

Visit www.CardiologyOptions.com

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

June 2005

EDITORIAL

Liability Concerns Lead to Defensive Practices 2

CARDIOLOGY STRATEGY

Study Shows Depression, CHF Link 3

PRACTICE MANAGEMENT

Consider Re-Engineering Your Office 6

Liability Concerns Lead to Defensive Practices

Recent survey results document that physicians practice defensive medicine in an effort to prevent malpractice suits. Among 824 physicians surveyed in Pennsylvania in 2003, 93% said they sometimes or often practice defensive medicine because of malpractice worries. Practicing defensive medicine may include an extensive workup involving diagnostic testing, prescribing medicine, or performing procedures to minimize chances of patients suing for negligence.

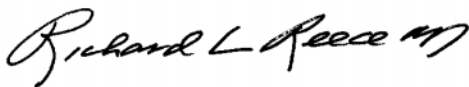
The researchers said they were surprised by the widespread use of the practice. But in fact, such a high percentage should be expected for two reasons. First, physicians want to ensure that they are doing all they can to make a proper diagnosis and treat each patient's condition properly. Therefore, many physicians tend to err on the side of caution on behalf of their patients. And, second, physicians have learned that in the current litigious climate, it is easier to defend against a test that was done than it is to defend against one that was not done.

In 1996, Mark McClelland, MD, PhD, administrator of the Centers for Medicare & Medicaid Services, said malpractice reform could decrease medical expenditures by 5% to 9%. If reform is able to reduce the number of lawsuits, it might also decrease the number of tests done in doctors' offices, the unnecessary antibiotics prescribed for viral illnesses, the number of Caesarean sections performed, or the use of CT scans and MRIs.

But what can be done until significant reform occurs? Neil Baum, MD, a urologist in New Orleans, says warding off malpractice suits is often a matter of being able to spot potentially troublesome patients. Physicians should be wary of patients who have complex problems, who have seen numerous other doctors, and who complain about past treatment, he says. Physicians should make sure these patients understand what you are saying by carefully spelling out potential complications and having them repeat what you have said, he advises. He also says physicians should take meticulous notes and always have patients sign informed consent forms.

The use of electronic medical records in physician offices to appropriately document patient histories and clinical findings may help improve patient-doctor communication. Allen Wenner, MD, an expert in electronic patient records and a family physician in Columbia, S.C., says a patient-generated history could help to eliminate malpractice suits because it would capture the patient's history in their own words.

The practice of defensive medicine represents a convergence of three factors in American medicine: the relentless rise of medical costs, a lack of electronic medical records in physicians' offices, and the lack of effective malpractice reform.



Richard L. Reece, MD
Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, PA
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD
Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Cap Gemini Ernst & Young
Vienna, Va.

John W. McDaniel
President and CEO
Peak Performance Physicians, LLC
New Orleans

Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD
Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD
Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Study Shows Depression, CHF Link

The onset of depression in heart failure patients can be predicted by several environmental and social factors, as well as the patient's perception of health status, according to a recent study.

The main objective of the study was to identify those factors that are associated with the subsequent development of depressive symptoms in heart failure patients over one year of follow-up care. "Our goal was to determine who might need to be monitored or screened for depression. By defining factors associated with depression in heart failure patients, we hope to lead the way to future research on prevention or early intervention for these patients," says Edward P. Havranek, MD, staff cardiologist at the Denver Health Medical Center and lead author of the study.

Reviewing Data

"If cardiologists can recognize characteristics of patients likely to experience depression along with heart failure, they would have a heightened index of suspicion and could screen those patients for depression," Havranek continues. "By monitoring high-risk patients carefully and treating appropriately for depression, cardiologists will enhance the quality of care they provide to their heart failure patients. Furthermore, it may be possible to design preventive treatments if we can define which patients are at high risk for developing depression once they develop heart failure."

The study authors note that a fairly high portion of heart failure patients (approximately 30%) have significant depressive symptoms, according to the literature. "Depression incidence among all people typically seen in primary care practices is approximately 5% to 10%," says Havranek. "So depression is markedly elevated in patients with heart failure." The study is unusual in that, while other researchers have documented the increased incidence of depression in cardiac patients, they have not identified the factors associated with this incidence, he adds.

