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# DIABETES PRACTICE OPTIONS™

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IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

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*June 2009*

## INNOVATIONS

PCPs Feel the Need for Innovations 2

---

## DIABETES STRATEGY

Group Improves Diabetes Care, Financial Performance With EMR 3

---

## PATIENT CARE

Clinic Approach Cuts Complications 6

---

## COMMENTARY

Doctor Gets Patient's View of Care 9

---

## HEALTH POLICY

The Many Obstacles to Health Reform 12

---

## TECHNOLOGY

How IT Would Benefit Medical Homes 14

---

## MEDICAL HOMES

Report Defines PCMH IT Needs 15

## PCPs Feel the Need for Innovations

By Richard L. Reece, MD, editor-in-chief

There are not enough primary care physicians (PCPs), and the reasons for this shortage are numerous and difficult to fix in a short time. There are few incentives for medical students to practice patient-centered primary care. Pediatricians, internal medicine specialists, and family physicians face low pay compared with other specialists and have high debt but perhaps heavier workloads, since they need to be on call at unusual hours. In addition, there are not enough residency slots. It takes eight to 10 years to produce a PCP, meaning that even if more medical students began pursuing careers in primary care today, there would be a lag of at least eight years before the number of practicing PCPs begins to rise.

In the meantime, we can start to raise the pay for PCPs, forgive their medical school debt, pay for them to go to medical school, retrain specialists to provide primary care, import foreign-trained PCPs, or replace PCPs with nurse practitioners or physician assistants. Also, practicing PCPs could consider some practical changes that would benefit patients and physicians. For example, PCPs might consider:

- Using online tools, such as Instant Medical History (at [www.instantmedicalhistory.com](http://www.instantmedicalhistory.com)), that are driven by the patient. Guided by clinical algorithms, tools like this allow patients to enter their chief complaints and histories from home before visiting the office, or they can do so at a computer in the waiting room. This step can save a PCP six to 10 minutes per patient, and the physician can then code the encounter as a complete workup.
- Seeking certification from the National Procedures Institute to perform simple procedures, such as echocardiography, ultrasound, colonoscopy, or dozens of other procedures. By providing such procedures in the office, the physician would be offering patients convenience while also generating additional revenue.
- Guaranteeing patients that they will be seen on time or they will receive refunds. If the physician posts a notice in the office about this guarantee, it could improve patient satisfaction and create more loyal patients. Also, it will enable the physician to see more patients per day.
- Restructuring the practice so that patients can choose from among three types of visits: simple, medium, and long. Predictable fees can then be charged for each type of visit, such as \$59, \$79, and \$99 for 10-minute, 20-minute, and 30-minute visits, respectively. A practice structured in this way will be likely to attract more uninsured patients, because patients will know ahead of time how much they will be charged per visit.
- Dispensing drugs from the office using an inventory of commonly prescribed medications. This is completely legal in most states, and there are outside companies that can help physicians select an inventory and set prices. The practice will make a profit on each prescription and save patients' time and money while helping to ensure compliance with prescription orders.
- Offering e-mail consults. Physicians who make themselves available in this way can charge a modest fee for answering questions by e-mail or for providing advice on common problems. But physicians should ensure that patients understand that e-mail is not an appropriate tool for use in a crisis.

—More information on physician practice strategies is available on our Web site (see page 16).

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# Group Improves Diabetes Care, Financial Performance With EMR

**M**any physicians are reluctant to adopt an electronic medical record (EMR) system, citing high costs, the initial reduction in practice productivity as physicians and staff learn the system, and the desire to wait for additional advances in technology. But at Village Health Partners in Plano, Texas, which has approximately 40,000 patient visits and treats almost 1,000 diabetes patients annually, EMR adoption has improved care quality, enhanced efficiency, reduced costs, and helped the practice improve its relationships with payers. Furthermore, Village Health Partners achieved a return on its investment in only 18 months, helping to boost each physician's income by \$60,000 to \$80,000 annually.

## **System Implementation**

The practice received the 2007 Healthcare Information and Management Systems Society (HIMSS) Davies Ambulatory Care Award and was named Practice of the Year by a physician journal in 2006. Village Health Partners also earned recognition through the Diabetes Physician Recognition Program, a joint program from the National Committee on Quality Assurance (NCQA) and the American Diabetes Association that recognizes physicians who provide excellent care to diabetes patients and track their performance along 10 measures of care.

When it implemented its EMR in 2003, Village Health Partners had four goals in mind: improve business

efficiency; improve patient, employee, and physician satisfaction; improve clinical quality; and achieve a return on investment.

"We implemented the EMR when our practice had only two doctors, which made selection and adoption somewhat easier," says Christopher Crow, MD, MBA, who founded the practice with Sander Gothard, MD, in 2001. "Relatively few practices were using EMRs at that time, but I had used one in my residency and recognized its value for improving care quality and efficiency."

Crow identified a few physicians who had adopted EMRs and went on site visits. "There were very few all-in-one products that included both practice management and clinical functionality," he recalls. "Most practices purchased two separate systems and then linked them."

Ultimately, Village Health Partners selected the GE Centricity Physician Office, which cost the practice approximately \$100,000. "Having a name-brand system was critical, because we knew the company was stable and would be around in the future," Crow says. "The software captured clinical data in a way that was reportable. This feature was important because we knew that data reporting would become a requirement. Also, the GE Centricity system is an EMR that is NCQA certified for diabetes reporting."

The practice implemented the EMR's physician management component in June 2003. It took about

one month to implement the system and train the five staff members. Next, the practice implemented the clinical component. Interfaces were created and training was conducted over six weeks, and the system went live on August 15.

## **Working With Patients**

Today, Village Health Partners includes nine physicians, two physician extenders, and 28 staff members handling approximately 3,500 patient visits per month. "We have about 70 computer stations spread throughout the office so that everyone in the practice can use the EMR conveniently," Crow says. "A computer is in every examination room, and we make a point of including patients in our use of the system to enhance the physician-patient relationship." In each exam room, the computer and seating are arranged so that the patient and the doctor can view the computer screen together and discuss health trends and next steps.

