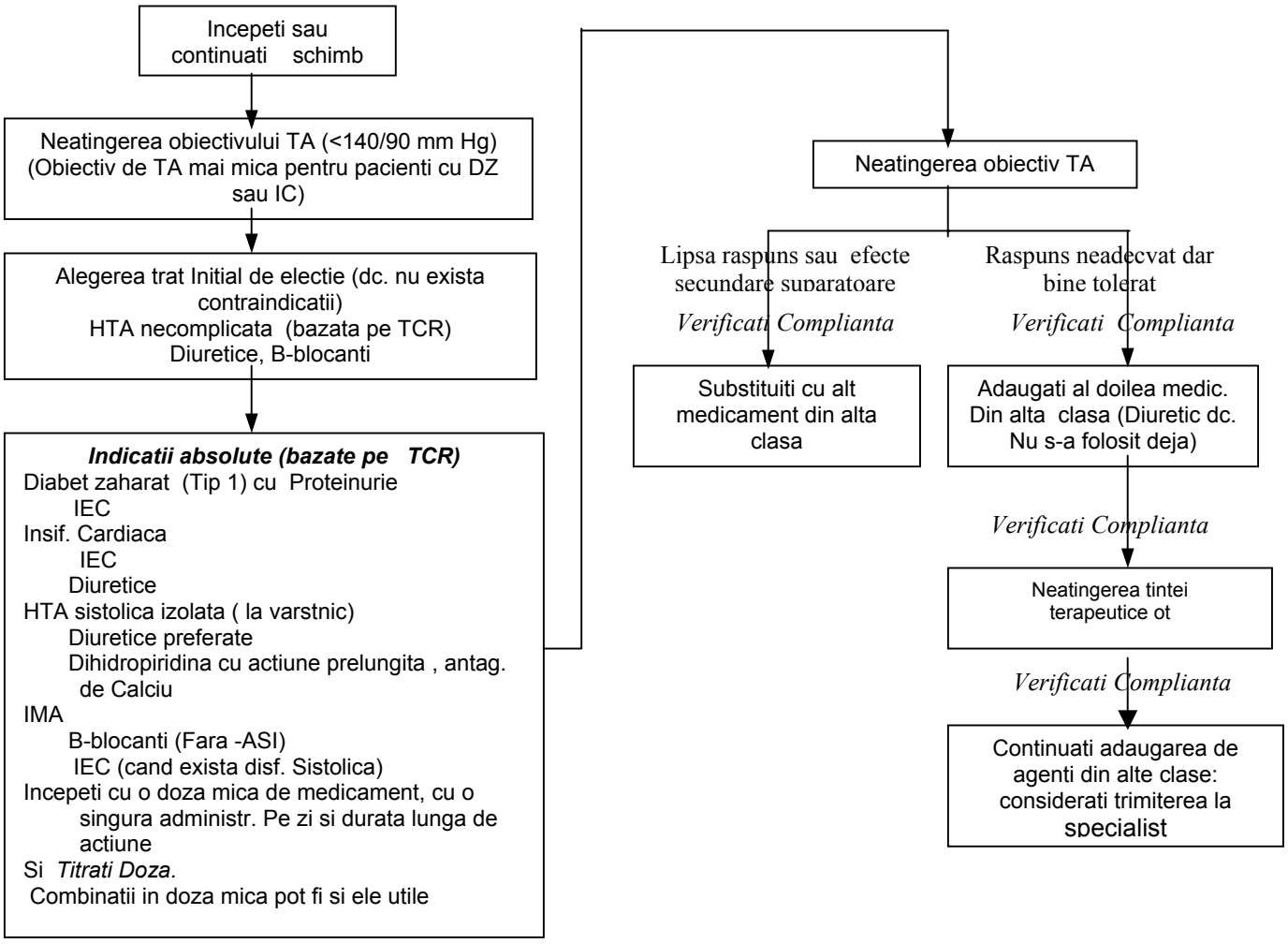
Ghid Terapeutic

Stadiu (TA)	Grup A	Grup B	Grup C
Factori de Risc	Nu	+FR (exceptia DZ)	DZ +/- alti FR
AOT/ACC ←	Nu	Nu	Da
Normala crescuta	Modificarea stil de viata	*Modificarea stil de viata ?*	Tratament medicamentos (dc. DZ, ICC, Insuf. Renala)
Stadiu 1	Modificare a stil de viata	Modificarea stil de viata (pana la 6 luni)	Trat. medicamentos
Stadiu 2 si 3	Trat. Medicamentos	Trat. medicamentos	Trat. medicamentos

Modificarea stil de viata:

2. Reduceti G , dc. Supraponderal
3. Limit. alcool la max. 30ml/ zi (720 ml bere sau 300 ml vin sau 60 ml whiskey) sau 15 ml dc. Pers. De talie mica)
4. Cresteti activitatea fizica la 30-45 min 4-7 zile pe sapt.
5. Reduceti sodium (<6 g NaCl)
6. Mentineti potassium adecvat (legume fructe)
7. Mentineti un aport adecvat de calcium and magnesium Renuntati la fumat
8. Reduceti aportul de grasimi saturate si colesterol
9. *Reduceti cafeaua*
10. *Evitati expunerea la stress –tehnici de relaxare*
11. *Dormiti bine*

ALGORITMUL TERAPEUTIC



Indicatii	Tratament Medic.
Indicatii absolute /(daca nu exista contraindicatii)	
Diabet zaharat (tip 1) cu proteinurie	IEC 1
ICC	IEC 1, Diuretice
HTA sistolica izolata (varstnici)	Diuretice (preferate), bloc. de calciu (cu actiune lunga)
IMA	B-blocanti (fara-ASI), IEC 1 (cu disfunctie sistolica)
Cu efecte favorabile asupra afect. Comorbide	
Angina pectorala	B-blocanti, Antagonisti de calciu
Tahicardie sau Fibrilatie atriala	B-blocanti , Antagonisti de calciu (nu DHP)
Diabet zaharat (tip 1 si 2) cu proteinurie	IEC 1 (preferat), Antagonisti de calciu
Diabet zharat (tip 2)	Diuretice in doza mica
Dislipidemia	A - blocanti
Tremorul esential	B-blocanti (ne-CS)
ICC	Carvedilol, losartan potassium
Hipertiroidism	B-blocanti
Migrena	B-blocanti (non-CS), Antagonisti de calciu (nu-HDP)
IMA	Diltiazem hidrochloride, verapamil hidroclorid
Osteoporoza	Thiazidice
HTA preoperatorie	B-blocanti
Prostatism (BPH)	A – blocanti
Insuficienta renala (atentie la HTA renovasculara si creatinina serica ≥ 265.2 □ mol/L (3 mg/dL)	IEC 1
Cu efecte nefavorabile asupra afectiunilor comorbide	
Boala obstructiva respiratorie	B-blocanti (contra-indicat (CI))
Depresie	B-blocanti, central a-antagonisti, rezerpine (CI)
Diabet zaharat (tip 1 si 2)	B-blocanti, diuretice doza mari
Dislipidemia	B-blocanti (fara-ASI), diuretic (doza mare)
Guta	Diuretic
BAV 2 or 3	B-blocanti (CI), Antagonisti de calciu non DHP (CI)
ICC	B-bloc (exceptie carvedilol), Antagonisti de calciu (exceptie amlodipin besylate, felodipin)
Boli hepatice	Labetalol hydrochloride, metildopa (CI)
Arterioapatie periferica	B-blocanti
Sarcina	IEC 1; angiotensin II blocanti ai receptori (CI)
Insuficienta renala	Economizori de potasiu
Boli renovasculare	IEC 1, blocanti ai receptori pt. angiotensin II

Ghid de Practica in Tratarea Diabetului
Adapted by Romanian General Practice Physicians
In Iasi – March 2000

Introducere
Rolul medicului de familie in tratarea diabetului va fi diferit de la o zona la alta, in functie de resursele disponibile pe care medicul de familie le are la dispozitie §i de disponibilitatea §i raza de actiune a sectiei de specialitate di clinici. Este clar ca multi diabetici din cadrul comunitatii nu sint diagnosticati §i ca este necesara depistarea cazutilor de pacienti simptomatici.