The researchers analyzed data on a cohort of patients enrolled in the Kansas City Cardiomyopathy Questionnaire (KCCQ) Interpretability Study, which examined the clinically meaningful differences in KCCQ scores over time. Investigators at 14 outpatient clinics in the United States and Canada collected data for the study. Participants included patients who had a heart failure diagnosis in their medical record or who had been hospitalized for heart failure during the previous three years; had a left ventricular ejection fraction of <0.40; and were at least 30 years of age. Among other data, the investigators collected information on patients' depressive symptoms at baseline using the Medical Outcomes Study-Depression (MOS-D) questionnaire.

"We were fortunate to have access to longitudinal data on depressive symptoms in a well characterized cohort of heart failure patients,"

Havranek notes. The researchers had KCCQ and MOS-D scores for heart failure patients at baseline and at one-year follow-up.

Of the 245 patients who did not exhibit depressive symptoms at baseline, 52 (21%) had developed symptoms of depression after one year. The analysis revealed that four factors were associated with the onset of depression in these heart failure patients. Compared with heart failure patients without symptoms of depression, depressed patients were more likely to live alone (40.4% vs. 22.9%); perceive medical care to be a severe economic burden (59.6% vs. 34.3%); have a history of alcohol abuse (23.1% vs. 11.4%); and have a worse perception of their health status, as indicated by KCCQ scores (59.7 vs. 71.1, in which higher scores indicate better health status).

The researchers noted that the incidence of significant depression symptoms doubled with each additional risk factor. Patients with none of the four risk factors had a 7.9% chance of having significant depressive symptoms at one year; the chance of developing depression was 15.5% for patients with one risk factor, 36.2% for patients with two risk factors, and 69.2% for patients with three risk factors; none of the patients in the analysis had all four risk factors.

Surprising Findings

Interestingly, the researchers found that several factors that might be assumed to have an association with

"By monitoring high-risk patients carefully and treating appropriately for depression, cardiologists will enhance the quality of care they provide to their heart failure patients."

—Edward P. Havranek, MD, Denver Health Medical Center

(Continued on page 4)

(Continued from page 3)

the onset of depression were not, in fact, linked with the onset of depressive symptoms.

A number of markers of heart failure disease severity, for example, did not differ in patients with depressive symptoms compared with those without depression. The markers included the New York Heart Association functional class, exercise capacity according to six-minute walking test, ejection fraction rate, presence of atrial fibrillation, and B-type natriuretic peptide levels.

“Overall, we were surprised by these findings,” says Havranek. “Many hypotheses about the genesis of depression in heart failure patients have centered on biological explanations, such as whether high levels of circulating catecholamines affect brain neurotransmission. We assumed that patients with more severe heart failure would be more likely to develop depression. We were surprised that the only marker of disease severity that was associated with the onset of depressive symptoms was the KCCQ score (the patient’s perception of his or her health status) rather than all the clinical markers we usually use to indicate disease severity.”

Since the KCCQ was the most important disease severity predictor of developing depression, having a formal method of measuring quality of life or health status may be useful in treating heart failure patients.

Such a measure could be especially useful because health status results have been shown to predict mortality in cardiac events in certain populations, including patients with heart failure, Havranek explains.

Seeking a Gender Link

The second surprise was that the researchers found no difference between the depressive and non-depressive groups based on gender, given that depression incidence in the general population is much higher among females. “The biggest deviation from predictors of depression in the general population relates to the gender link,” Havranek observes. “Most research in Western countries has identified female gender as a significant predictor of depression. Typically, experts consider female gender to be a significant risk factor. Nevertheless, our analysis found that gender was not a predictor of the development of depression in heart failure patients.”

There may be several reasons for the lack of a gender link between depression and heart failure. “Perhaps there is a gender effect and our sample size was too small to detect it,” Havranek says. “However, even if there is a gender effect for heart failure patients, it is likely to be smaller than it is in the general population and is much less significant than the other factors asso-

For More Information

Readers may find more information in, “Predictors of the onset of depressive symptoms in patients with heart failure,” published in the *Journal of the American College of Cardiology*, Dec. 21, (volume 44, issue 12, pp 2333–2338).