The clinical protocols for diabetes care embedded in the EMR are based on NCQA guidelines, Crow says. "Before I even walk into the examination room, the nurse asks the patient about diet, exercise, smoking status, and blood sugar levels; confirms the patient's medications; performs a urine albumin test; provides a pneumonia shot; generates a referral for an eye examination; and asks the patient to remove his or her shoes for the foot exam," he states. "The nurse

*(Continued on page 4)*

**"The practice's physicians earn \$60,000 to \$80,000 more per year because of the EMR."**

**—Christopher Crow, MD, MBA, Village Health Partners**

(Continued from page 3)

also recommends the practice's diabetic education and wellness and weight loss management programs if the patient is not already enrolled."

By the time Crow sees the patient, he has all the necessary information available on the screen. "The patient and I then look at the trends together," he says. "I remind the patient of the goal values and make medication changes as necessary." Crow also can submit laboratory orders automatically. "Within 24 hours, we get the blood results back to them with comments regarding whether any further medication adjustments are required," he says. All care is entered into the record, coded, and billed automatically.

One feature of the system that physicians find useful is the clinical decision support function, which provides reminders on the screen during the visit, enabling the clinician to address gaps in care in real time. "For example, if the patient has nephropathy, the system will remind me to consider prescribing an ACE inhibitor," Crow says. Some physicians resist such decision support tools, but Crow believes that this attitude is archaic, given the complexity of medical care and the large number of patients busy physicians manage. "The decision support function improves patient

## Award Recipient Offers Advice

**S**keptical about the value of electronic medical records (EMRs), many physicians are reluctant to invest in these systems. However, Christopher Crow, MD, MBA, of Village Health Partners in Plano, Texas, which was a recipient of the 2007 Healthcare Information and Management Systems Society (HIMSS) Davies Ambulatory Care Award for the successful implementation of an EMR system, views EMR adoption as a crucial step in improving care quality and addressing many of the administrative problems physicians face.

"An EMR offers an opportunity for physicians to measure and improve the care they provide," Crow comments. "It can improve clinic operations, and can generate a return on investment. We all hear many horror stories about how EMR implementation has failed, but those experiences do not mean that the EMR itself was bad. It just means that the mindset of the users and the skills needed to prompt reengineering are not present in those practices."

Crow believes EMRs can help physicians improve patient care. "The traditional method of providing health care no longer works," he says. "U.S. health care costs have continued to skyrocket, partly as a result of poor preventive care and suboptimal disease management. We need to have new systems in place and leverage this technology to help us provide better care at a lower cost. This requires a mindset shift, not just at the industry level but also at the individual practitioner level. Physicians need to open their minds to the possibilities an EMR can offer," he asserts. "An EMR can be powerful if utilized effectively, but physicians have to believe in it, take the time to learn how to use it, and reengineer care processes accordingly."  
—DJN

care and alleviates physicians' need to rely on memory," he says. "Also, decision support can prompt the automatic generation of order sets."

### Return on Investment

Records are flagged so that patients are automatically recalled for follow-up visits every three months. If a patient doesn't come in for a visit, the system generates an e-mail reminder automatically. If the patient does not have e-mail or does not respond, the system generates an automated phone call. A staff member receives a list of patients who have not scheduled a visit within one month of this phone call, and calls each one personally to arrange the appointment.

Crow credits the EMR with improving the efficiency of his practice, thanks to the automation of many clinical and administrative functions. The ratio of staff to providers is less than three to one, lower than the Medical Group Management Association's industry benchmark of about five to one. "The system handles about 10,000

## EMR Helps Practice Track Quality Scores

| Diabetes measure        | NCQA goal (percentage of patients) | Practice performance (percentage of patients on average as of March 2009) |
|-------------------------|------------------------------------|---|
| HbA1c > 9%              | < 20%                              | 6%  |
| HbA1c < 7%              | > 40                               | 62  |
| Blood pressure < 130/80 | > 35                               | 35  |
| Annual eye examination  | > 60                               | 60  |
| Foot examination        | > 80                               | 80  |
| Smoking status/advice   | > 80                               | 96  |
| LDL cholesterol < 130   | < 63                               | 9   |
| LDL cholesterol < 100   | > 36                               | 63  |
| Urine albumin test      | > 80                               | 90  |

Source: National Committee on Quality Assurance and Village Health Partners, 2009.

prescription refills a month and approximately 100 laboratory orders per day. Under a paper-based system, we would have to hire two or three additional staff members to handle this workload," Crow notes, adding that because of the EMR's automated appointment confirmation capability, the practice's no-show rate is less than 5%.

Improvements in operational efficiency and increased revenue helped the practice achieve a return on its investment in 18 months. "The practice's physicians earn \$60,000 to \$80,000 more per year because of the EMR," says Crow. "We grew but did not need to hire as many support people as we might have otherwise needed. Automated coding increased practice revenue by ensuring that the code matches the level of documentation. The automated patient recall function helps us to provide needed services by getting patients back in for monitoring and recommended evidence-based preventive services."

Another significant benefit is that the practice has improved its managed care contracting position as a result of the EMR. "Our clinical quality is excellent, and we can prove it with data," he asserts. "Payers realize that our data are better than their data, and they can't say that about many practices. As a result, we have won more contracts and have greater contracting leverage, even though our group is relatively small."

Despite all these improvements, Crow believes helping the practice's physicians provide exceptional quality of care is the most important outcome of EMR adoption. For example, only 6% of the practice's diabetes patients have a hemoglobin A1c level of greater than 9%, and 62% have

## Providing Better Care

**E**lectronic medical record (EMR) systems improve operational efficiency by automating such common tasks as test ordering, prescription refills, and communications with staff and colleagues, says Christopher Crow, MD, MBA, of Village Health Partners in Plano, Texas. The practice received a 2007 Davies Award for its successful implementation of an EMR system.

"All staff members can access the electronic patient charts at the same time, and physicians have remote access to information from any location," he explains. "When patients ask a question, the information is at our fingertips, presented in a well organized way. Immediate access to complete information is simply not possible when using paper charts."

Better disease management leads to better care quality. "The EMR includes preventive care and disease management protocols, which are overlaid with electronic task requests," Crow says. "This functionality ensures that we are eliminating gaps in care." After using an EMR correctly over time, physicians find that the system holds enough data on each patient to enable them to view health trends and determine whether care protocols have been followed. "In addition, we can look at populations of patients to determine the practice's overall quality of care, and then implement improvement activities to address a particular problem," he says. —DJN

achieved a level of less than 7%. Approximately 90% have had a nephrology assessment via urine albumin test (see the table, EMR Helps Practice Track Quality Scores). In addition, these averages will likely improve over time, given that they had declined somewhat to reflect the performance of new physicians who recently joined the practice, Crow explains. "Our newer physicians, who have used the EMR for less than 18 months, have not yet fully realized their potential to improve their performance," he says. Similar clinical successes have been achieved on cardiovascular and general preventive health measures.

