

Response: Re: How Evolving United States Payment Models Influence Primary Care and Its Impact on the Quadruple Aim

To the Editor: We appreciate Dr. Fiscella and Dr. Carroll's amendment to our article and enthusiastically agree with the assertion that health equity is an important lens through which to gauge the effectiveness of payment models. While we assessed how these models affected health outcomes broadly, we agree that an important addition would be to specifically examine their impact on health equity.

As Dr. Fiscella and Dr. Carroll note, risk-adjusted (based on social determinants of health in addition to medical determinants) global payments are one potential path toward equity, by ensuring that adequate resources are dedicated to patients with more complex needs and that there is flexibility in funds to meet social needs in addition to medical needs. In our characterization of payment models we have included whether the model includes risk adjustment.

Another consideration relevant to payment models is to include measures of equity in performance metrics. We have raised concerns that models like the Merit-Based Incentive Payment System have the potential to widen existing disparities.¹ There is important work underway to develop measures that adequately assess primary care, including impact on health equity, begun at Starfield Summit III and being continued at the Larry A. Green Center for the Advancement of Primary Health Care for the Public Good.

While primary care has been shown to attenuate health disparities, improved payment for primary care is necessary but not sufficient for achieving health equity. Achieving population health equity goals also requires ensuring access to health care for all, looking further upstream to payment for social services, and systematically addressing structural racism and discrimination.

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The above letter was referred to the author of the article in question, who offers the following reply.

Re: If We Don't Ask, They Won't Tell: Screening for Urinary and Fecal Incontinence by Primary Care Providers

Dear Editor, we read the publication on “*If We Don't Ask, They Won't Tell: Screening for Urinary and Fecal Incontinence by Primary Care Providers*” with a great interest.¹ Brown et al.¹ found that most practitioners screened for urinary incontinence (UI) but not fecal continence (FI). We would like to share ideas on this issue. As noted by Brown et al., the problems about UI and FI are considered possibly shameful to talk among our patients in our setting in Indochina. The history about urination and defecation is rarely given by the patients unless there is a serious clinical problem. Asking for the UI and FI might get denial response or disguised information. Due to the possible taboo,^{2–3} it is suggested that the primary care practitioners should specially focus on the possible hidden problems. Special focus might be given to the elderly group whom the problems are common. Establishing trust is needed and it usually takes time to achieve success.⁴ The primary care nurse might take important role for this activity.⁴ Using a questionnaire of session interview might be considered, and the additional use of laboratory screening to seek for possible hidden problem in urinary and gastrointestinal tract, regardless of compliant or history of UI and FI, is recommended.

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2. Papenkordt U, Pfluge Z. The urinary and fecal incontinence taboo topic: counseled well, secure travel. *Pflege* 2011;64:329–33.
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4. Gray M, Burns SM. Continence management. *Crit Care Nurs Clin North Am* 1996;8:29–38.

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Response: Re: If We Don't Ask, They Won't Tell: Screening for Urinary and Fecal Incontinence by Primary Care Providers

The above letter was referred to the author of the article in question, who offers the following reply.

To the Authors: We are thrilled that you took the time to read and comment on our article. Thank you for offering a cultural perspective on the stigma surrounding urinary and fecal incontinence. Importantly, you note that pa-

tients may deny that they suffer from these conditions, even when physicians ask about them, and that building trust with patients will facilitate more honest and open discussions about urination and defecation, which are taboo topics for many people.

In a previous qualitative study, we learned that patients find it difficult to initiate discussions about incontinence with medical providers because of the associated shame and embarrassment.¹ These patients prefer that their providers ask openly about possible urinary or fecal incontinence. Providers, on the other hand, say they prefer that patients volunteer this information. This predicament makes fecal incontinence a “hidden problem” in itself.

Your suggestion of initiating the discussion with less taboo topics such as diarrhea or constipation may be a successful approach that preserves patient comfort. Initiating discussion in a patient-centered manner, possibly with assistance of questionnaires or universal screening by allied health professionals, is crucial to bringing the problem of fecal incontinence out of hiding. Thankfully, a broad range of effective treatments is available to patients.

Thank you again for your input on this important topic.

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1. Brown HW, Rogers RG, Wise ME. Barriers to seeking care for accidental bowel leakage: A qualitative study. *Int Urogynecol J* 2017;28:543–551.

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Re: Impact of Medical Scribes in Primary Care on Productivity, Face-to-Face Time, and Patient Comfort

To the Editor: In their article reporting the impact of medical scribes, Zallman et al.¹ reported greater physician productivity with scribes due to an increase in the mean number of patients seen per hour (from 1.82 to 1.98), while also reporting that visit length and visit cycle times were approximately 2 minutes longer, on average, when scribes were used. These results seem contradictory, calling into question the validity of their measures, but this issue was not addressed in the discussion.

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Reference

1. Zallman L, Finnegan K, Roll D, Todaro M, Oneiz R, Sayah A. Impact of medical scribes in primary care on productivity, face-to-face time, and patient comfort. *J Am Board Fam Med* 2018;31:612–9.

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