

DIABETES PRACTICE OPTIONS™

Improving Patient Care Through Increased Practice Efficiency

AUGUST 2009

CONTRIBUTING FACULTY



Randy Moore, MD



Maureen Glabman

INNOVATIONS

Is a Patient- and Physician-Friendly Health Care System Possible?

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

One of the biggest concerns about health care reform is that it will be unfriendly to patients and physicians. Given this concern, here is my idea for a health care system that would be friendly to both parties.

Employers, Medicare, Medicaid, and the government should agree on a reasonable sum of tax-free money, probably around \$6,000 to \$10,000 per year, for every citizen, and let consumers of health services spend this money as they see fit. To protect against bankruptcy, each American should be required to buy health insurance, relevant to their income and assets, that will cover their catastrophic needs. Consumers who do not spend their money in a given year should be allowed to roll it over into a health retirement account. A health security commission, much like the present Securities and Exchange Commission, should oversee the details.

The tax code should be reconfigured so that everyone can buy health insurance with

Continued on Page 2

IN THIS ISSUE



Page 6

- 3 | **DIABETES STRATEGY**
Cell Phones Facilitate Diabetes Control
- 6 | **QUALITY IMPROVEMENT**
Tests Help Identify Diabetes Patients at Risk
- 9 | **Q&A**
Can Telehealth Improve Care for Patients with Chronic Illness?
- 12 | **TECHNOLOGY**
EHR Helps Physician Practice Cut Errors and Delays
- 14 | **PRACTICE MANAGEMENT NEWS**
Report Outlines Need for Disability Insurance

ADVISORY BOARD

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

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, MHA
Senior Vice President, Oncology
UnitedHealthcare
Minneapolis

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.

Continued from Page 1

pre-tax funds. Congress should establish an American version of the universal consumer-driven Swiss and Dutch health systems, which require all citizens to buy health insurance and provide quality care at a one-third lower cost than ours. Under the Swiss and Dutch systems, the poor receive funds to buy insurance.

Borrowed in part from the writings and books of U.S. Senator Tom Coburn (R-Oklahoma) and Professor Regina Herzlinger of Harvard Business School, further elements of the plan include:

1. Require all Americans to buy insurance, using pre-tax funds
2. Require insurance to cover all possible catastrophic events, based on all expenses exceeding some percentage of income
3. Have government subsidize patients who cannot afford insurance



Editor-in-Chief Richard L. Reece, MD

4. Let hospitals and providers bundle care as they wish and quote their own prices, and publish comparative price information
5. Require data on quality, performance, and outcomes to be published
6. Risk-adjust prices so that providers can make a profit caring for sicker patients
7. Incentivize providers to compete, creating delivery systems that insurers will be interested in covering.

This plan is about free-market principles instead of government mandates. It encourages innovations to provide more and better care for less. It discourages third-party bureaucracies that reward the status quo, and fosters patient-centered care. ■

STAFF

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

Associate Editor
Rev DiCerto

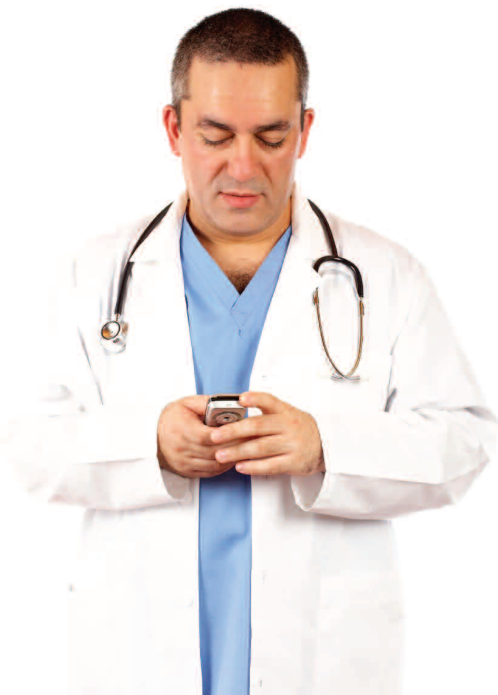
Art Director
Meridith Feldman

Publisher
Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
973/682-9003; Fax: 973/682-9077
publisher@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.

More information on physician practice strategies is available at www.DiabetesOptions.net



DIABETES STRATEGY

Cell Phones Facilitate Diabetes Control

Monitoring and managing diabetes is challenging in part because many patients cannot manage their conditions on their own without ongoing support from providers. Now, a growing number of physicians are finding that the practical use of an everyday technology—cell phones—can yield improved outcomes

for patients with diabetes. A growing number of interactive applications are allowing patients to use their cell phones to submit glucose values and communicate with and receive real-time feedback from providers daily.