Practica primara in cazul diabetului este limitata in multe zone ale Romaniei. Monitorizarea controlului glicemiei poate fi imposibila datorita restrictiilor privind raza de actiune a practicii. Totusi, pot fi aduse contributii substantiale la prevenirea morbiditatii datorate diabetului. In mare masura, morbiditatea de tip 2 la (instalarea bolii la adulti) este legata de complicatiile aterosclerozei. Controlul sustinit al hipertensiunii, despistarea problemelor vasculare §i neuropatologice ale picioarelor, controlul hiperlipidemiei §i colaborarea cu specialistii in vederea instaurarii unui stil de viata sanatos (alimentatie corespunzatoare, exercitiu fizic §i renunlarea la fumat) pot duce la o stare functionala mai buna a pacientului §i la reducerea spitalizarilor. De aceea, aceste indrumari de practica se concentreaza asupra reducerii complicatiilor diabetului mai degraba decit asupra controlului glicemiei in sine.

Cele doua tabele prezentate aici sint rezultatul seminarului Ghid de practica pentru mgrijirea primara a diabetului in Romania, care a avut loc in luna mai 2000. Intrucit diabetui este tratat cu medicamente de catre diabetolog, iar majoritatea diabetologilor au prea multi pacienti pentru a le putea monitoriza complet starea sanatatii a§a cum este recomandat in aceste tabele, de aceea monitorizarea starii de sanatate §i ingrijirea non-medicala a diabeticilor trebuie efectuate de doctorul de familie.

Tabelul de patru pagini intitulat *"Foaia de observatie pentru bolnavul de diabet de tip II"* enumera lucrurile pe care medicul are nevoie sa le cunoasca atunci cind vad prima oara un bolnav de diabet (paginile 1-2). Detaliile necesare referitoare la anamneza diabeticului sint enumerate in josul paginii urmatorului tabel de o pagina *("Lista examinarilor... ")* Paginile 3- 4 vin in ajutorul medicului §i pacientului, pentru ca acestia sa poata face un plan de monitorizare a starii de sanatate. Daca pacientul nu fumeaza sau nu consuma alcool, aceste doua puncte pot fi scoase de pe lista. Analizele trebuie sa fie programate la intervale convenabile pentru pacient.

Tabelul de o pagina intitulat *"Lista examinarilor care* nu *trebuie sa lipseasca la examinarea* unuii *pacient diabetic"* poate fi utilizat pentru a simplifica foile de observatie ale bolnavilor de diabet. Se pot adauga greutatea §i tensiunea arteriala, pentru a avea toate informatiile necesare asupra bolnavilor de diabet. Medicii care nu dispun de timp pot face pe grupuri aceste examinari, precum §i discutiile pe teme de sanatate preventiva.

Technical assistance provided by DHHS Primary Care Team and supported by USAID.

-2-

Cine ar trebui sa isi faca analiza glicemiei?

- femeile in a 24-a saptamina de sarcina, mai ales daca au nascut deja un copil cu greutatea
  >4kg sau cu indicele de masa corporala (greutatea in kg/inaltimea in metri)~>27,
- persoanele in virsta de peste 45 ani avind una dintre urmatoarele caracteristici:
    - indicele de masa corporala (greutatea in kg/inaltimea in metri)~>27
    - o ruda apropiata care sufera de diabet
    - o femeie care nascut deja un copil cu greutatea >4kg
    - tensiunea arteriala >180/110
    - are trigliceride > 250mg/dl sau colesterol >250mg/dl
- diabetici: Este util sa se faca o pauza in alimentatie (post) §i sa se efectueze o analiza a glucozei dupa prinz la un diabetic care se va prezenta in curind la un specialist in diabetologie.

IMC - Indicele de Masa Corporala este egal cu greutatea in kg impartita la inaltimea masurata in metri, totul la patrat (kilogram/metri)~. Daca o persoana obeza cu diabet de tip 2 nu mai este obeza (IMC <25) sau daca IMC-ul sau scade, s-ar putea sa nu mai aiba hiperglicemie sau diabetul sau poate fi mai bine tinut sub control.

IMC<20 subponderal
IMC 20-25 normoponderal
IMC 25-27 supraponderal
IMC >27 obez

Cinc este diabetic?

Glucoza pe stomacul gol >125mg/dl sau glucoza la doua ore (sau mai mult) de la ora prinzului >200mg/dl indica diabet

Glucoza pe stomacul gol 115-125mg/dl sau glucoza la doua ore (sau mai mult) de la ora prinzului 140-199mg/dl indica posibil diabet. La persoanele care pot face diabet (sint la limita), o crestere in greutate cu numai 5 kg poate fi suficienta pentru declansarea diabetului.

Glucoza pe stomacul gol <115 sau glucoza la doua ore (sau mai mult) de la ora prinzului <140

sint valori normale, nu indica diabet.

Glucoza luata prin inteparea degetului

Glucoza pe stomacul gol (nu se consuma nici un aliment, in afara de apa, timp de 8 ore) >125mg/dl indica diabet.

Glucoza pe stomacul gol avind valori de 110-126mg/dl indica toleranta scazuta la glucoza.

Glucoza la doua ore de la ora prinzului >200mg/dl indica aproape intotdeauna diabet. Valorile glucozei de 140-199 dupa prinz indica toleranta scazuta la glucoza.

Analiza urinei

Fisiile de analiza a urinei pot fi taiate longitudinal pe jumatate, sau puteti sa va hotariti sa faceti doar una dintre analizele care va intereseaza (fie proteinele, fie glucoza) §i sa pastrati restul pe mai tirziu.

Analiza urinei se va face intotdeauna intr-un pahar curat cu urina proaspata (unii detergenti de curatare pot mari cantitatea de proteine, a§a ca va trebui sa clatiti bine paharul daca ati folosit detergenti pentru curtatarea lui). Ca o alternativa, pacientul poate trece fi§ia de analiza prin jetul de urina in timp ce urineaza.

In Romania, rezultatele analizei urinei sint interpretate astfel: partea galbena a fisiei indicaproteine, partea albastra a fisiei indica glucoza. Nivelurile proteinelor pot fi citite imediat dupa scufundarea fi§iei in urina (dar nu o tineti in urina mai mult de doua minute inainte de a o citi). Pentru a citi nivelurile glucozei, persoana care face testul trebuie sa astepte 30 secunde pentru a compara culoarea capatata de fi§ie cu culorile de pe cutie. Glucoza in orice cantitate in urina indica diabet (daca paharul in care s-a colectat urina esteperfect curat - daca anterior a fost in el vreo bautura racoritoare, rezultatul va fi fals pozitiv). 0 exceptie posibila este analizarea urinei la mai putin de doua ore de la consumarea multor dulciuri si /sau produse cu continut ridicat de amidon. Proteinele in urina indica o afectiune renala. Exceptie fac femeile la care "urmele" sau "+" sau "30 mg/dl" de proteine in urina se pot datora unei infectii vaginale, contactului sexual, menstruatiei sau oricarei escuamari a peretelui vaginal. Puteti cere pacientei sa colecteze urina in alta zi §i sa i§i clateasca bine cu apa zona pubiana inainte de a colecta urina. Un rezultat pozitiv privind proteinele se poate datora diabetului sau hipertensiunii arteriale, care afecteaza capacitatea de filtrare a rinichilor. S-a demonstrat ca inhibitorii ACE precum captoprilul sau enaloprilul protejeaza rinichii de o inrautatire a situatiei. Trebuie mentionat, totu§i, ca nu orice afectiune renala datorata diabetului se reflecta intr-un rezultat pozitiv al proteinelor in urina.