“MOS” stands for “Medical Outcomes Study,” a study started in the mid 1980s that involves collecting data on outcomes of care for different diseases by provider specialty. One of the illnesses addressed is depression, and researchers developed a brief questionnaire to follow these patients. Readers may want to see: Burnam MA, Wells KB, Leake B, Landsverk J. “Development of a brief screening instrument for detecting depressive disorders.” *Med Care* 1988; 26: 775–89. —DJN

ciated with depression specifically in heart failure patients. The other possibility is that the effect of heart failure on psychological status is so striking that it overwhelms the gender predisposition to depression.”

Furthermore, there was no difference between the two groups with regard to history of treated depression. “This finding is somewhat less surprising, given that many of the heart failure patients in the study may not have been diagnosed with depression,” Havranek states. “As cardiologists, we are relatively unskilled at detecting or identifying depression in patients with heart failure because the two conditions, at least on the surface, have very similar appearances. It is very difficult for cardiologists to make a diagnosis of depression unless they really dig for information. Therefore, many heart failure patients probably have untreated depression.”

Rising Risk

Researchers found the incidence of having significant symptoms of depression doubled among patients with each additional risk factor.

Risk Factors	Chance of Symptoms (at one year)
0	7.9%
1	15.5%
2	36.2%
3	69.2%

Source: Havranek et al., *JACC*, Vol. 44, No. 12, 2004, *Predictors of the onset of depressive symptoms in patients with heart failure*, Dec. 21, 2004: 2333-8.

Even when depression is identified and treated, under-treatment is common. "Medication is started at a low or modest dose, not titrated up or followed in a way that represents the most skillful treatment of depression available," Havranek explains.

Finally, there were no significant differences between the two groups in baseline use of cardiovascular medications. "Beta blockers have a reputation for precipitating depression in patients who are pre-disposed," says Havranek. "After digging through the literature, we found it hard to document that association strongly. But we did think it was important to look for that association, and, in fact, we were not able to show that beta blockers, which are now used to treat heart failure, contributed to the genesis of depression."

Implications for Care

Unfortunately, the factors contributing to depression in heart failure patients are those that cardiologists often do not focus on during the care of their patients. "Questions about whether the patient lives alone or is socially isolated, or whether the patient is struggling with the financial burden of illness, are not typically posed," he says. "But those factors really do drive the incidence of depression in heart failure patients. Being aware of the factors we identified in our analysis may help cardiologists identify patients who need intervention for depression, thereby facilitating the provision of high-quality care." In fact, the study notes that, according to the literature, depressed heart failure patients are at increased risk for mortality, heart failure hospitalization, and worsening of heart failure symptoms, functional status, and quality of life.

Since a diagnosis of depression can be subtle, appropriate screening may be warranted for all heart failure patients, given that 8% of patients with no risk factors developed depres-

Researcher Recommends Depression Screening

Screening heart failure patients for depression could improve patient outcomes, suggests Edward P. Havranek, MD, staff cardiologist at the Denver Health Medical Center. "In order to uncover depression in heart failure patients, a cardiologist needs a very high index of suspicion," he comments. "Cardiologists might consider routinely administering brief depression screening questionnaires to patients with heart failure. Physicians who treat many heart failure patients may find such screening to be highly time-efficient: The heart failure patients can be screened in the waiting room as they await their appointment."

Such screening requires minimal time and effort. "There is no reason an individual cardiologist couldn't screen for depression, either formally by using a questionnaire or informally by asking about the risk factors we have identified," Havranek says. "During follow-up visits, heart failure patients could complete a short questionnaire before or after a nurse gathers data on heart rate, blood pressure, and weight. The questionnaire can be quickly scored before the cardiologist meets with the patient. Overall, it is very possible for a cardiologist to incorporate this sort of approach into his or her practice."

Cardiologists might consider several well validated and easy-to-use screening instruments, such as the MOS-D, an eight-question screening tool that Havranek and his colleagues used; the Center for Epidemiologic Studies Depression (CES-D) scale, a 20-question questionnaire published by the National Institutes of Mental Health; and the Patient Health Questionnaire (PHQ-9) a standard instrument for diagnosing depression in primary care, developed by Pfizer, Inc.

"While depression screening may be easily incorporated into the formal offerings of heart failure disease management programs, any cardiologist can incorporate depression screening into heart failure care," Havranek observes. "Depression is only one of several prominent comorbidities in heart failure patients. Cardiologists who treat a significant number of heart failure patients wind up with a moderate amount of experience treating other conditions such as gout, renal dysfunction, and depression."