Each physician in the practice receives a quarterly report illustrating his or her performance on a number

of key preventive care and disease management measures and comparing it to that of colleagues in the practice and national benchmark levels. "[Because of] these reports, physicians are aware of their own performance, and their natural competitiveness and desire to help people prompts performance improvements," Crow says. "Performance feedback has the potential to change individual physician behavior so that the practice can achieve overall improvements in quality of care." The practice offers annual financial incentives to physicians for excellent clinical performance, he adds.

—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 16).

**"Having a name-brand system was critical, because we knew the company was stable and would be around in the future."**

**—Christopher Crow, MD, MBA, Village Health Partners**

# Clinic Approach Cuts Complications

**R**ecognizing that patients with diabetes account for the majority of cases of chronic kidney disease (CKD) because of the link between diabetes and kidney injury, nephrologists at the University of Cincinnati have embraced the concept of multidisciplinary care by opening two CKD clinics. One is at the university's Diabetes Center and the other is at a University of Cincinnati internal medicine practice located in nearby Montgomery, Ohio. Enlisting the expertise of nephrologists early in the care of patients with CKD can improve quality of care, experts say.

"Decline in kidney function affects multiple body systems," says Satwant Singh, MD, a professor of medicine at the University of Cincinnati College of Medicine. "Many diseases that occur in other organ systems affect the kidneys. This interaction means that a multidisciplinary approach is critical to the understanding, diagnosis, prevention, and treatment of CKD."

## Combining Specialties

Multidisciplinary care also is a valued approach because of continuing advancements in different medical specialties. "The involvement of multiple specialists leads to better care, since a team of physicians with different areas of expertise can identify different clinical problems more quickly and then choose the most important problem to tackle at that time," Singh notes.

Patients with diabetes and high

blood pressure are at greatest risk of developing kidney disease. Formalizing interdisciplinary relationships can facilitate a patient's early referral to a nephrologist. "CKD is a highly prevalent disease associated with a significant clinical and economic burden," says Janet Boyle, MD, a nephrologist at the university and a proponent of multidisciplinary CKD care. Recent data from the federal Centers for Disease Control and Prevention in Atlanta show that approximately 26 million Americans (17% of the population) have CKD.

"The problem is that the early stages of kidney disease, when kidney function is gradually declining, can be clinically silent," Boyle says. "Patients may have no symptoms for years. When CKD is finally diagnosed, the ability to modify the progression of the disease in its later stages is limited."

Such organizations as the National Institute of Diabetes and Digestive and Kidney Diseases and the National Kidney Foundation (NKF) have sponsored sizeable campaigns to increase awareness of kidney disease among medical professionals and in high-risk populations including those with diabetes.

"Many patients in high-risk groups with impaired renal function are cared for in primary care settings and in diabetes centers, and while not all of them need to see a nephrologist, there are many who could benefit from a timely referral," Boyle explains. "The driving force behind

a multidisciplinary approach is to allow different subspecialists to work together to identify people who are at high risk of CKD and then intervene in the hope of modifying their disease process, thereby helping them achieve a better quality of life for a longer period of time."

The likelihood of improving a CKD patient's quality of life is greatest when clinicians have an opportunity to intervene early with medical therapies that control blood pressure and limit protein excretion, Boyle adds. In fact, intervention should be so early as to be almost before patients even realize they have a problem, she says.

Research has confirmed the value of early referral to nephrologists. The authors of a meta-analysis, "Outcomes in patients with chronic kidney disease referred late to nephrologists: a meta-analysis," published in the *American Journal of Medicine* (Am J Med. 2007 Dec; 120(12):1078-83), found that compared with early referral, late referral of CKD patients to nephrologists was associated with a twofold increase in the risk of death. In addition, the duration of patients' hospital stays when dialysis was initiated was longer in the late referral group by an average of 12 days.

## Starting a Clinic

In 2006, endocrinologists at the University of Cincinnati Diabetes Center found that they were treating increasing numbers of patients with early kidney disease. The endocri-

**"When we meet patients for the first time who are already nearing the stage where they are going to need dialysis, we have a little time to prepare them."**

**—Janet Boyle, MD, University of Cincinnati**

nologists and the university's nephrologists agreed that it would be in patients' best interests to involve nephrologists at the earliest possible stage.

### Identifying Patients

"The endocrinologists were seeing diabetic patients who had progressed to the point where their renal function was impaired," Boyle recalls. "Some were having considerable degrees of protein excretion even if their renal function was not impaired, and others were having difficulty controlling their blood pressure as a consequence of abnormal kidney function."

In January 2007, Boyle and Kotagal Kant, MD, a nephrologist colleague, began running a half-day clinic at the Diabetes Center. The two nephrologists staff the clinic on alternate weeks. The clinic's endocrinologists refer patients for a variety of reasons, but very often a consultation follows the identification of abnormalities in blood or urine tests.

"No specific referral eligibility criteria are set," Boyle explains. "We see anyone who is referred to us. But the goal is to target patients who are early in the disease process." Referred patients typically have Stage II or III CKD or worse. "The lower the level of kidney function, the more likely it is that the patient will be referred," Boyle says. In general, referred patients tend to be those who have renal dysfunction, difficult-to-control blood pressure, or both, she says.

### Evidence-Based Care

The nephrologists may provide a number of interventions, including the use of medications that inhibit the renin-angiotensin-aldosterone system to achieve strict blood pressure control and to modify protein excretion. "We also assess for and treat other effects of CKD such as anemia, metabolic bone disease, and

## Success at One Clinic Leads to Another

After getting positive results at the Diabetes Center, nephrologists at the University of Cincinnati established a second CKD clinic. The second clinic is located at a University of Cincinnati internal medicine practice in Montgomery, Ohio, about 25 minutes away from the main university campus. Four physicians who specialize in primary care staff this second clinic.

