

TAKE-OUT MEDICINE

HOW TO STIR UP HEALTH CARE IN ONE EASY READ

BY CHUCK STARESINIC

ILLUSTRATIONS BY DAVID POHL

Here's a story with the potential to raise the blood pressure of a physician.

Geoff Larrson is the father of two girls, ages 2 and 4. They live in Pittsburgh. When both girls woke up feverish and generally miserable back in November, their father didn't think there was much mystery as to what was bothering them. Different playmates up and down their street had strep throat. Five children at the local day-care center had been diagnosed with it, and Larrson's girls were probably sheltering their own little colonies of *Streptococcus* bacteria. If so, all they needed was a course of antibiotics, and they'd soon be right as rain.

But Larrson never took his girls to see their doctor. The family has health insurance and a good relationship with the girls' pediatrician, but he didn't want to wait until the office was open to schedule an appointment for another day.

Instead, he drove 10 minutes to a strip mall with one of those ubiquitous national chain stores with a pharmacy. There, at an in-store clinic, a nurse-practitioner swabbed the back of the girls' throats. No appointment necessary. The clinic accepted their medical insurance with a small copay, as their pediatrician would. They waited a few minutes for the results of a rapid strep test, which came back positive, and their prescriptions were filled at the pharmacy in the same store.

Around the country, the number of these "retail clinics," as they are called, is increasing rapidly. One national chain opened 10 clinics in the Pittsburgh area in 2007 and was on pace to start 100 nationwide by the end of that same year. The company's executives recently reported their plan to have 500 clinics in 2008.

Retail clinics offer treatment for a limited menu of ailments, including urinary tract infections, ear infections, sinusitis, pink eye, and early Lyme disease. They also offer vaccinations, including those for influenza, hepatitis B, and human papilloma virus. Under Pennsylvania law, a physician need not be on the premises for these visits and for certain prescriptions.

The trend concerns some physicians. A pediatrician in a small group practice near Pittsburgh, for example, worries that clinics like this will weaken the relationship between doctor and patient and lower the standards for health care. As a doctor in private practice, she also worries about how the trend will affect her bottom line.

Terence Starz, chair of the Allegheny County Medical Society, addresses retail clinics in a November 2007 column in the *Pittsburgh Post-Gazette* with the headline "Quick health care is not the same as primary care." He writes, "In a setting where a physician is not present to examine patients, there is a risk of an inaccurate diagnosis or of missing a serious medical condition. Seemingly 'simple' cases often aren't simple."

Hal Rosenbluth, the chair of Take Care Health Systems, countered a week later in the *Post-Gazette* that Americans are not adequately served by the health care system in this country. Retail clinics were created to fill a critical need for accessible, high-quality, and affordable health care, he says.

"Patients are not our patients or your patients," he writes. "They have options and their own rights."

How do we begin to answer the questions raised here? Enter the policy wonk.

Ateev Mehrotra is a physician who isn't afraid of shaking things up. He's not an advocate of change for the sake of change. He's just extremely curious about fundamental issues of cost, quality, and access in our health care system. Give him a tough question—about retail clinics, for example—and his response is to ask more questions. How can we learn more about the phenomenon? How can we get some data? Intuition is the enemy of data here. Data have the power to remove at least some of the emotion and assumptions from the discussion.

Mehrotra, a Pitt assistant professor of medicine, occupies an academic office in the School of Medicine's Center for Research on Health Care. A photo of his two preschool-age children is posted outside his office just above the nameplate. There would be nothing to make Mehrotra stand out from other young dads at the playground, except his resume makes it seem that he might have arrived in Pittsburgh in 2006 rather breathless. This was his first job since completing a decade or so of medical training that began at the University of California, San Francisco (MD) and ended at Harvard University (fellowship in general internal medicine). In between, there was a master's degree in public health at UC Berkeley, an internal medicine and pediatrics residency at Massachusetts General Hospital and Boston Children's Hospital, and a master's degree in epidemiology from Harvard.

Mehrotra is a chimera of sorts. He practices medicine and analyzes health policy for RAND, the independent policy think tank with a reputation for dispassionate analysis, rigor, and excellence.

The phrase "health policy research" might sound drier than month-old pound cake, but Mehrotra explores nuts-and-bolts questions that are of interest to almost anyone. He asks what keeps your doctor from giving you an appointment within 48 hours of your call. He explores alternative ways of paying your doctor and ways your doctor might provide better care. In September 2007, he authored a study in the *Archives of Internal Medicine* that dared to address the question of whether the annual physical exam was good or bad for your health. (The answers to such questions can be surprising and, to say the least, counterintuitive.)