Hipertensiunea

Medicamentele antihipertensive vor fi administrate la niveluri mai scazute ale tensiunii arteriale la pacientii cu diabet decit la cei fara diabet. Tensiunea arteriala la care trebuie inceput tratamentul antihipertensiv la diabetici este $\geq$ 130/85. Inhibitorii ACE (captopril §i enalapril) sint tratamentul de prima electie pentru diabetici, intrucit aceasta clasa de medicamente le protejeaza rinichii.

Exceptii de la ghidul de practica

Unele dintre recomandari, precum cele referitoare la efectuarea EKG-urilor, a analizei glucozei pe stomacul gol sau a microalbuminuriei la fiecare 3 luni, pot fi imposibil de realizat datorita inexistentei anumitor servicii in zonele respective. Se poate folosi proteinuria in locul microalbuminuriei, daca analiza acesteia din urma nu este disponibila. Controlul ochilor se va face cei mai bine prin controlul fundului de ochi

(retinei), dar s-ar putea ca singurul test pe care il puteti face la clinica Dv. sa fie simpla verificare a acuitatii vizuale, intrebind pacientul cit de bine vede cu fiecare ochi.

Tuberculoza

Este binecunoscut faptul ca diabeticii prezinta risc crescut pentru tuberculoza. La intilnirea pe tema ghidului de practica s-a mentionat necesitatea verificarii daca pacientul nu sufera de tuberculoza (care poate fi adaugata pe Lista de examinari). Trebuie sa tineti cont de faptul ca inhibitorii ACE pot cauza ocazional tuse, dar aceste medicamente nu se asociaza cu modificarile la nivel pulmonar.

Lista examinarilor care nu trebuie omise in examinarea pacientului diabetic

	6 luni	1 an	1 1/2 an	2 ani
Cardiac				
Tiroida				
Puls				
Ex picioarelor				
Exercitiu fizic				
Dieta				
Tutun /alcool				
Educatie in grup				
Controlul ochilor		*****		
Glicemia				
Porteinuria		*****		
Colesterol		*****		
Rezultatele de la specialist				

Vizita initiala

1 anamneza

- Simptome,rezultate de laborator in legatura cu diagnosticului
- Evaluarea dietei si evolutia grutatii infectioase
- Planuri anterioare si actuale de tratament actual
  - Medicatie
  - Regim alimentar
  - Realizarea autocontrolulu
- Exercitiu fizic
- Complicatii acute
- Istoricul bolilor
- Programul tratamentului
- Complicatiile diabetu

Cabinet medical _____
DR. _____
Medic de famile _____

ACTIVITATEA	FRECVENTA	REZULTATUL
1. VIZITA INITIALA		
1.1. ANAMNEZA	In cadrul primei vizite	
• Motivele prezentarii		
• AHC		
• factori de risc pt. DZ		
• factori psiho-sociali economici		
• simptomatomatologie, rezultate de laborator anterioare episodului actual, dar sugestive pentru diagnostic • planuri anterioare si actuale de tratament		
1.2. EXAMENUL FIZIC	In cadrul primei vizite	
• Inaltime		
• Greutate		
• IMC		
• TA		
• Puls		
• Examenul cardiologic		
• Examenul glandei tiroide		
• Examenul picioarelor		
• Examenul neurologic		
• Examenul dermatologic		
• Examinarea cavitatii bucale		
• Maturizarea sexuala		
1.3. ANALIZE DE LABORATOR		
• Glicemia a jeun		
• Colesterol		
• Trigliceride		
• Proteinurie/microproteinuria		
• Creatinina		
• EKG (adulti)		

ACTIVITATEA	FRECVENTA	REZULTATUL
1.4. PLANUL DE CONTROL		
• Schimbarea stilului de viata		
• Regim alimentar		
• Alcool		
• Fumat		
• Exercitiu fizic		
• Instructiuni de monitorizare		
• Medicatie		
• Planificarea analizelor		
- profil lipidic (colesterol, trigliceride)	1 data/ an	
- glicemia a jeun	1 data/la 2 luni	
- microalbuminurie	1 data/ an	
2. VIZITA ULTERIOARA	Lunar(pentru initierea tratamentului) Trimestrial (DZ stabil)	
2.1. ANAMNEZA		
• Simptomatomatologie • Planuri actuale de tratament		
2.2. EXAMENUL FIZIC	In cadrul fiecarei vizite	
• Greutate		
• IMC		
• TA		
• Puls		
• Examenul cardiologic		
• Examenul glandei tiroide		
• Examenul picioarelor		
• Examenul neurologic		
• Examenul dermatologic		
• Examinarea cavitatii bucale		
• Maturizarea sexuala		
2.3. ANALIZE DE LABORATOR		
• Glicemia a jeun	1 data la 3 luni	
• Colesterol	1 data/ an	
• Trigliceride	1 data/ an	
• Proteinurie	1 data/ an	
• Creatinina	1 data/ an	
• EKG (adulti)	1 data/ 3 luni	

2.4. PLANUL DE CONTROL		
• Schimbarea stilului de viata	La indicatia medicului	
• Regim alimentar		
• Alcool		
• Fumat		
• Exercitiu fizic		
• Instructiuni de monitorizare	in cadrul fiecarei vizite	
• Medicatie		
• Planificarea analizelor		
- profil lipidic (colesterol, trigliceride)	1 data/ an	
- glicemia a jeun	1 data/la 2 luni	
- microalbuminurie	1 data/ an	

SEMNATURA SI PARAFA MEDICULUI DE FAMILIE,

_____

Diabetes Guidelines

Introduction

The role of the primary care physician in diabetes care will vary from area to area depending on the resources available to the primary care physician and the availability and scope of practice of specialty clinics. It is clear that many diabetic patients in the community are not diagnosed, and active case finding of symptomatic patients is needed.

Current primary care practice regarding diabetes is restricted in many areas of Romania. Monitoring of glycemic control may not be possible due to restrictions on the scope of practice. However, substantial contributions to the prevention of diabetes-related morbidity can be achieved nonetheless. Much of the morbidity of Type 2 (adult onset) diabetes is related to atherosclerotic complications. Close control of hypertension, screening for vascular and neuropathic foot problems, control of hyperlipidemia, and joint management with specialists in achieving a healthy lifestyle (appropriate diet, exercise and smoking cessation) can result in improved patient functioning and reduction in hospitalizations. Therefore, the focus of these adopted guidelines is on reduction in the complications of diabetes rather than glycemic control, per se.

The two tables presented here are the results of Romanian Diabetic Guidelines for Primary Care meeting held in Iasi, May 2000. While diabetes is treated with medication by the diabetologist, almost all diabetologists in Romania have too many patients for the full diabetic health monitoring recommended on these tables. For this reason the health monitoring and non-medicine care of diabetes must be done by the family doctor.

The three page table labeled ***"Follow-up Record Sheet of the Type II Diabetes Patient"*** lists the things which the doctor needs to know when they first see a diabetic patient. Details needed about a diabetics history are listed at the bottom of the other, single-paged table (A List of examinations...@). Other items at the end of the three-page table are to help the doctor and patient to make a plan of health monitoring. If a patient does not smoke or drink alcohol, these two items may be removed from the list. Tests need to be scheduled at attainable intervals for the patient.

The single page table ***"List of examinations not to be omitted in examining the diabetic patient"***, can be used to simplify follow-up records of diabetic patients. Weight and blood pressure could be added to include all of the basic information necessary on diabetic patients. Doctors who are short on time may wish to do these exams in groups, and preventive health discussions in groups.

Who should get their glucose tested?

- Women in their 24^{th} week of pregnancy especially if they have had a child of >4kg birthweight or if their Body Mass Index (BMI, (weight in kg) / (height in meters)^2)>27

- People > 45 years old (and one of the following):
  - (weight in kg) / (height in meters)^2 > 27 (BMI)
  - with a close relative with diabetes
  - a woman who has had a child of >4kg birthweight
  - with blood pressure >180/110
  - have triglycerides > 250mg/dl or cholesterol >250mg/dl
- Diabetics: It is helpful to do a fasting and a post-prandial glucose test for a diabetic who will soon be seeing their diabetes specialist.