"Just like at the Diabetes Center, we run a half-day renal clinic at the practice," says Janet Boyle, MD, a University of Cincinnati nephrologist who is involved in multidisciplinary CKD care. The clinic is currently held every other week, but eventually it will be held weekly. Just as the endocrinologists at the University of Cincinnati clinic found, the physicians in Montgomery had discovered they were treating many patients with impaired renal function. While managing patients' renal complications, they wanted to facilitate early referral to nephrologists.

"The internal medicine physicians knew they had a substantial number of patients waiting to see nephrologists and wanted to ensure that these patients could receive nephrology assessment as soon as possible," Boyle explains.

The clinic opened in January 2008 and has treated a more diverse population than those seen in the clinic at the university in part because the patients the internal medicine physicians refer do not all have diabetes. "We see patients with any kind of kidney-related issues, such as hypertension, kidney stones, and glomerular diseases," Boyle observes. To date, the clinic has received positive comments from patients and physicians.

"Now that we hold a clinic at the medical practice, these patients are being seen by a nephrologist sooner than they would have been if they had been referred in the typical manner," says Satwant Singh, MD, a professor of medicine at the University of Cincinnati College of Medicine. One factor that helps improve care is that physicians share patient records, facilitating communication. "After each patient encounter, I generate a detailed written report for the record," he explains. "Also, I call the physician and give him or her a brief summary of my assessment and a suggested treatment plan."

It is important to provide as many aspects of patient care as possible at one site, Singh believes. "The increased convenience to patients increases the likelihood that they will participate more actively and be more compliant with care recommendations," he says.

—DJN

acid-base and electrolyte disturbances," Boyle says. Care is based on the evidence-based NKF Kidney Disease Outcomes Quality Initiative clinical guidelines, Boyle adds.

Having nephrologists on site at the Diabetes Center significantly benefits patients. "University of

Cincinnati diabetes patients have access to the expertise of different subspecialists in one location, a location where they are comfortable and are already familiar with the staff," Boyle continues. "Furthermore, physicians from different specialties working together facilitates the

*(Continued on page 8)*

(Continued from page 7)

movement of patients among physicians. The Diabetes Center represents a collegial atmosphere that fosters communication about patient care.”

Communication is crucial to the collaborative effort to assess each patient’s needs and the effect of interventions. “Communication is facilitated because we are in the same practice, seeing each other face to face,” Boyle adds. In fact, communication takes place through both formal and informal channels. “Information about patients is readily available and is shared in both written and oral forms,” she says. While formal meetings among doctors and nurses are not scheduled to discuss the care of each patient, there is a considerable amount of informal communication among the doctors and between the doctors and the staff.

**Improving Benefits**

The Diabetes Center has not done a formal study to determine whether multidisciplinary care has slowed the progression of CKD in patients or otherwise improved outcomes. “Nevertheless, anecdotally we hear from the endocrinologists that multidisciplinary care has resulted in earlier identification of CKD patients, overall improvements in hypertension control, and, in some cases, new diagnoses,” Boyle says.

In addition to improving quality of care, multidisciplinary CKD care also can improve clinician efficiency. “This has not been measured, but instinctively I believe there must be an improvement in care efficiency because the subspecialists are located in the same facility and can communicate easily and quickly,” Boyle says. “In addition, if we can intervene early with large numbers of patients, we can find ourselves treating a patient population with much less severity of illness.”

Professional satisfaction is enhanced as well. “Because referral is

## Expert Suggests Reaching Out to Patients

**N**ephrologists should seek opportunities to work with patients who have early indications of kidney disease, either in a diabetes center or in individual medical practices, suggests Janet Boyle, MD, a nephrologist at the University of Cincinnati. “Nephrologists can try to collaborate with endocrinologists and primary care physicians treating patients who, by the nature of their medical condition, are already at increased risk of developing renal disease and who may benefit from referral to a nephrologist,” she says.

Satwant Singh, MD, a professor of medicine at the University of Cincinnati College of Medicine, agrees. “Given the burden of CKD, nephrologists should highlight their services aggressively,” he says. “Nephrologists can contact primary care and internal medicine physicians and endocrinologists in the area, let them know how we can help their patients, and determine how we can develop joint ventures.”

Formalizing relationships with their referral sources could help community-based nephrologists to improve their flow of referrals and promote more timely care of patients. “If institutional circumstances preclude the development of a formal program, community nephrologists can still promote closer clinician relationships and educate other physicians about timely referral of patients at risk for CKD,” Boyle says.

In addition, community nephrologists should have no difficulty building formal relationships with referral sources, Singh comments. “The clinical need is there,” he says. “Furthermore, excessive delays in obtaining a specialist appointment are a common complaint of patients. Physicians who refer a substantial number of patients to nephrologists would likely be willing to host a nephrology clinic or set up some other form of formalized relationship.”

—DJN

facilitated, nephrologists get to see these patients more quickly, and as a result we can have a meaningful, positive impact on outcomes,” Boyle observes. “When we meet patients for the first time who are already nearing the stage where they are going to need dialysis, we have a little time to prepare them and make arrangements for access and other needed interventions. It is much more professionally satisfying to intervene early. We can achieve a better patient outcome, prepare the patients for whatever next steps may be ahead of them, or possibly delay disease progression in the hope that they may never need dialysis.”

Communication is the key to a

good multidisciplinary working relationship. “Clinicians should have the patient’s best interest at heart, consult with evidence-based guidelines for care, and discuss individual patients’ circumstances in order to devise the optimal treatment plan,” Boyle counsels.

Singh agrees, saying, “Referring physicians appreciate quick feedback about their patients. A focus on timely and clear communication about what is best for the patient will help ensure that the relationship is successful.”

—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 16).

# Doctor Gets Patient's View of Care

By Richard L. Reece, MD, editor in chief

**A**s I lay on my back on the hospital bed, after the catheter was removed and the stent inserted, and tethered by intravenous lines and health monitoring leads, a quote from journalist Alistair Cooke came to mind. I was connected to a devilish device called Femstop, a pressure-driven plastic globe, pressing down on my femoral entry site to prevent a hematoma. At that moment, I recalled a quote from a talk by Cooke, "The Patient Has the Floor," delivered at the Mayo Clinic in 1965. Cooke said, "I wish to talk of the fears of some statesman, lawyer, or other grandee who never appears before a doctor except to have his chest tapped, his knees jerked, his tongue depressed, his innards photographed, his rectum protoscoped, and his juices filtered, measured and pronounced upon. It is, though you may not know it, a permanently humiliating relationship: I mean the relationship between doctors and the rest of mankind. And it is because most people do not care to bring it up in public that I believe it might be useful for me to do so."