If Mehrotra's research bio were turned into a late-night comedy bit, it could be titled, "Top 10 Ways to Shake up Your Doctor's World."

(Number one: Tell him you're skipping your annual physical for health reasons.)

RAND has a storied history that began in the 1950s, when the federal government realized that the Cold War called for defense policy analysis from outside Pentagon circles. RAND recruited some of the brightest economists, statisticians, and analysts to the cause. In the 1970s, RAND (born of the phrase "research and development") made the strategic decision to expand into other arenas. While defense work remains a RAND mainstay, health policy research has become another pillar of the think tank's expertise.

About 10 years ago, RAND started casting about for a new city in which to expand. It was based in two of the most expensive real estate markets in the country—Santa Monica, Calif., and Washington, D.C. These were good locations, except when it came to recruiting talented young staffers who were starting families and purchasing first homes. They looked at several cities, and Pittsburgh won out.

"The main driving force behind the selection of Pittsburgh was to offer an alternative to staff that was lower cost of living and higher quality of life," says RAND senior health policy analyst Donna Farley. The new RAND building on Fifth Avenue was built to house 200 employees, and she says they are approaching that number ahead of schedule. Some RAND statisticians have relocated to Pittsburgh solely for quality of life, despite the fact that their main collaborators are in California or Washington, D.C. (Lucky for them, data travel well.)

Shortly after RAND's arrival in Pittsburgh, the organization's representatives met with Arthur S. Levine, dean of Pitt's School of Medicine and senior vice chancellor for the health sciences, about collaborations with Pitt. This was quickly followed by a financial commitment from the School of Medicine and RAND to formalize the arrangement as RUPHI (RAND–University of Pittsburgh Health Institute), which is pronounced the same as the Indian unit of currency. The institute is jointly headed by Farley, of RAND, and Wishwa Kapoor, Pitt professor of medicine and chief of the Division of General Internal Medicine.

Kapoor says that one of the surprising things for RAND was the strength of health policy research already under way at Pitt.

"There were 60 investigators studying health policy and $50 million dollars in funded studies. There were studies going on in the community, which RAND was very interested in, plus studies in hospitals and clinics."

Nevertheless, Pittsburgh was not considered a go-to location for health policy research. That has changed in less than 10 years.

Mehrotra was a fellow at Harvard University, which has a med school department devoted to policy research, when he interviewed with RAND in Santa Monica and separately with the University of Pittsburgh. In 2006, he became the first joint hire under RUPHI. (At least two others have followed. In addition, dozens of collaborations have sprung up between existing Pitt and RAND researchers.)

Like a lot of Pitt researchers, Mehrotra splits his time between different locations on Pitt's urban campus. At his RAND office, he is an MD surrounded by PhD economists, sociologists, policy analysts, and even lawyers. He calls it a very enriching environment when paired with the School of Medicine and the clinic. For weeks at a time, Mehrotra will go on clinical service as a hospitalist, which he says keeps his policy work grounded in the real world of patients, doctors, and hospitals.

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While still at Harvard, Mehrotra's work as a primary care physician caused him to rethink the annual exam.

"I was spending a lot of time doing physical exams for patients," he says. "I was encouraging them all to come on an annual basis. Yet I knew the literature on the physical exam was limited. There were no guidelines out there to tell me how often, or what they should entail. I just did what I learned in residency."

Something else that contributed to his doubts was that he would occasionally get telephone calls from friends and relatives, saying, "I got this blood work at my annual exam, and a few things came back abnormal. What should I do?"

"In the back of my head," says Mehrotra, "I'm thinking, 'You shouldn't have had that blood work.'"

He goes on to explain, "I was trained in the era of evidence-based medicine and taught that ordering annual blood work [a complete blood count and electrolyte panel] was more likely to result in a false positive than detect true disease." Doctors trained in another era, however, may believe they are not doing their jobs if they don't order these tests.

"Yet there's no guidelines to support it," says Mehrotra. "No evidence. … No consensus on who should get a physical exam and what the content should be."

In 1979, Mehrotra points out, a Canadian task force charged with studying the annual exam stated their conclusion as plainly and forcefully as they could in the *Canadian Medical Association Journal*: "We recommend that the annual checkup, as practiced almost ritualistically for several decades in North America, be abandoned."