BMI: Body Mass Index (Romania IMC - Indice Masa Corporala) is equal to weight in kilograms divided by height in meters-squared (kilogram/meters^2). If an obese person with type 2 diabetes is no longer obese (BMI<25) or if their BMI drops, they may no longer have hyperglycemia or their diabetes may be better controlled.

BMI<20 underweight
BMI 20-25 normal weight
BMI 25-27 over weight
BMI >27 obese

Who is Diabetic?

Fasting glucose >125mg/dl or two-hour (or more) post-prandial glucose >200mg/dl are diabetes
Fasting glucose 115-125mg/dl or two-hour (or more) post-prandial glucose 140-199mg/dl are borderline diabetes. For people who are borderline for diabetes, an increase in weight by only 5 kg may be enough to make them diabetic.
Fasting glucose <115 or two-hour (or less) post-prandial glucose <140 are normal, non diabetic

Fingerstick Glucose

Fasting (no food other than water for 8 hours) glucose >125mg/dl is diabetes.
Fasting glucose 110-126mg/dl is impaired glucose tolerance.
Two hour post-prandial glucose >200mg/dl is almost always diabetes.
Two hour post-prandial glucose 140-199 is impaired glucose tolerance.

Urine Analysis

Urine dipsticks may be cut lengthwise into half, or you may decide to use only the one test of interest (either protein or glucose) and save the rest for later.

Urine analysis should always be made in a clean cup with fresh urine (some cleaning detergents can increase protein, so rinse cup thoroughly if detergents are used). Alternatively, the patient could be asked to pass the strip through the urine stream, when they urinate.

These are the Romanian readings for urine analysis: the yellow part of the strip tests protein; the blue part of the strip tests glucose. Protein levels can be read immediately

after dipping the stick into the urine (but do not wait longer than two minutes after dipping in urine for reading). For reading glucose levels the test reader must wait to compare color with the colors on the container for 30 seconds.

Glucose in any quantity in urine suggests diabetes (as long as the collection cup is thoroughly clean -- juice or soda previously in the cup would result in a "false" positive). A possible exception is tests on urine less than 2 hours after eating a lot of sweets and/or starches.

Protein in the urine suggests some kidney damage. An exception to this occurs in women for whom "trace" or "+" or "30 mg/dL" of protein in the urine, may be because of vaginal infection, intercourse, menstruation, or any sloughing of the vaginal wall. You may ask the female patient to make the collection on a different day and be sure to rinse the pubic area well with water before the collection. A positive protein test could be due diabetes or high blood pressures which affect the kidneys' ability to filter. ACE inhibitors such as captopril and enalopril have been demonstrated to protect the kidneys from getting worse. It should be noted, however, not all kidney damage from diabetes will be positive for protein in urine.

Hypertension

Anti-hypertensive medications should be started at lower blood pressure levels for patients with diabetes compared with those without diabetes. The blood pressure at which to start anti-hypertensive treatment of a diabetic is $\geq$ **130/85**. ACE inhibitors (captopril and enalapril) are first line treatment for diabetics as this class of medication protects their kidneys.

Exceptions to guidelines

Some of the recommendations, such as EKGs, fasting glucose, or microalbuminuria every 3 months may be impossible because not all services will be available in all locations. Proteinuria may be used instead of microalbuminuria, if the test for the latter is unavailable. Eye checks are best done with fundoscopy, but simple visual acuity tests asking the patient how clearly they are seeing out of either eye may be all that is available at your clinic.

Tuberculosis

Diabetics are well known to be at increased risk for tuberculosis.
The guidelines meeting also mentioned the need of screening the diabetic patient for tuberculosis (which could be added to the Alist of examinations@). One word of caution is that the ACE inhibitors may cause occasional coughing, but this medication is **not** associated with lung changes.

Appendix I: Guidelines for Breast and Cervical Cancer Screening

These Guidelines were presented and discussed at the Workshop entitled "Enhancing Rural Health Care in the 21st Century." Botasani, Romania, 10-12 September 2001.

Proposed Guidelines for Breast Cancer Screening

Why screen for Breast cancer?

The incidence of breast cancer is increasing in most parts of the world. Early detection is prudent to decrease mortality among women at high risk for breast cancer. Studies in the US have shown that although the proportion of women receiving mammography and performing breast self-exams have increased, there is still need for increased awareness and education.[i] Previous studies confirm that the earlier breast cancer is detected, the greater the benefit. Use of mammography, clinical breast exams, and breast self-exams, are still low among women with limited education, those with low income, and those with limited access to care secondary to no healthcare insurance. In rural areas, screening may also be limited by access to technologic screening tools such as mammography and ultrasonography and trained professionals who are capable of performing these studies. Additionally, overall mortality is not decreased since women who are highest risk for other chronic diseases seem to be the same group that have routine mammograms. In these communities, teaching professionals and women to perform breast exams may be a plausible alternative and/or adjunct to improve early detection of breast cancer.

Identifying Risk for Breast Cancer

The most important risk factors for breast cancer are increasing age and family history of breast cancer. Additional risks for breast cancer include: Nulliparity, increased age at first delivery, early age at menarche, and late age at menopause. Although most clinicians feel that oral contraceptive use does not increase the overall risk for breast cancer, others believe that the risk is increased for certain women with oral contraceptive use. Evidence for hormone replacement therapy, diet, body mass index, and alcohol are inconclusive. Risk factors with inconsistent evidence include abortion, smoking, breast implants, environmental toxins, stress, and lactation.[ii]

Screening tool for patients.

Routine History during the Well woman exam:

Age
Age at first period
Number of first-degree relatives diagnosed with breast cancer (mother, sister, daughter, etc.)
Number of babies delivered
Age at first live birth
Number of previous breast biopsies (whether positive or negative)
At least one biopsy with atypical hyperplasia

Adapted from the STAR trial National Cancer Institute questionnaire.

Clinical Breast exam

Beginning

- ❑ Review the patient's history
- ❑ Discuss risk factors identified from questions above

- ❑ Review the steps in performing the clinical breast exam and demonstrate the breast self-exam
- ❑ Review other common findings on the breast exam
- ❑ Explain to the patient that not all lumps are cancer
- ❑ Encourage the patient that any new suspected lumps should be discussed with the doctor

	• Ask the patient to sit at the edge of the exam table. • Ask the patient to remove her gown to her waist. • Ask her to place her arms to the side. • Check for symmetry, dimpling of the skin, retraction of the skin, the 'orange peel' effect of the skin, and the nipple position.
	• Watch the breast movement when the patient raises her arms, move her shoulders. • Reassure the patient that the exam is normal at this time.
	• Use the fat pads of the 3 middle fingers • Move in circular motion • Advance about 1cm breadth each movement
	• Now have the patient move in the supine position • Ask the patient to remove the gown and place one hand behind the head on the side you are examining • Press the breast tissue against the wall in a circular motion • Palpate the breast in the overlying area • Palpate the entire breast including the axillary areas
	• Palpate around the areola and nipple • Check for discharge • Lower the arm and check the axilla • Now tell the patient the exam is normal if there are no abnormalities

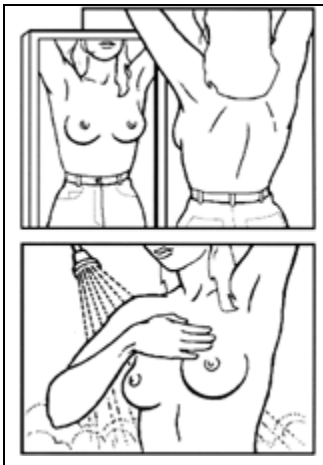
At the end,

- ❑ Review your findings with the patient
- ❑ Reassure the patient
- ❑ Review the breast self-exam
- ❑ Review symptoms of breast cancer

Breast self-exam

Breast cancer is one form of cancer we can check for and find. So mark your calendar for a monthly breast self-exam. For women still menstruating, pick a day soon after your cycle, when your breasts are least swollen. But remember it's important to get to know your breasts and check them throughout the month, especially during menopause, when your cycle may become irregular. Examine your breasts regularly!