In retrospect I would not consider my experience as "humiliating," but rather I felt a mix of helplessness, appreciation, and curiosity.

## A Medical Crisis

On April 3, I experienced an uncomfortable substernal pressure. I self-diagnosed gastroesophageal reflux disease (GERD). But one rarely has GERD for the first time at my age. The discomfort, a dull ache, three or four on a scale of 10, didn't respond to self-prescribed over-the-counter medications. I have no personal or family history of heart disease but I had clues of coronary precursors: an untreated blood pressure of 140/150/85-90 and a recent gout attack.

My lipid panel—total cholesterol 141, low-density lipoprotein 69, high-density lipoprotein 47, and triglycerides 120—gave no indications of an impending occlusion. I dismissed the possibility that I was having a heart attack.

The pain came and went. It was worse when I lay down, better when I sat up. It didn't radiate, and was not accompanied by sweating, nausea, dizziness, shortness of breath, or pain on exertion. It persisted for three days, and the third night, it prevented sleep. On the morning of day 4, I felt unwell. On the advice of my general practitioner, my wife drove me to

an emergency clinic in a nearby town.

The emergency room (ER) visit began my bottom-up view of the health system. The ER physician, an athletic-looking, alert 45 year-old man, quizzed me briefly, did an electrocardiogram, and drew blood. Ten minutes later, he informed me I had suffered a myocardial infarction, gave me nitroglycerin to relieve the pain, and ordered an ambulance to transport me to an academic medical center 45 minutes away for a heart catheterization.

In the ambulance, the emergency medical technician (EMT) said heart attack riders like me were more frequent. *(Continued on page 10)*

## Patient Finds High Quality Care

**R**eports show that adverse events are common in hospitals. Fortunately, I did not experience any adverse events, and in fact I am grateful for the care I received when I had my heart attack. I am also grateful for the clear explanations the doctors and health professionals gave me about what to expect. From my point of view, the money invested in new life-saving technologies in cardiology is worth it, and the quality of care and attention to safety by the hospital staff were superb.

Could it be that the dangers of hospitalization in the United States are overstated? The incidence of adverse events in U.S. hospitals is only half that of hospitals in England and Australia.

In my case, I received a daily dose of subcutaneous heparin, to prevent pulmonary embolism, the number one cause of sudden death in hospitals. A nurse said subcutaneous heparin is part of hospitals' efforts to follow The Institute of Healthcare Improvement campaign to save 100,000 lives in hospitals and to avoid Medicare nonpayment for complications of pulmonary embolism.

Six days after my infarct diagnosis, I was at home, taking a statin, a beta blocker, aspirin, clopidogrel, and a medication to lower my blood pressure and heart rhythm. I have been assigned to a cardiac rehab unit. Sometimes in our efforts to identify villains in the health system, we point fingers at the pharmaceutical industry for profiteering, and forget that the industry provides life-saving technologies. In the case of heart disease, these technologies have tremendous preventive and therapeutic benefits. I'm happy with the system, though I realize that as a physician I enjoy certain courtesies and privileges.

—RLR

(Continued from page 9)

quent in the spring. He was 40 years old, a father of three, and a full-time firefighter who worked 16 hours a week at the ER to make ends meet. He was riding with me in case my pain worsened or I arrested.

Technology is said to account for 70% of health care inflation. The EMT said a new device had come onto the market that could be placed under and on top of a patient and delivered chest compression at rates of up to 100 beats a minute. This device, and the more pervasive presence of external defibrillators in public places, had increased immediate survival rates after cardiac arrest to about 40% compared with about 5% in the past, he estimated. Not a bad investment.

### Receiving Intensive Care

Upon arrival at the hospital, I was whisked directly into the catheter lab, a large room bristling with overhead imaging equipment, tables strewn with gear, and three or four nurses and technicians. I was one of the 12 “caths” for the day. In the United States, cardiologists perform about 4 million cardiac catheterizations annually, inpatient and outpatient, diagnostic and interventional, and roughly 1.5 million of these procedures involve inserting stents to bypass blockages.

Within about 30 minutes, a right femoral artery cut-down had been performed and a drug-coated stent had been placed in my right circumflex artery. I was told that patients average some 1.7 stents per cath. I was awake during the procedure. There was little pain other than a lidocaine stick before the femoral artery cut-down. After the procedure, the cardiologist explained what had been done.

## Reform Faces Obstacles

**D**uring a forum on health care in March, President Obama explained that the call for health care reform is coming from the bottom up, meaning from doctors, nurses and patients, unions and businesses, hospitals, health care providers and community groups, as well as state and local officials.

It is Obama’s vision that health reform will mean the uninsured will have coverage while also cutting costs to government and corporations, and making U.S. businesses more competitive around the globe.

While these goals are laudable, it may not be possible to expand coverage while reducing costs. There are several reasons why expanding coverage and reducing costs may not be possible, and I witnessed each one during a recent five-day hospital stay.

First, we are a technological nation that looks at the body as a machine. When plumbing clogs up, we unplug it or bypass it; when the joints cease working, we replace them; when the face of the machine sags, we lift it up. We are also an impatient, even a spoiled nation. We have 78 million baby boomers who will become eligible for Medicare in 2011, and many of them believe they deserve quick access to new technology. Like them, many of us believe in choice, freedom, and the pursuit of longevity, and maybe even in eternal youth—or at least the appearance of it.

Second, we believe in equal opportunity, but not necessarily in equal results, making it difficult to create homogeneous federal health policies that cover everyone equally in a multicultural nation in which one of five people is a recent immigrant or a close relative of one.

Third, we also believe in putting specialists in command of various organ systems and specific diseases, even though this belief engenders inefficiencies, high costs, and a fragmented delivery system.

Fourth, Medicare and Medicaid do not reward primary care doctors sufficiently to attract medical students to primary care and to create a comprehensive, coordinated health system. Government regulatory and payment pressures on hospitals create an environment in which documenting the steps provided while delivering care seems to be more important than actually providing patient care.

Fifth, Americans still believe in private health care, which pays 68% of the nation’s health bill. The other 32% is paid by Medicare, Medicaid, Veterans Affairs, and Department of Defense health services.

