

➤
Employing RNs to make EMRs work in my practice is not financially feasible. Neither is employing 2 medical assistants per physician.

EMRs: Tyranny vs triumph

I'm a rural family doc and employing RNs to make EMRs work in my practice is not financially feasible (Success with team care. *J Fam Pract.* 2013;62:225). Neither is employing 2 medical assistants per physician. So I end up taking up the slack. Because of the EMR, I see 2 or 3 fewer patients per day and do 3 to 4 hours of extra data entry at night—with no proven benefit for the patients.

Perhaps we should have insisted on evidence that EMRs work prior to mandating them. Team care indeed!

Frank Moskos, MD
Canton, NC

I'm proud of the fact that I have sufficient time to see 30 patients a day, and—with the use of EMR templates and open text voice-activated dictation—get home no later than 6:15 pm.

I bring a laptop on a mobile stand into the room so I can make eye contact with patients while I review their history. I complete prescriptions and test ordering in the room with the patient, then dictate and enter the data into templates on a desktop with a secure line from my office. This satisfies P4P metrics, meaningful use criteria, and National Committee for Quality Assurance standards.

Patient satisfaction has little to do with technology and much more to do with maintaining eye contact, listening without interrupting, and demonstrating respect for what the patient has to say.

Andrew Selinger, MD
Bristol, Conn

A supplement for heart failure?

"Heart failure: Best options when ejection fraction is preserved" (*J Fam Pract.* 2013;62:236-243) was an excellent article about a tough problem. I have been using d-ribose for more than 5 years, with good results for both systolic and diastolic heart fail-



ure. D-ribose—which is made in the body from riboflavin found in many foods or can be purchased as an inexpensive supplement—has been cited in the literature for its beneficial effects.^{1,2}

Art Sands, MD
Fort Collins, Colo

1. Omran H, Illien S, MacCarter D, et al. D-Ribose improves diastolic function and quality of life in congestive heart failure patients: a prospective feasibility study. *Eur J Heart Fail.* 2003;5:615-619.

2. Wagner S, Herrick J, Schecterle LM, et al. D-ribose, a metabolic substrate for heart failure. *Prog Cardiovasc Nurs.* 2009;24:59-60.

Our success with a single-visit smoking cessation intervention

Tobacco use is the leading preventable cause of death and disease in the United States,¹ but how best to help patients quit? US Public Health Service guidelines recommend a 2-tiered approach consisting of counseling and pharmaceutical treatment.² Because primary care physicians are busy caring for other patients, however, and pharmacists in our state can prescribe medication under collaborative practice agreements with physicians, we piloted a single-visit smoking cessation group intervention conducted by a pharmacist (NP) and health coach (HW).

Patients were recruited from 2 primary care practices to participate in a 2-hour group visit that included both behavioral and pharmacologic interventions. Follow-up phone calls and in-person visits with the health coach were made available, but were not part of the structured curriculum.

We used motivational interviewing to assist patients in developing individualized quit plans and offered small rewards for stopping, such as a note pad and 6-month certificate. Patients did not pay for the group visit, but were required to pay for pharmacotherapy (health insurance or out of pocket).

Between September 2011 and May 2012, a total of 35 patients attended one of 7 smoking cessation group visits. Twenty-seven (77%) participants opted for medication or nicotine replacement therapy and 23 (65.7%) used the health coach services.

CONTINUED

As of June 2012—with participants ranging from one month to 9 months' follow-up—23% remained tobacco free. This compares with documented one-year quit rates of 3% to 5% (unassisted), 7% to 16% (with behavioral intervention), and up to 24% with pharmacologic treatment and ongoing behavioral support.³ Similar smoking cessation rates have been described with multiple-session pharmacist-led group visits.⁴ This pilot program demonstrated that a single group intervention can be performed in a primary care setting with a pharmacist and health coach, freeing physicians to care for other patients.

Challenges include variable reimbursement from insurers for pharmacist-led tobacco cessation group visits and disparate pharmacy policies—pharmacists are not allowed to prescribe medication in every state.

Nonetheless, this pilot, funded by Fairview Physician Associates and the University of Minnesota Academic Health Center, represents a promising means of delivering effective preventive services by leveraging team members in a busy primary care clinic.

Nicole Paterson, PharmD, BCPS
Holly Wiest, MA
Lynne Fiscus, MD, MPH
Minneapolis, Minn

- Centers for Disease Control and Prevention. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. *MMWR*. 2008;57:1226–1228.
- Fiore MC, Jaen CR, Baker TB, et al. Treating tobacco use and dependence: 2008 update—clinical practice guideline. Available at: <http://bphc.hrsa.gov/buckets/treatingtobacco.pdf>. Accessed July 21, 2012.
- Laniado-Laborin R. Smoking cessation intervention: an evidence-based approach. *Postgrad Med*. 2009;122:74–82.
- Dent LA, Harris KJ, Noonan CW. Randomized trial assessing the effectiveness of a pharmacist-delivered program for smoking cessation. *Ann Pharmacother*. 2009;43:194–201.

NEW CONTENT ADDED

AnticoagulationHUB



The **Anticoagulation Hub** contains news and clinical review articles for physicians seeking the most up-to-date information on the rapidly evolving treatment options for preventing stroke, acute coronary events, deep vein thrombosis, and pulmonary embolism in at-risk patients.

www.AnticoagulationHub.com

DEVELOPED BY
FRONTLINE
MEDICAL COMMUNICATIONS