Don't panic if you feel a lump. Most are not cancer, tell your doctor about any lumps you find.

<table>
<tr>
<td>  </td>
<td><u>FACING A MIRROR</u>
• Stand or sit in front of a mirror, keeping your arms relaxed at your sides.
• Look at the shape and size of your breasts. Check for any changes in the way they look. It's not unusual for one breast to be larger than the other is.

<u>Inspect your breasts in four steps: 1) arms at your sides; 2) arms over your head; 3) hands on your hips; 4) hands on your hips, flexing your chest muscles and leaning forward as you pull your elbows forward. In each position, look for changes in the texture and color of your breasts and nipples. Specifically, dimpling, redness, swelling, flaky or scaly skin, lumps and nipple discharge.</u>

The next step may be performed in the shower (standing) or lying down.

<u>IN THE SHOWER</u>
In the shower you can lather up your chest with soapy water. This makes the exam much easier. Now raise your right arm and place your hand behind your head. Using your soapy hand and the pads of your fingers, check your right breast.</td>
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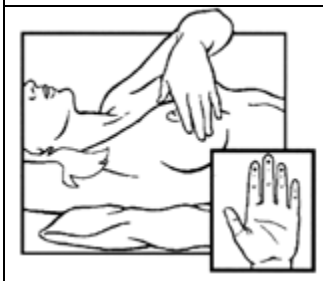
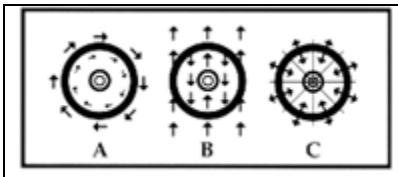
<td>  </td>
<td><u>LYING DOWN</u>
Lie down on your bed and place a pillow under your right shoulder.
Put your right hand under your head. This position flattens your breast, making it easier to examine. Using the pads of three or four fingers on your left hand, Check your right breast.</td>
</tr>
</table>

	You can choose one of three patterns: 1. very small circles around the breast starting from the outside to inward toward the nipple 2. like a wedge- outside of the breast in toward the nipple, making the shape of an orange slice 3. Move up and down in vertical strips *Exam B has been shown to be the most sensitive of the 3 patterns.

No matter which pattern you choose, there are three things you should remember: Vary the pressure while performing the exam so you can feel all levels of your breast tissue; don't lift your fingers during the exam; and don't forget to examine your armpit. Finally, gently squeeze the nipple, look for any discharge and feel the tissues deep in the nipple. **Now repeat on the other side.**

Teaching the breast self-exam.

Review the warning signs of Breast cancer

- Any new lump in the breast
- A dimple (puckering) in the skin or a change in color
- Change in the size or shape of the breast
- A nipple that becomes inverted (pulled in)
- A discharge from the nipple, especially if the fluid comes out by itself or is bloody

When teaching the exam,

- Review the patient education flyer
- Discuss the patient's fears about doing the exam
- Express the importance of doing these exams regularly (The patient becomes better familiar with her own breast)
- Demonstrate correct positioning of hands above head
- Demonstrate hand position and how to palpate lesions
- Demonstrate the approximate amount of pressure to use
- Explain dimpling, retraction of skin, and the orange peel effect
- Demonstrate to the patient how to check lymph nodes
- Talk about other findings that may be normal or abnormal
- Encourage the patient to discuss any changes in breast size, color, or shape with you
- Reassure the patient that majority of lumps are not cancerous!

Recommendations for Screening

Adapted from the US Preventive Services Task Force recommendations and the American Medical Association guidelines.

- Annual clinical breast exam for women aged 40-49
- Routine regular breast self-exams beginning at age 20 (Report any abnormalities to your doctor)
- Screening Mammogram with or without clinical breast exam every 1-2 years for any woman aged 50-69
- Women < 50 years of age who are high risk may begin earlier after consultation with their doctors

[i] Anderson, LM, May DS. Has the use of cervical, breast, and colorectal cancer screening increased in the United States? Am J Public Health 1995; 85:840-2.

[ii] Morbidity and Mortality Weekly report. Trends in Self-Reported Use of Mammograms and Papanicolaou Behavioral Risk factor Surveillance System. US department of Health and Human Services, CDC, October 1999; 48: No. SS-6

Implementing A Program For Early Detection Of Cervical Cancer

Introduction:
Although cervical cancer mortality in the US and Canada has declined in the last 2-3 decades, the incidence and mortality rates for women in developing countries continue to be a problem. Cervical cancer is the third most common cancer worldwide.[1]In Romania, cervical cancer is second to breast cancer in incidence and mortality. Cervical cancer rates in Romania are reported as being the highest in Europe.[1] Development of sound practice guidelines for providers and women of developing countries may prove beneficial in improving screening and early detection of pre-cancerous lesions.

Screening programs must be cost-effective, easily accessible, and practical. A good screening program must have a mechanism to identify women at risk prior to the onset of disease with minimal risk and discomfort during testing. In many developing countries, screening is limited by lack of education (for both provider and patient), economic resources, lack of cohesiveness and sharing among care providers, cultural standards, trust issues, and access to care.

Cost-effectiveness of screening is very important in developing guidelines since the cost of screening may become more cumbersome in a country with limited resources. The guideline must take into consideration the locale, cost of performing the test, emotional cost to women being tested, costs incorporated in developing a system for handling results and follow-up. Sometimes, using more advanced methods of screening may not be plausible because of the introduction of more costly tools and training of specialized providers. A well-developed early detection and prevention program should identify patients at risk, treat others in early disease states, and reduce overall morbidity and mortality.

Ultimately, every woman must be educated about the need for cervical cancer screening.
Cervical cancer is preventable or curable if detected early.

Methods of screening:
Although visual inspection may prove useful in the future, training doctors to do adequate screening by pap smears can contribute to early detection of cervical cancer and reduction in mortality. Both methods require education and training of providers to achieve the best results. Visual screening would require providers to correctly identify abnormal tissue and know what action to take based on visualization. This guideline will not go into the details of the visual exam method.
Pap smears require proper collection technique; appropriate storage and transport to the cytologist; and results must be accurately interpreted and returned to providers.[1] Any method of screening must be accompanied by provider education on the clinical and counseling issues surrounding cervical cancer prevention and its impact on women's health.

The Pap smear exam:

Since the initiation of screening with the Pap smear more than 50 year ago, epidemiologic studies in the US have shown a positive correlation between cytologic screening and decreasing morbidity and mortality. [1] Early detection programs will depend on effective pap screening with good follow-up and management guidelines.

The Pap test is one of the most effective screening tools for cervical cancer. It is relatively inexpensive and simple to perform. The limitations of the Pap test include accuracy of sampling and interpretation. The false negative rate ranges from 10-20% and can be as high as 70%. Therefore, training primary care providers to adequately perform pap smears can enhance early detection of cervical cancer.

Important steps in Pap screening:

1. Patient education
2. Provider education
    - Patient preparation for exam
    - Pap smear collection
    - Preparation of smear for transport to cytologist
3. Cytologic interpretation
    - Understanding interpretation
    - Establishing guidelines for dispensing results to patient
4. Establishing guidelines referral and management of abnormal results
5. Establishing guidelines for follow-up

Patient Education on Pap smear exam:

Patient education need not be a cumbersome task. Doctors, nurses, community educators, schools, and laypersons can provide education. In developing a program to promote early detection, the community resources should be evaluated and all persons willing and available can be utilized to pass on the knowledge concerning cervical cancer risks, the community burden of treating invasive cancer, and the available methods of testing. Patient education should also include methods for follow-up and available resources for support and management.