—RLR

Then it was off to the intensive care unit (ICU), where my rhythm and vital signs were monitored. I was told to stay flat, not to raise my head, not to cross my legs, but to wiggle my

toes. A parade of cardiologists, cardiology fellows, nurses, residents, nurse assistants, a nurse practitioner, medical technicians, and others passed through. Each was courteous and

**“My experience as a patient showed me first-hand how decreasing revenue and increasing government regulation affect health professionals at every level of the system,” the author says.**

scrupulous about reading my wrist identification band. Each asked if I had pain. Most listened to my chest, and felt my ankle pulses, which is important when you've had a femoral cut down. A wireless heart monitoring device, which displayed my heart rhythms at the nursing desk, was placed in my pocket.

When my vital signs had stabilized, I was sent to the general cardiology ward, where I had the luxury of ordering my own food from a menu. The assortment of choices was impressive, but because I was on a heart diet, no salt or sugar was allowed.

### **Interviewing Care Givers**

While I was in the ICU, a number of staff came to interview and examine me. I made a point of asking each one's name, and inquired about each one's background and view of the health system.

Most nurses were pleased and preoccupied with their work and didn't complain about the terms of their employment. A few grouched about the ceaseless paperwork and requirements to record the same data in multiple locations. One nurse unfurled a three-foot-long spreadsheet with multiple columns like a paper accordion. Some of the older nurses expressed skepticism about the chances for health reform under the Obama administration and foresaw a flurry of new regulations.

They may have a point. I've read that 25% of hospital costs are devoted to meeting federal regulations. The volume of paperwork that needs to be done is certain to increase as programs are implemented requiring hospitals to meet all quality indicators and to show irrefutable evidence

## Reform Has Its Price

**H**ow do we realize President Obama's vision of a reformed health system that will help reduce America's financial woes? After being a patient of the U.S. health system recently, it was clear to me that Obama's plan will require some sweeping changes, some of which will not be popular. Federal regulators may yet do what foreign health regulators do now, such as:

- Reduce payments to doctors, other health care providers, and hospitals. Doing so will lead to fewer American students seeking careers in medicine. As American-trained doctors become scarce, more foreign-trained doctors and physician-extenders will be needed.
- Limit payment for and access to medical technology. In Canada, patients have to wait months for MRIs, driving many to come to America for immediate diagnostic services.
- Ration available treatment to fit within the federal budget. Universal digitized health data may be used to justify nontreatment on a cost-benefit basis.

It seems unlikely that many Americans are ready for such changes at this time.

—RLR

that safety standards have been met.

Among doctors, apprehension about the present and future workings of the system was prevalent. The younger doctors in training were worried about paying off \$200,000 debts, and many said they would not enter private practice but instead would choose work as hospitalists, proceduralists, or ER doctors, with regular hours and predictable income.

### **EMR Experience**

Two of the younger doctors had received part of their training at the Veterans Administration (VA). Although they found the VA's electronic medical record (EMR) system functional and useful, they doubted it would work in small practices. One of the older cardiologists, a nationally prominent figure, commented, "They're always talking about primary care doctors being unhappy. I'm

unhappy, too. Most paperwork in the name of quality wastes my time. The paperwork kills satisfaction and hampers productivity." He went on, "Documenting isn't the same as doctoring. We're sometimes asked to be on standby if a president is in town on a weekend. The next time that happens, I'll tell them, 'No, I'm a government employee, and I don't work weekends.'" He ended by saying that he would never recommend medicine as a career for his children.

While my experience as a patient was largely positive, and showed me how effective the current US health care system can be, it also showed me first-hand how decreasing revenue and increasing government regulation affect health professionals at every level of the system.

—*Edited by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).*

**"Ten minutes later, he informed me I had suffered a myocardial infarction, gave me nitroglycerin to relieve the pain, and ordered an ambulance to transport me to an academic medical center."**

# The Many Obstacles to Health Reform

By Richard L. Reece, MD, editor-in-chief

Editor's Note: *This article was adapted from Obama, Health Reform, and Primary Care Shortages: Gloom for Improvement, Glimmers of Hope (Iuniverse, Inc., 2009), by Practice Options editor-in-chief Richard L. Reece, MD.*

In a way, it is meaningless to talk of universal health care. It may even be misleading to talk of a national health system. It is equally misleading to say we have a “non-system.” We have many systems—public, private, state-wide as in Massachusetts, city-wide as in San Francisco, and regional like the Mayo Clinic and other major health organizations. But we are transforming into a new kind of care: patient-centered care.

President Obama has vowed to lower costs, expand access, increase efficiency, and cut spending. He proposes spending more than \$1 trillion over the next 10 years to reform the system. Here is Mr. Obama's vow, as set forth in a health care summit conference held at the White House on March 5, 2009:

“If we want to create jobs and rebuild our economy, then we must address the crushing cost of health care this year, in this Administration...

“I believe that this time is different. This time, the call for reform is coming from the bottom up, from all across the spectrum—from doctors, nurses and patients; unions and businesses; hospitals, health care providers and community groups... This time, there's no debate about *whether* all Americans should have quality, affordable health care—the only question is, *how?* ...

“[I]f we want to cover all Americans, we can't make the mistake of trying to fix what isn't broken. So if you have insurance you like, you'll be able to keep that insurance. If you have a doctor you like, you can keep that doctor. You'll just pay less for the care that you receive.”

## Difficulties Loom

Although Obama strikes a determined, even combative tone, the odds for sweeping reform are probably only 30/70 in his first term. The odds are far better, however, for immediate incremental changes such as coverage for children, funding for stem cell research and electronic medical records (EMRs), setting in motion a Comparative Effectiveness Institute, and extended Medicaid unemployment benefits.

Other issues currently being debated in Congress—such as pay-for-performance, competitive bidding for Medicare Advantage plans, health insurance for patients with pre-existing illness, government negotiation of drug prices, bundling of hospital-physician bills, creating integrated group practices, and mandatory use of EMRs as a condition for payment—will likely make slow progress.

Suppose Congress passed a Medicare-like plan for all Americans, and mandated that everyone must buy insurance, regardless of health status. Private plans have been unable to negotiate prices at Medicare levels. Hospitals and doctors claim they have no profit margins at Medicare rates. Such a plan

would undercut private plans, driving them out of business, along with many hospitals and doctors.