More than 25 years later, Mehrotra's study, done with colleagues at Harvard, turned up some striking numbers: Physical exams are the number one reason adults see their doctors. Doctors perform such exams 63 million times a year, adding up to $7.8 billion in revenues.

An intuitive response is to say that an annual exam could hardly be bad. It strengthens the relationship between doctor and patient that could become vital when health fails. That may be true, says Mehrotra, but rates of preventative care are much too low in this country. And unnecessary tests, by definition, lead to more problems than they solve. They do this at significant costs.

Unscientific polls indicate a level of support among doctors and patients for continuing the annual exam. Advocates say that allows the doctor to keep the patient current on preventative care measures like mammograms and smoking cessation counseling. Others say that there's no reason preventative care can't be delivered during the periodic office visits scheduled for acute problems.

"We did some back-of-the-envelope calculations," Mehrotra says. "And we found that there's no way an individual physician could provide an annual exam for all [his] patients," without spending half of all the available time doing them.

Reporters covering the story came to Mehrotra with various versions of the question, "Why do you have yourself up on a wire, doc?" His answer comes from another of his research interests: patient access to doctors.



No appointment necessary at many retail clinics popping up around the country.

In Massachusetts, he worked with a number of practices that experimented with open access scheduling, meaning that a patient could get an appointment within a day or two of calling. The goal was to open the schedule for patients who were ill and needed to be seen right away. Problem was, the schedule filled up with annual physical exams anyway. Around the same time, Mehrotra talked to doctors from a large practice in Minnesota who had decided to stop encouraging annual exams. It sounds like a bad business model, but it worked. The doctors were more available to their ill patients, and it didn't hurt the bottom line. The schedule filled up. Preventative care wasn't compromised.

The question of access brings us back to the topic of retail clinics. Mehrotra is in the middle of a major study to find out who goes to these clinics and why. His team is interviewing patients to find out why they choose the clinic over a primary care doctor. His goal is simply to get the facts about this emerging way of delivering care. How many clinic visits are supplanting visits to physicians? What is the economic impact? Are the clinics delivering care to the uninsured and others who might not get it otherwise? Do the clinics have something to teach us about the delivery of preventative care such as vaccinations? Is the quality of care higher or lower than that provided in a doctor's office?

Speaking of paradigm shifts, Mehrotra has a career development award from the National Institutes of Health to look at "consumer-directed health care." The idea behind this reform? People who pay a small amount for health insurance but pay out of pocket for their care become more discerning consumers. This model requires that patients know their options, including the costs of different procedures and tests, the pros and cons of different treatment options, exact fees that specific doctors charge, and a given doctor's track record in treating patients.

Mehrotra also studies the pay-for-performance model, in which hospitals get rated on quality metrics and rewarded accordingly.

"But the devil is in the details," says Mehrotra. "How can you create reliable and valid metrics upon which to judge a provider?"

Over the past year, he and colleagues have been helping Medicare explore pay-for-performance options through a contract with RAND.

"Congress told [Medicare] that they wanted to create a pay-for-performance program," Mehrotra says. A plan went to Congress a couple of months ago. "If approved, it's probably one of the largest pay-for-performance programs in the world, with billions of dollars involved in terms of incentive payments."

"These are really important questions," says Kapoor.

"Pay for performance is huge. Studies from England show it to be very successful in primary care, but there were huge incentives." The incentives proposed in this country include more modest reimbursements for meeting guidelines for care of certain conditions.

"It's not clear whether that's going to work, or if it's going to be a waste of money," says Kapoor. "I think Ateev is going to be one of the national leaders in this area, because he's going to look at this as pay for performance evolves in this country."

In the world of retail clinics, Mehrotra's research won't be completed for some time, but he is finding the emerging story fascinating.

In interviews with people who patronized retail clinics, for example, it seems that many had already visited a clinic in another part of the country. They chose the same chain pharmacy's clinic when they were traveling, or after moving to another location, for the same reason that people patronize Starbucks for coffee or Curves for a workout as they travel—because they know what they are getting.

Some physicians may be uncomfortable with retail clinics for the opposite reason: They are not certain what these patients are getting.

Whatever the future is for retail clinics, payment reforms, and other mass experiments in care, it leaves plenty of work for health policy researchers like Mehrotra. ■

A family's name and details were changed in this story to protect privacy.