Education can begin as early as elementary school. Health educators, teachers, and parents can teach young girls and boys about good hygiene, begin abstinence education, promote self-esteem, and teach about the risks associated with early sexual intercourse. Female adolescents should be educated about normal findings of the female reproductive organs as they mature. Young boys should be educated about their role in preventing STIs and cervical cancer. Additional educational materials can be given during the routine doctor's visit.

The Gynecologic exam and collection of Pap smear:

General information:

The pap should not be collected during menstruation. Additionally, the Pap smear results may be obscured by infection, inflammation, or in the presence of bleeding. The optimal time to do the Pap smear is about 2 weeks after the first day of the patient's last period.

Instruct the patient to avoid douching, vaginal foams or medication for 24-48 hours prior to examination. Although all of the listed equipment might not be available, below is a suggested list and a guideline for performing the Pap smear.

Tools needed:

- Speculum
- Gloves
- Water soluble lubricant
- Lamp or light source
- Sterile cotton swabs
- Wooden or plastic spatula
- Cytologic fixative
- Culture tube
- Optional: slide for wet mount, saline solution, KOH

Step 1.

Explain in general to the patient what you are about to do.
Ask: Is this her first pelvic exam?
Discuss the equipment if this is her first exam.
Make sure the room is comfortable.
Make sure privacy is insured.
Have the patient empty her bladder before the exam is started.

Step 2.

Assist the patient to the lithotomy position.
Drape the patient in a way that she is minimally exposed.

Step3.

Make sure the equipment is nearby and easy to reach.
Wash your hands and put on gloves.
Arrange the lamp.
Have the patient slide down until her hips reach your hand at the edge of the table.
Have the patient relax her knees outward just beyond the angle of the stirrups.

The External Exam:

Minimally uncover the vulva and external genitalia.
Gently touch the thighs with the back of your hand.
Tell the patient you are beginning the external exam.
Palpate the external genitalia.
Look at hair distribution.
The skin should be smooth and clean.
Labial swelling may be indicative of Bartholin's gland abscess.
Excoriation, rashes, and lesions suggest inflammation and infection.

* Observe for trauma, varicosities, discolorations, or scarring.

Separate the labia majora of one hand to assess the labia minora. *Hyperemia* of the forchette may indicate recent sexual activity.
Inspect the minora, clitoris, urethral orifice, vaginal introitus, and perineum. Look for cracking skin, inflammation, irritation, and excoriation. Ulcers and vesicles suggest *STIs.*
Inspect the clitoris (normal size ~2cm or less in length and 0.5cm in diameter). Enlargement may be a sign of a masculinizing condition.
Inspect and palpate the introitus and perineum.

Obtaining the Pap, Vaginal Smears and Cultures:

**** Always collect the Pap smear first and collect the cultures second!***

Pap smear Procedure:

1. Tell the patient you are about to begin the speculum exam.
2. Warm and lubricate the speculum with water.
3. Expose the introitus by spreading the labia from below using the index finger and middle finger.
4. Gently insert the speculum at a 45-degree angle positioning downward.
5. Secure the speculum by tightening the thumb nut.
6. Observe the vagina and cervix for discharge and lesions.
7. Prepare to collect your sample for the Pap smear.
8. Insert the cytobrush or cotton swab into the cervical os to sample endocervical cells.
9. Next collect the outer cells of the cervix.
10. Rotate the spatula 360 degrees keeping it flush against the cervical tissue.
11. Withdraw the spatula and spread the specimen on a glass slide. (Cervical specimen)
12. Spray with Cytologic fixative.

Cultures (GC and Chlamydia) Procedure:

1. Introduce a sterile swab into the vagina and insert it into the cervical os.
2. Hold it in place for 10 to 30 seconds.
3. Withdraw the swab and place in the tube.
4. Label the tube and place in bag for lab.

Wet mount and KOH:

1. Prepare the slides prior to collecting the sample.
2. Smear the secretions on the slide with about 2 drops of saline for wet mount (BV and Trichomonas) and KOH for Candida.
3. Apply cover slips.

The Bimanual Exam:

1. Inform the woman that you are now going to examine her internally with your fingers.
2. Palpate the vaginal wall as you insert your fingers.
3. Feel for cysts, nodules, masses, and growths.
4. Palpate the cervix with the palmar surface of your fingers.

5. Move it gently. ***Painful cervical motion*** implies Pelvic Inflammatory disease.
6. Insert the tip of one finger into the cervical os to evaluate patency.
7. Palpate the uterus.
8. Confirm the location and position of the uterus. ***Deviation to the right or left*** is indicative of adhesions, pelvic masses, or pregnancy. It should be pear-shaped, 5.5 to 8 cm long, contour rounded, and the walls should feel smooth and firm.
9. Assess the uterus for mobility and tenderness.
10. Palpate the adnexal areas and ovaries. The ovaries if palpable should feel firm, smooth, ovoid and approximately 3x2x1 cm in size.

After the exam:

- Assist the woman to the sitting position.
- Share with her your findings.

Preparing the sample:

1. Label the slide with the patient's name prior to collection
2. Complete a requisition to accompany sample

Include: date of exam, identifying #, name, birthdate, and some locator ID (address or phone number)
Insurance information
Last menstrual period
Last pap date
Last pap results
Brief clinical history (e.g. irregular bleeding, prior abnormal paps, age, whether on hormonal medication, contraceptive method, etc.)[1]

***** Remember a good smear that is properly fixed and labeled properly is a prerequisite to a quality Pap smear result.

Developing an infrastructure for collecting, maintaining, and dispersing pap results:
The pap record can be organized in a manner for easy access and recall. Sample collection systems include the index card and the electronic data system.

The record should include:

- Patient's name and birth date
- Age at menarche
- Age at 1st intercourse
- Number of sexual partners
- Significant medical history
- Method of contraception
- Allergies
- Family history
- Pap history with date of smears, results, and appropriate follow-up or management

- Any prior STIs (Gonorrhea, Chlamydia, genital warts, human immunodeficiency virus, syphilis, herpes, etc.)
- History of HPV (human papilloma virus)
- Exposure to DES
- History of cigarette smoking

* Developing a system to receive results from cytologist and notify patients should be organized and systematic to reduce error in reporting to patients and to reduce chance of missing invasive disease. On the following page is an example of a recommended Pap smear guideline.

Pap Smear Guidelines

Pap Screening:

Virgin patient never had sex < 18

- External surveillance only unless indicated (i.e. evidence of trauma, abuse, vaginal bleeding, discharge.
- First Pap screen due at 18 or when the patient is sexually active.

Low risk patient not sexually active age 18-menopause

- Routine screening annually times three. If normal, then every other to every three years as long as the patient has never been sexually active and has no signs of infection.
- If the patient has previously been sexually active annual Pap smears are recommended.
- If no cervix (i.e. s/p hysterectomy) for non malignant disease no further Pap smear
- If hysterectomy for cancerous lesions, Annual pap until 3 normal paps then every 1-3 years (history of prior abnormal pap, warrants more frequent screening)

Low risk patient age >18 years old – Menopause who are sexually active

- Recommend annual screening.

Who is high risk?

- Young age at first intercourse
- Multiple sexual partners
- Previous HPV associated disease
- History of other Sexually Transmitted Infections
- Previous Cervical Intraepithelial Neoplasia or abnormal Pap

Recommendations: These patients require annual screening including STI screening. When an abnormal pap smear is obtained, more frequent screening is required as suggested below.

Pap Results:
This example is based upon the Bethesda reporting system. The Bethesda system introduced a uniform more reproducible reporting system for cervical cancer smears.

