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Primary Care: A Key Role in Managing Transitions of Care

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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Editorial

Primary Care: A Key Role in Managing Transitions of Care

By David B. Nash, MD, MBA

Editor-in-Chief

A little more than a year ago, I began to experience what seemed to be unrelated symptoms. The most annoying of these were mid-morning headaches and frequent hunger pangs, which I satisfied with a muffin. Like many of my patients, I ignored these subtle signals.

I finally paid attention one evening when I was literally “off my game.” As my tennis partner racked up point after point in our weekly match, I realized that I was sweating profusely and uncharacteristically short of breath. Instead of calling my primary care physician (PCP) as I should have, I ordered some standard lab tests. When, to my amazement, my fasting blood sugar was just over 100, I made an appointment with my PCP.

After a thorough workup, my PCP informed me that I have what we now call prediabetes and issued me a new “game plan,” ie, lose 5% of my body weight by reducing my carbohydrate intake to 60 grams a day.

Although I am a physician who has in-depth knowledge of metabolic syndrome and easy access to the best health care providers and services, I spent the next year discovering how

difficult it is for a person to manage diabetes – even in its very early stages.

I relate this personal experience because, in addition to making me more empathetic with my patients, it impressed upon me how vital the PCP’s role is as diagnostician, teacher, advisor, and partner in managing the complexities and multiple care transitions associated with chronic conditions.

From a population health perspective, improvements in primary care delivery for people with chronic conditions translate into fewer complications and lower health care costs – a perfect segue to the first 2 articles in this issue of “*Prescriptions for Excellence in Health Care*.”

The lead article, “*Reducing Hospital Costs by Means of Enhanced Primary Care*,” focuses on the Patient-Centered Medical Home (PCMH). The author outlines the rationale and traces the development of this promising model for primary care, and reviews the evidence of hospital cost reductions associated with PCMH demonstration projects throughout the country.

The second article, “*Reducing Regional Hospital Readmissions: The PAVE Project*,” describes a novel initiative designed to reduce regional hospital readmission rates by 10% over an 18-month period by means of improved transitions of care among providers and increased patient and family engagement in care management.

Regular readers of the newsletter will recognize that the final article – a book review – is a new feature. We plan to include these reviews occasionally as we become aware of new books related to health care quality that may be of interest to hospital administrators and health care practitioners. “*Safe Patients, Smart Hospitals: How One Editor’s Checklist Can Help Us Change Health Care from the Inside Out*,” is the subject of the review in this issue.

As always, I welcome reader comments and questions. I can be reached at david.nash@jefferson.edu.

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