Congress is actively considering such a plan, but it stands little chance of passing. Americans tend to mistrust government, and don't like radical change. Most of the 253 million insured Americans want to keep their existing policies. Such a plan would also worsen the mounting physician shortage—now 50,000 and estimated to grow to 200,000 by 2025—and weaken hospitals, which are already struggling under the expensive burden of meeting Medicare regulations.

## Accumulating Debt

It is hard to see how in the next few years Obama can create 3.5 million jobs, redesign the health system, save the auto industry, reinvent the energy sector, revitalize the banks, and reform education with one swipe of his magic wand. But he will try, partly by attacking business. In health care, Obama's main business targets will be private health plans and pharmaceutical companies. He plans to save \$196.2 billion by reducing payments to these two industries over the next ten years. He seeks to set aside \$634 billion as a “down-payment” for a plan that will eventually cost over \$1 trillion. Half the money would come from higher taxes and lower deductions for Americans earning over \$250,000 annually; the other half from Medicare and Medicaid cuts, with the biggest hits coming from hospitals, doctors, health plans, drug com-

**Physicians know it will be impossible to superimpose a single-payer plan on the current system without rationing care and spending trillions of additional dollars.**

panies, and home health agencies.

Debts incurred by the economic stimulus package may be too steep a hill to climb for those calling for universal coverage or a single payer plan in the short term. On March 20, the Congressional Business Office estimated the White House would create a budget deficit of \$2.3 trillion more than Obama's projections over the next decade. By 2020, the deficit may be \$7 trillion or more. When Obama says it may take ten years to achieve universal coverage, he's hedging his bets.

### **Seeking New Revenue**

Obama's other options for raising revenues to cover reform are fraught with political problems. He could, for example, tax employers' health benefits for employees. Such a removal of deductions would raise \$246 billion the first year and \$3.6 trillion over the course of ten years.

But government figures estimate 253 million Americans receive 70% of their coverage from employers. Taxing employers for providing these benefits would almost certainly cause many employers to drop benefits. This would increase the number of uninsured patients, denting the original purpose of providing universal coverage.

Private health plans could be forced to meet or beat the drug prices of the Veteran's Administration; or the government could negotiate Medicare Part D drugs at the same levels now offered by Medicaid. But either of these moves would jeopardize the drug industry and result in layoffs of hundreds of thousands of pharmaceutical workers.

The Obama plan dedicates \$330 million for loan repayments and other support for primary care doc-

tors who practice in doctor-shortage areas. It also protects doctors against across-the-board Medicare budget cuts based on the sustained rate growth formula, subsidizes EMR implementation, and in general supports primary care physicians.

Obama hopes to "tighten" payment to doctors and hospitals. This means lowering payments to hospitals and specialists—perhaps even requiring specialists to participate with hospitals in bundled payments for high-ticket procedures.

"Tightening" payment might even entail doing away with fee-for-service payments and substituting payment for episodes of illness, or episodes surrounding an operation.

### **Reform Is Complex**

Health reform is complex because it involves patients' expectations. We all will need health care at some point in our lives; we all will expect the best American medicine has to offer; and we all, directly out of our pocketbooks or through higher taxes or smaller employer benefits, will have to pay for it. In our aging population with high expectations, health care tends to be an open-ended sinkhole.

Nothing exemplifies the unlikelihood of being able to simultaneously cut costs and expand coverage better than Massachusetts, now in the third year of its universal coverage plan. The number of uninsured patients in Massachusetts is down to 2.6%, far below the national average, but health costs in the state have exploded by 42% over the three years. Massachusetts now spends 33% more

on health care than the national average. To make mandated care affordable, the state subsidizes premiums for families of four making up to \$66,150 annually, and requires health plans to accept all applicants regardless of pre-existing illnesses. To cover the cost of enrolling sick patients, insurance companies are increasing premiums for Massachusetts residents. The state's policy experts say that to contain costs its main options are to do away with fee-for-service, to reimburse for episodes of care rather than individual visits, and to bundle payments to groups of doctors and hospitals.

Physicians know it will be impossible to superimpose a single-payer plan on the current system without rationing care and spending trillions of additional dollars. The existing infrastructure must be firmed up, and costs cut, before we impose a new health care structure on a shaky foundation.

The present state of affairs, with unhappy patients and doctors, soaring costs, and 15% uninsured, can't last. Health care costs, mainly Medicare and Medicaid, now consume 25% of the federal budget. More cost increases are on the way. The Centers for Medicare and Medicaid may run out of cash by 2016. Before that happens, rationing of care will become a reality. Under Obama, health reform is coming fast, ready or not. But reforms will likely be incremental, rather than an immediate switch to universal coverage.

—More information on physician practice strategies is available on our Web site (see page 16).

## **Americans tend to mistrust government, and don't like radical change.**

## **A Medicare-like plan for all Americans would undercut private plans, driving them out of business, along with many hospitals and doctors.**

# How IT Would Benefit Medical Homes

A recent report, *Meaningful Connections: A resource guide for using health IT to support the patient centered medical home*, from the Patient-Centered Primary Care Collaborative (at [www.pcpcc.net](http://www.pcpcc.net)), in Washington-D.C., contains case study examples of how medical homes would work in practice. In the report, physicians and others in PCPCC member practices that are currently certified as patient-centered medical homes (PCMHs) or considering becoming certified describe the effects that health information technology (HIT) has had on their practices and patients.

These case examples provide insight, in the words of the practitioners themselves, into the effect that HIT can have on primary care. In particular, of the 19 examples provided in the report, seven mention the effect HIT has had on helping practices manage the care of patients with diabetes. The section was prepared based on responses to questions PCPCC sent to its member practices.

## Focusing on Diabetes

The main body of the report comprises a set of guidelines suggesting how HIT should be used in a fully integrated PCMH. It contains an overview or the value of HIT in a PCMH, a description of the HIT capabilities that PCPCC regards as essential for supporting a PCMH, a detailed description of how each piece of functionality serves the PCMH and the patient, and guidelines on engaging patients through the use of HIT. Appendices list guidelines for PCMH demonstration projects and principles for protecting consumers and patients.

Of the seven case examples specif-

ically relating to diabetes care, only one comes from a practice that is not currently employing an integrated electronic health record (EHR) system. The one practice not employing an EHR describes its information system as an “in-house, stand-alone HIT&E components” and “off-site, Web-based stand-alone e-prescription software.” (HIT&E stands for “health information technology and exchange.”) Five of the practices describe themselves as planning to be certified as PCMHs; the other two are currently participating in pilot programs. The National Committee for Quality Assurance (NCQA) certifies practices that meet its standards as PCMHs.