Normal Pap **(benign cellular changes, satisfactory for evaluation, satisfactory for evaluation but limited by…(if it's due to unavailable LMP, history such as STI history but it is benign)**

- Repeat annually
- Prior abnormal smear, repeat pap every 6 months for 2 years. Continue until 3 documented normal paps, then continue annually

Unsatisfactory for evaluation or no endocervical cells in a non- pregnant patient

- Repeat in 3 months

Benign cellular changes with infection or reactive changes

- Treat infection
- Counsel patient on STI prevention and vaginal hygiene
- If due to atrophy consider estrogen cream
- Repeat annually

Atypical Squamous of undetermined origin

- Premenopausal
  - Repeat pap in 6 months
  - If persistent or the doctor feels the patient will not return, refer for colposcopy
- Postmenopausal
  - Estrogen cream for six weeks then repeat pap
  - If persistent, refer for colposcopy
- Pregnancy
  - Repeat postpartum

ASCUS suggestive for dysplasia

- Refer for colposcopy

Glandular atypia

- Refer for colposcopy
- If <35 years old, Endocervical curettage (ECC)
- If> 35 years old ECC and endometrial biopsy
- AGUS consistent with adenocarcinoma – refer for colposcopy and cone biopsy

LGSIL

- Consider repeat pap in 6 months if patient is reliable
- Otherwise refer for colposcopy and ECC
- If normal, repeat pap q 6 months x 2 years
- When 3 normal paps are obtained, return to annual pap
- LGSIL confirmed, patient would be treated accordingly (cryotherapy or LEEP).
- After procedure, repeat pap q 4-6 months X 1 year.
- ***Pregnancy***
  - Follow with colposcopy every trimester to observe for progression
  - Repeat colposcopy postpartum with biopsies as necessary

HGSIL

- Refer for colposcopy and ECC
- If normal, repeat ECC in 6 months. If normal, repeat pap q 6 months x 2 years.
- If HGSIL confirmed, the patient will be treated accordingly. After procedure repeat pap q 4-6 months x 2 years
- ***Pregnancy***
  - Refer for colposcopy

**** Malignant cells present, consistent with adenocarcinoma – Further investigation! Refer immediately!***

Patient with prior abnormal pap and colposcopy exam:

- Any abnormal pap ASCUS or greater requires referral for repeat colposcopy

Visible cervical lesion:

- Refer for colposcopy

Adapted from the Guidelines of the American College of Gynecology, American Cancer Society, the Canadian Task Force, and drafted guidelines of Capri-Mara Fillmore, MD, MPH, Consultant for USAID, August 1999.

Appendix J: Preventive Health Care Services

Preventive Health Care Services

Immunization activities are carried out under the National Immunization Program. Family doctors are responsible for storing and maintaining the necessary supplies of vaccines.

- Immunizations A list of persons needing immunizations will need to be prepared. The immunizations should be performed in collaboration with the Public Health Directorate.
  - BCG, including an examination of the first immunization scar;
  - PPD test;
  - Hepatitis B;
  - Poliomyelitis;
  - Diphtheria, tetanus and pertussis/whooping cough - DTP (or DT in cases where DTP immunization is not recommended);
  - Measles;
  - Diphtheria and tetanus in adults - DT;
  - Tetanus or VTA;
  - Other immunizations, when needed, as requested by the Ministry of Health or the family.

- Counseling on disease risk factors
- Preventive examinations for tuberculosis, venereal diseases etc.
- Well baby, well child and adult examinations:
  1. children – after birth and at exit from hospital, at 1, 2, 4, 6, 9, 12, 15, and18 months between 2-7 years – annually
  2. between 7-30 years – a complete medical exam every 2 years (including clinical screening for cancer as appropriate)
  3. Over 30 years of age – yearly - a complete medical exam (including clinical screening for cancer). The standard for the annual examination of patients over 30 years of age consists of one general clinic examination per year (as specified in Article 66, paragraph 2 of the Framework Contract with the Insurance House).
- Detecting, isolating, and reporting transmissible diseases, in accordance with Order No. 8/2000 of the Ministry of Health and Family, including tuberculosis and venereal diseases as well; preventive activities against infectious diseases in infected families and/or among students without assigned medical physicians.
- Monitoring of pregnant women
  1. registering pregnant women
  2. monthly monitoring between 3rd to 9th month of pregnancy
  3. monitoring confined women – at exit from hospital and at 4 weeks post partum
- ***Basic family planning services***
  1. family planning consultation including risk assessment for various methods
  2. Prescription of contraceptive method
- Screening for cervical cancer (Pap Smear and pelvic and rectal examinations) and breast cancer according to the norms established by the Ministry of Health and Family.
- Child health examinations (0 – 1 year) as necessary for specific diseases or problems.

Appendix K: Form to Monitor Pregnant Women

This form can be used for an individual physician and also as a summary form for the Group Practice. Data should be collected monthly.

EVIDENTA GRAVIDE - 2000

LUNA	Aflate in evid.	LUNA DE SARCINA							Consult. gravide	Gravide noi luate in evid.	Nasteri la termen	Nasteri premature	Cezariană	Feți morți	Avort spontan	Gravide cu risc	Vizite lauze	Gravide ramase in evid.	Vaccin ATPA
		III	IV	V	VI	VII	VIII	IX											
Ianuarie																			
Februarie																			
Martie																			
Aprilie																			
Mai																			
Iunie																			
Iulie																			
August																			
Septembrie																			
Octombrie																			
Noiembrie																			
Decembrie																			
TOTAL																			

Dr. Beuran

S.C.M. "Medfam Grup"

PREGNANT WOMEN - 1999

MONTH	TOTAL	MONTH OF PREGNANCY							No. of consul-tations	New pregn. Women	No. of birth at term	No. of premature birth	No of abortions	Preg. women at risk	Home visits	Preg. women in evidence	Vaccin ATPA
		III	IV	V	VI	VII	VIII	IX									
October	6	1	0	1	1	2	1	0	8	1	2	0	0	2	4	6	6
November	7	1	1	0	1	1	3	0	10	3	2	0	0	3	2	7	0
December	6	1	0	2	0	1	1	1	20	1	2	0	0	2	4	6	0

Appendix L: Hypertension Data Collection Form and Results Table

MEDFAM
High Blood Pressure Guideline
Monthly Reporting Form July 2001
SCM MEDFAM GROUP **Date** 6.07.2001

Number of patients with hypertension saw by doctors today 14

	Nr.	%
Percentage of charts that contain a "hypertension guideline"	11	78.57
Of the patients with a diagnosis of hypertension		
How many are men?	7	50.00
How many are women?	7	50.00
Total	14	100.00
Age (years old)		
< 30	0	0.00
30-39	0	0.00
40-49	1	7.14
50-59	0	0.00
60-69	10	71.43
70-80	3	21.43
>80	0	0.00
Total	14	100.00
Treatment		
Diuretic	0	0.00
B-blocker	1	7.14
ACE inhibitor	5	35.71
Alpha blocker	0	0.00
Calcium channel blockers	2	14.29
Combination therapy	6	42.86
Other (example diet)	0	0.00
Total	14	100.00
		%
How many patients have documented risk factors	9	64.29
How many patients have documented discussion of "lifestyle modification as treatment for their blood pressure?	8	57.14