There is no way to know whether treating depression will improve cardiac outcomes, but given that many studies show that patients' mental and emotional states can affect their physical condition, Havranek believes the potential exists for researchers to determine whether managing depression would lead to better heart failure outcomes. In fact, he is currently running a pilot study in preparation for a larger research effort. —DJN

sion by one year. "My anecdotal experience with heart failure patients indicates that patient perceptions of their health and their physical functioning are outcomes that are likely to improve after depression is treated," Havranek asserts. "Treating depression allows heart failure patients to improve the level of functioning in their daily lives. We would like to

help patients get to the point where they say, 'I can do more than I could before.' The goal should be having patients who feel better and can do more. This approach will contribute to that goal."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

Consider Re-Engineering Your Office

By Neil Baum, MD

It's 9:55 am, and you are 25 minutes late for your first patient. Your nurse tells you the patient must be seen as soon as possible. A referring doctor is on the telephone waiting to discuss a patient he wants to send you. For your first patient, the result of the CT scan you ordered last week is not in the chart. Upon entering the exam room of your next patient, you address the patient as Mr. Jones, and he tells you he is Mr. Smith!

These are probably situations that have happened to each and every physician more frequently than they would like to admit. Yet most of these circumstances can be avoided.

We all know the difference between a well-run office and an office going from one crisis to the next. When the latter occurs, there is less personal satisfaction with the practice of medicine, staff gets burned out, and patient satisfaction deteriorates.

So if you are feeling overwhelmed, overworked, and underappreciated, then you may want to consider re-engineering your practice. Here are some practical ideas that will help you fine-tune your practice without a major overhaul and without increasing your already bulging overhead expenses.

Looking Inward

I suggest that we all do some introspection. Many of us, me included, are in a funk about the significant loss of income from the administration of medications. If we come to

Neil Baum, MD, is a urologist in New Orleans and the author of Marketing Your Medical Practice—Ethically, Effectively, and Economically. (Sudbury, Mass.: Jones and Bartlett Publishers, 2004). Readers may contact Baum by phone at 504/891-8454 or by e-mail at neilb89@aol.com.

Take Charge of Your Practice

Practice management expert and author, Michael Gerber writes in his highly recommended book, *The E-Myth Physician: Why Most Medical Practices Don't Work and What to Do About It*, (HarperCollins Publishers, New York, 2003) that physicians need to stop working in our practices and begin working on our practices. "All physicians are being pulled in so many different directions that we tend to spend most of our time being run by our practices rather than being in control of them. Because we are so busy and suffer from time constraints, we often feel that it is impossible to stop and take an objective look at what is happening in our practices. It is then that we need to give our office protocols, processes, and procedures, a check up.

One of the best ways to accomplish this check up is to ask patients what they think of our practice and the services we provide them. I survey every patient on every office visit with a brief questionnaire. This simple 5-question form allows me to get a daily pulse on my practice. The patients simply check "yes" or "no" on the form and a nurse or office manager addresses all positive and negative comments every day.

Here are the questions:

- Was it easy for you to get an appointment in this office?
- Is your general impression of this office favorable?
- Was the office staff friendly and concerned?
- Did the doctor adequately answer your questions?
- Would you recommend this office to someone else?

I also leave space for and ask if the patient wants to add any other additional comments.

In addition, I ask each patient upon entering the office what three questions he or she would like answered during the visit. A nurse gives the patient a form with space to provide three separate problems to address and the form says, "What three questions would you like answered today."

Invariably, I find out about problems that I can address that I might not have learned about otherwise.

—NB

the office and are grumpy or distracted, we pass this attitude along to our staff who in turn pass it on to our patients. Let us not forget that we set the tone. Attitudes are contagious. We want to be sure that ours are worth catching!

Many doctors are resistant to making changes and adjustments in the processes or procedures that we have

used for so many years. Remember you can't continue to repeat past performances and hope to achieve new results. Re-engineering your practice means taking a leap of faith. You have to rid yourself of that hurried, rushed, distracted behavior that results in loss of enjoyment and burnout that so many of us are experiencing.