“People with chronic diseases live most of their lives outside of doctors’ offices,” says David L. Katz, MD, MPH,

director of the Prevention Research Center at the Yale University School of Medicine in New Haven, Conn. “No matter how high-quality the patient’s visit with the doctor, nurse, diabetes educator, or dietitian is, this exchange constitutes only a very small part of that patient’s life. Rather, the weeks and months between office visits are really when health is either cultivated or compromised. Cell phone technology can be used to extend a provider’s voice outside of the clinical setting.”

Getting Patients Involved

The high degree of patient involvement needed to achieve optimal clinical outcomes makes diabetes unusual among chronic diseases, says David G. Marrero, PhD, professor of medicine at the Indiana University School of Medicine’s Division of Endocrinology and Metabolism in Indianapolis. “Diabetes is very much a lifestyle disease, requiring patients to make numerous decisions on a daily basis with regard to behaviors that will affect their health,” he comments. “Cell phone glucose monitoring applications offer several opportunities to affect those decisions.”

Katz led the Novel Interactive Cell Phone Technology for Health

Continued on page 4

TECHNOLOGY MUST BE USER FRIENDLY

If cell phone-based technology is going to improve patient-care, it should be user-friendly, involve two-way communication, and should be assessed regularly, experts say.

“First, if health coaching is to be part of a patient’s daily life, it has to fit in,” explains David L. Katz, MD, MPH, director of the Prevention Research Center at the Yale University School of Medicine in New Haven, Conn. “The use of the system should not take a lot of time and the design of the technology has to account for how people actually live their lives.”

Also, Katz says, the system should involve two-way communication. “It’s fine to ask patients to enter data, but the system should not shut down completely if patients don’t take the initiative,” he states. “The system should accommodate data upload, but should also be capable of contacting the patient to prompt that data upload if it does not occur.”

David G. Marrero, PhD, professor of medicine at the Indiana University School of Medicine’s Division of Endocrinology and Metabolism, adds that when adopting a new technology, physicians should never assume that all patients will like it or be ready to use it the way physicians want them to. “They should sit down with patients, talk about what the technology can and cannot do, and set expectations for interaction content and frequency,” he says.

Such technology could transform how medicine is practiced, Katz adds. “Increasing emphasis on the concept of the medical home and new innovations prompted by Recovery Act funding for medical record keeping enhancements are promoting the development of electronic-based communications that will center on patient outreach,” he says. “The wave is still small, but it is rising, and it will gather momentum quickly.”

—DJN

Continued from page 3

Enhancement (NICHE) trial, a pilot test of a cell phone-based biometric diabetes tracking system developed by Confidant, Inc. (at www.confidantinc.com). The system enables HbA1c readings measured by the patient's glucometer to be transmitted wirelessly to Confidant's cell phone application via Bluetooth technology. Measures are then transmitted to a computer server that compiles and tracks the data.

Immediate Feedback

Patients receive personalized feedback via text message showing glucose status. They also get encouragement to continue healthy behaviors, tips for behavioral adjustments, and guidance regarding when to contact the physician. Physicians are alerted to values outside of the normal range so that they can contact patients immediately, and can also access trend data via a secure Web site to guide discussions with patients during follow-up visits. Patients who neglect to take a timely HbA1c reading are reminded to do so via a cell phone message.

Results of the NICHE trial were published in the June 2008 issue of the *Journal of Evaluation in Clinical Practice*. Over three months, the researchers found a significant decrease in HbA1c levels in the intervention group compared with the control group of patients receiving usual diabetes care. "Patients using the system were able to achieve better control of their diabetes," Katz says. In fact outcomes improved despite using an early prototype in the study that was not very user-friendly and that has since been enhanced.

Improving Care

"Our results are testimony to the potential power of interventions like this," Katz adds. "If we can find ways to incorporate good, empowering medical information into the daily lives of patients with chronic disease, these patients will be better able to effectively self-manage their condition."

Marrero is the principal investigator of a study of 120 adolescents with Type 1 diabetes who used a device that combined a cell phone and glucose meter in one unit. "Patients test their blood glucose using the device, which then automatically transmits readings to a Web-based computer application," he explains. "Nurses at the Indiana University Hospital monitored the application, which flags values or cases that are problematic. The nurse could then send an encouraging text message to an adolescent who was doing fine, or could text the patient with a suggestion about alternative therapy or behaviors or a request to call for a more detailed discussion. In this way, patients receive immediate feedback rather than waiting for the three-month follow-up visit."