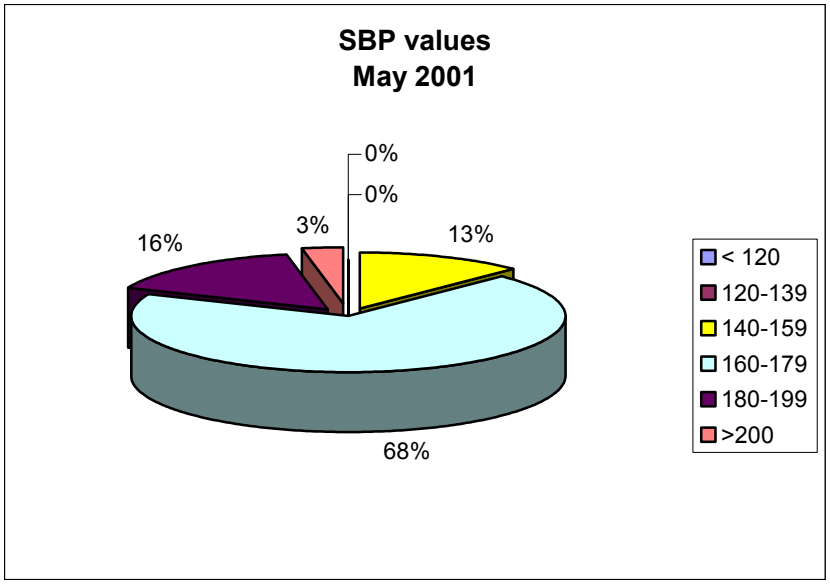
How many have a documented blood pressure at this visit of	nr	%		nr	%
(please check only one – the highest value)					
TAS < 120		0.00	TAD < 80		0.00
TAS 120-139		0.00	TAD 80-89	2	14.29
TAS 140-159	3	21.43	TAD 90-99	1	7.14
TAS 160-179	5	35.71	TAD 100-109	2	14.29
TAS 180-199		0.00	TAD 110-119		0.00
TAS >200		0.00	TAD >120	1	7.14
Total	8			6	

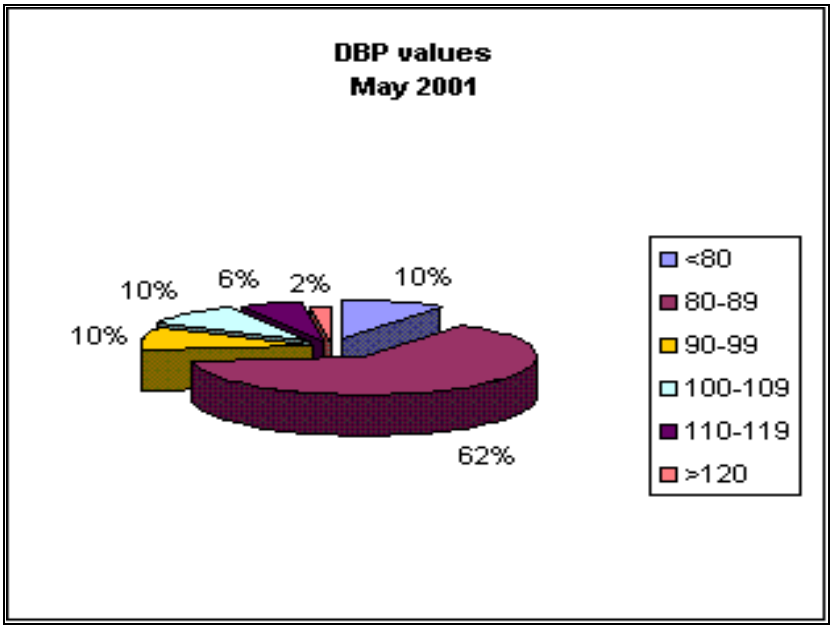
4

SCM MEDFAM GROUP

MEDFAM Monthly Hypertension Continuous Quality Improvement (CQI) Report

SCM MEDFAM GROUP																									
MedFam monthly hypertension Continuous Quality Improvement (CQI) Report																									
Month	Nr. patients.	SYSTOLIC BP												DIASTOLIC BP											
		< 120	%	120-139	%	140-159	%	160-179	%	180-199	%	>200	%	<80	%	80-89	%	90-99	%	100-109	%	110-119	%	>120	%
Nov.	52	1	1.92	10	19.23	14	26.92	13	25	8	15.38	2	3.85	0	0	2	3.85	1	1.92	1	1.92	0	0	0	0
Dec.	62	0	0	3	4.839	17	27.42	20	32.26	6	9.677	1	1.61	0	0	9	14.5	4	6.45	2	3.23	0	0	0	0
Jan.	71	0	0	3	4.225	22	30.99	17	23.94	9	12.68	4	5.63	0	0	6	8.45	5	7.04	3	4.23	2	2.82	0	0
Febr.	104	6	5.77	20	19.23	28	26.92	28	26.92	9	8.654	1	0.96	0	0	7	6.73	1	0.96	3	2.88	1	0.96	0	0
March	57	1	1.75	8	14.04	23	40.35	7	12.28	5	8.772	1	1.75	0	0	0	0	0	0	9	15.8	2	3.51	1	1.75
Apr.	60	0	0	1	1.667	6	10	9	15	6	10	0	0	1	1.67	19	31.7	10	16.7	4	6.67	4	6.67	0	0
May	84	0	0	0	0	4	4.762	22	26.19	5	5.952	1	1.19	5	5.95	33	39.3	5	5.95	5	5.95	3	3.57	1	1.19
June	79	0	0	5	6.329	19	24.05	14	17.72	8	10.13	3	3.80	0	0	14	17.7	7	8.86	4	5.06	4	5.06	1	1.27
July	85	0	0	2	2.353	19	22.35	24	28.24	8	9.412	1	1.18	0	0	12	14.1	9	10.6	7	8.24	2	2.35	1	1.18
Aug.																									
Sept.																									
Oct.																									
Nov.																									
Dec.																									
TOTAL																									


SBP values
May 2001
0%
0%
3%
16%
13%
68%
< 120
120-139
140-159
160-179
180-199
>200


DBP values
May 2001
10%
6%
2%
10%
10%
62%
<80
80-89
90-99
100-109
110-119
>120

Appendix M: Staff Survey Form

Staff Survey Form

As MedFam positions itself as a strong competitor in the changing health care market, assessing the status of MedFam and redefining the priorities will be a major and recurring theme. Future success will be dependent upon the ability to implement and sustain major changes in the way we do business. To help in this effort, we would like you to share your thoughts, opinions and ideas about MedFam. Your ***honest and confidential*** responses will help prioritize our future efforts!

Some Background

1. What are your functions/tasks at MedFam? Please be specific

_____

_____

_____

2. What is your current position? Please circle:
   Receptionist Treatment Nurse Nurse Physician Other

_____

_____

Work Environment

Please answer the following items using the number associated with choice that comes closest to your own feelings:

1 2 3 4 5

Strongly disagree Disagree Neutral Agree Strongly agree

1. My job makes the best use of my skills and abilities _____
2. I am made to feel a worthwhile, valued, and important part of the team _____
3. The physicians encourage the staff to work together as a team _____
4. There is good communication and cooperation between my colleagues _____
5. I always know exactly what to do in order to do my job properly _____
6. I have enough authority to accomplish the work that is expected of me _____
7. I am encouraged to try new ways of accomplishing my job _____
8. The workload in my job function is evenly and fairly distributed _____
9. The staff at MedFam take pride in their job performance _____
10. Meeting patient expectations is the highest priority at MedFam_____

11. Efficiencies and productivity are rewarded at MedFam _____
12. There is continuous effort to improve group/work performance at MedFam_____
13. I receive regular feedback from my supervisor on my work performance _____
14. I am provided opportunities to increase my skills and knowledge through training and education. _____
15. The physicians effectively communicate the future and direction of the practice. _____
16. The organization makes the best use of technology to improve work methods. _____
17. Everyone cares about accomplishing the goals of MedFam. _____
18. I feel my job tasks contribute to the success of MedFam. _____
19. There is good cooperation between my colleagues and me. _____
20. MedFam encourages me and provides me the opportunity to improve my professional knowledge or job skills. _____
21. Compared to other similar practices, MedFam is a good place to work. _____
22. I have considered resigning in the last six months. _____
23. Staff meetings provide me an opportunity to state my views _____
24. What are the three things you like most about the changes that have taken place?

    1. _____

    2. _____

    3. _____

25. What are the three things you like the least about the changes that have taken place?

    1. _____

    2. _____

    3. _____

26. What feedback are you getting from patients?

    _____

    _____

    _____

    _____

    _____

27. What do you see as the top priorities for MedFam over the next few years? Please list in order of decreasing priority:

1. _____

2. _____

3. _____

4. _____

5. _____

28. Please provide any other feedback that you feel is important to the success of the MEDFAM Group Practice.