Physicians interested in taking re-

engineering to the next level, should consider the practice management workshops offered by medical specialty associations and state societies. A few years ago, I attended a seminar that focused on accurate coding and reimbursement, overhead reduction,

and practice efficiency. From this one seminar, I found dozens of ideas for improving my practice. Also, these seminars are an opportunity to share ideas with other physicians.

By being proactive and making an effort to control your practice instead

of being a slave to the practice, you can have a practice that is enjoyable, emotionally rewarding, profitable, and a practice that makes you proud.

—More information on physician practice strategies is available on our Web site (see page 8).

Steps to Take to Improve Scheduling

Scheduling problems can have a tsunami effect on your practice, or at least on the tone of your day. Physicians should establish protocols for staff to follow when scheduling patients. For example, look at your procedures for scheduling new patients. Are these new patients given the same 15-minute time slots that are allotted to an established patient? We all know that a new patient requires more time than most established patients. A re-engineered practice will designate certain times such as first appointment of the day when the doctor is fresh and hopefully less distracted or right after lunch.

One way to improve scheduling and to make sure that you maintain a good attitude is to be prepared for each day. Doing so usually means arriving early. Many physicians believe they can't get to the office any earlier. If that is the case, then your schedule needs to change. You may have to start earlier in the morning, or schedule patients later. If you are late coming from the hospital, you may convey an attitude of being overworked or rushed. If you start late, you can be sure you will never be able to play catch up even if you work through your lunch hour (also, not a very healthy example to set for staff and patients).

I suggest physicians build a cushion of 15 to 20 minutes before the start of each day to review charts or EMRs for patients you will see that morning. Leave notes for staff to be certain all reports are on the record or the chart, that equipment you will need for office procedures is ready when the patient arrives, and that special needs of certain patients, such as a wheel chair, are in place. Such simple planning will make your staff more efficient and will improve your processes of care, ultimately leading to increased patient satisfaction and better outcomes.

Making it easier for patients to schedule medical appointments and reducing waits in physicians' offices are the driving principles behind an approach to office practice called open access or advanced access, according to the Institute for Healthcare Improvement, in Cambridge, Mass. IHI (at www.ihl.org) has more information about innovative approaches to scheduling that are helping to improve care and patient satisfaction.

Through IHI, the five-physician Western Colorado Physicians Group in Grand Junction learned about open-access scheduling, sometimes called advanced access. Developed by Mark Murray, MD, and Catherine Tantau, RN, practice consultants in Sacramento, Calif., open access is designed to smooth out each day's schedule, give patients better and more timely access, and reduce the rate of no-shows. Gregg Omura, MD, a family physician in the group, was attracted to the idea of increasing efficiency and meeting patients' needs in a more timely manner. So, he decided to try open access with his patients.

Open access uses advanced queuing theory to reengineer the standard appointment scheduling system, leaving the majority of the slots on a given day open for patients who call that day. "Demand is relatively consistent, and the day fills like a glass, from the morning up, not piecemeal," says Omura. It's a rare day that doesn't fill, he says, but when that happens, he's glad to have the empty slots at the end of the day when he is tired, not at the beginning or scattered throughout. And for patients, the benefit is obvious. "Every patient can get in within an hour or so of when he or she calls," he adds.

Developing open access involves some short-term pain for long-term gain, namely working down the current backlog of patients. This is generally done by temporarily adding extra slots and working longer hours, or adding more staff.

Among the benefits of open-access scheduling are that both telephone access and staff availability improve because the need to triage patients over the phone, or "tease out information" as Omura puts it, is eliminated, as well as the sometimes lengthy negotiations involved in making appointments. Patients' use of urgent or emergency care settings also decreases.

Omura's foray into open access proved so successful that other physicians in the office use open-access scheduling today and one continues to use a standard approach to scheduling. Omura often sees his partners' overflow patients, since his schedule is more open than theirs.

—NB

CARDIOLOGY OPTIONS.com



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let CardiologyOptions.com come to you! CardiologyOptions.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at CardiologyOptions.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.


Name: _____

E-mail: _____

CARDIOLOGY PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

June 2005

 Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PRSR STD
U.S. POSTAGE
PAID
Permit No. 664
S.HACKENSACK,NJ

Provided as a
professional
courtesy by



U.S. Pharmaceuticals