The comments relating to care for patients with diabetes fall most frequently in the area of improved care processes, outcomes, and patient satisfaction. In this area, comments from various practices include the following:

- HIT improved diabetes indicators by enabling the practice to systematically follow and improve related processes.
- The rate of pneumonia vaccinations in patients with diabetes increased from 50% to 95%.
- Nearly 100% of patients with diabetes had low-density lipoprotein and HbA1c screening performed in the past year.
- The ability to look up test results off-site enabled one physician to obtain NCQA certification for diabetes care.

For the report, PCPCC asked practices to describe what objective evidence exists that HIT had a positive effect on patients’ and clinicians’ behavior. The practices had a variety of responses. One practice said two of

its physicians gained NCQA recognition for diabetes management since the practice adopted an EHR. Another practice said it had improved metrics for chronic disease. Two practices reduced the HbA1c levels in patients with diabetes. One practice reported that data collected in its information system helped it prepare for NCQA certification.

## Finding Themes

Additional comments made in the case examples that were not directly related to diabetes care also were telling. These include one practice’s statements that HIT has enabled it to eliminate all paper records and, “Financing IT improvements over three to five years is cost effective.” Another practice commented, “It would be impossible to improve quality as much as we have without an EHR!!!”

The introduction to the section contains a summary of the common themes running through all of the responses to questions that were used to prepare the examples. Some practices said, for example, there is a pressing need for improving patient access portals to practices. The report also says that despite the rosy picture of how HIT helps practices to improve primary care, HIT is a tool and is not in and of itself the answer. “Changes throughout the practice, in workflow and how medical staff work together, are essential,” the report adds. But once all the necessary adjustments have been made, the report says, practices find that, “Health IT support of medical care becomes a way of life.”

—Written by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).

**Health IT is a tool, and not in and of itself the answer.**

# Report Defines PCMH IT Needs

**H**ealth policy experts believe that one possible solution to some of the most difficult problems physicians and patients face in the current health care system may be to develop patient-centered medical homes (PCMHs). In a PCMH, each patient would have an ongoing relationship with a primary care physician who would coordinate and manage patient care.

Of central importance to the PCMH concept are the ideas of a patient having a relationship with a personal physician, care for the whole person, expanded access to care for patients, and coordination and integration of care. For physicians seeing patients in primary care, the concept may be appealing because PCPs would direct the care for their patients. Under the current health care system, health plans direct care for many patients, and others have no central source for care direction, such as when enrolled in a fee-for-service plan or in a preferred provider organization.

## Outcomes Data Needed

For PCMHs to be successful, they will need health information technology (HIT), in part because physicians managing patient care in medical homes will need data on outcomes and will need to communicate efficiently with other providers. A recent report, *Meaningful Connections: A resource guide for using health IT to support the patient centered medical home*, from the Patient-Centered Primary Care Collaborative (PCPCC) in Washington, D.C., provides guidelines on how HIT should be used in a fully integrated PCMH. It also contains an overview of the role of HIT in a PCMH, a description of the HIT capabilities that PCMHs will require, and describes how HIT serves the PCMH and the patient. The entire

report is available online from PCPCC (at [www.pcpcc.net](http://www.pcpcc.net)).

In addition, the report includes a section containing 19 case examples, in which PCPCC member practices that are currently operating as certified PCMHs or considering becoming certified PCMHs describe the effects HIT has had on their practices and their patients. The National Committee for Quality Assurance requires physician practices to adhere to certain standards to operate as certified PCMHs.

## Defining HIT Needs

According to the report, the following information technology capabilities are necessary to support a PCMH. Each PCMH needs to be able to:

- Collect, exchange, and manage patients' health data
- Facilitate communication among patients and providers at all times, including during the delivery of care
- Collect, measure, and report data on care and outcomes for individuals and populations
- Facilitate decision support for evidence-based medicine for physicians and practices
- Inform patients about health and medical conditions, and enable and facilitate self-management and monitoring of health status.

Without endorsing any specific technology or products, the report explains each of these important HIT capabilities and analyzes them in detail, explaining why each capability is important and what value it delivers to physicians and patients. Physicians will note that the authors of the report admit that some of the specific functionalities required to run a PCMH effectively are not yet available.

Patients are anxious for physician practices to have information systems that will allow them to access their medical records and test results

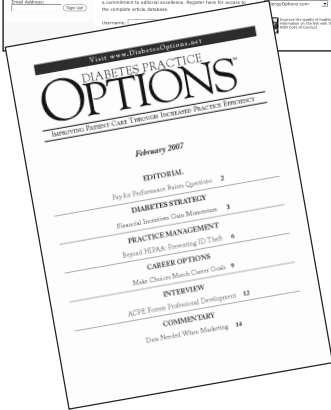
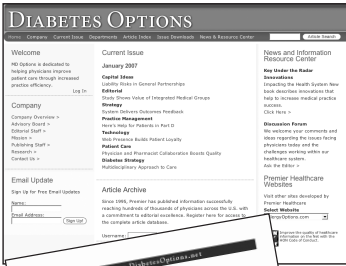
online and to schedule appointments electronically, the report says. Seventy-eight percent of patients would like to access online medical records and test results, 72% would like to be able to schedule appointments online, and 76% would like to be able to communicate with their doctors via e-mail, the report says. Currently, however, only 6%, 10%, and 9% of patients has access to each of these services, respectively. A significant number of patients indicated that they would be willing to pay for such access, the report added.

## Reaching Patients

The report is timely because the Obama administration is pushing the country toward universal coverage, while also developing legislation to require physicians to adopt electronic health records (EHRs) and other technology. The report also is significant because it helps to explain how a shrinking workforce of physicians can cope with the increasing demands to provide care to more patients while still delivering high quality care. Proponents of the PCMH concept believe it could be a viable solution to some of the current problems physicians face, a fact that makes the PCPCC report a useful resource for physicians and practices considering becoming certified as PCMHs. While health information technology is a crucial element in the coordination of care provided in a PCMH, the exact HIT functionalities required to support a working PCMH have not yet been defined. In the meantime, this report attempts to provide this important guidance to physicians considering operating in PCMHs.

—Written by Rev DiCerto. More information on physician practice strategies is available on our Web site (see page 16).

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