Assessing the Benefits

While Marrero and his colleagues are still analyzing the data, early findings suggest positive outcomes. "The kids loved it, and enjoyed having a personal and independent connection with the provider," he says. "The parents felt comfortable because their child's health was monitored on an ongoing basis, and they did not feel the need to nag." Other early findings include an increase in glucose testing and an increase in the rate at which patients initiated contact with the providers. Marrero also believes that the data analysis will reveal improvement in glycemic control.

Physicians were positive about the system because it facilitated their provision of care. "For example, physicians received printouts of glycemic values over time," Marrero notes. "Previously, they would be able to track this type of data only if the adolescents brought in a written log book, but even that was not necessarily reliable, comprehensive, or practical to read. With the printouts, physicians can identify recurring patterns and then address those issues before they get out of control."

Clearly, the most meaningful benefit of the cell phone glucose monitoring

INNOVATION EMPOWERS PHYSICIANS AND PATIENTS

In recent years, a number of technological innovations have made the benefits of face-to-face health coaching available to patients at any time. "Some innovations have been Internet-based, and some have used standard telephonic outreach," says David L. Katz, MD, MPH, director of the Prevention Research Center at the Yale University School of Medicine. "More recently, there have been efforts by several companies to provide coaching via cell phones, which in essence become personal health coaches that patients can carry in their pockets. That technology extends the power of medical guidance by providing ongoing access to information and connection to providers."

The use of cell phones to facilitate patient self-management combines technological innovation with another current trend: recognition of the primacy of the patient in health responsibility. "This is a natural merger of our evolving understanding of what chronic disease is really all about, namely how patients live their lives and manage their health every day," says Katz. "A growing body of research shows that we can use technology to enhance chronic disease self-management. The notion of self-management conveys to the patient, 'It's your life, it's your body, and you are in charge.' The health care professional can provide good information, but implementing that information on a daily basis is up to the patient."

Using cell phone technology to facilitate patient self-management is inherently appealing because it's familiar and nearly ubiquitous. "Technology is a means to an end; so simplicity is of major importance," Katz comments. "We really don't want to be overwhelmed by involvement in the technology; rather, we want it to serve our needs."

—DJN

technology is its ability to improve clinical outcomes. “Doctors really do want our patients to do well,” Katz says. “That is a reward in itself.” While the clinical outcomes assessed in NICHE and Marrero’s trials were limited to HbA1c levels, there are potential longer-term benefits, given that good glycemic control reduces a patient’s risk of developing severe diabetes-related complications, such as kidney failure, blindness, and cardiovascular disease, Katz adds.

“Doctors hope that when we have that periodic patient visit, we are able to impart information that makes a difference,” he continues. “But all too often, it’s not enough. Cell-phone based diabetes care technology is an extension of the provider’s voice. The technology changes the game for us, because information delivery is not limited to that brief office encounter, but follows the patient around on a daily basis, thereby increasing the likelihood that good clinical outcomes can be achieved and maintained.”

A secondary benefit to physicians is greater reward from the health system for improved performance based on outcomes. “With pay for performance and other strategies for measuring and rewarding the quality and efficiency of health care, better clinical outcomes for patients translate into better financial outcomes for doctors,” Katz says. Payers typically consider measuring and tracking HbA1c levels among

“If we can incorporate good, empowering medical information into the daily lives of patients with chronic disease, these patients will be better able to effectively self-manage their conditions.”

David L. Katz, MD, MPH

patients with diabetes to be low hanging fruit. “HbA1c tracking is routinely singled out,” he explains. “We have specific treatment guidelines, we know what good glycemic control is, and we have various means of getting there. Many systems incentivize doctors to achieve those goals.”

Ultimately, payers also receive financial rewards for improved glycemic control. “Payers are happy to pay physicians a little more if they can help diabetes patients achieve a lower HbA1c, because that translates into less expensive care: fewer trips to the emergency room, a lower risk of acute crises related to hyperglycemia, and, over time, a lower risk of severe—and costly—complications,” Katz points out.

Although some physicians are using such technology in their practices, it is not yet prevalent, possibly because researchers have not proven that these systems are directly related to lower costs of care, Katz comments. Nevertheless, he remains optimistic that such studies will be published soon.

“Given the high cost of poor glycemic control, it will not be that difficult to prove that cell phone-based technologies are cost effective,” he says. ■

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

DOES TEXTING HELP TEENS MANAGE DIABETES?

Among cell phone users, teenagers and young adults clearly get the most out of the technology. “The appeal of cell phones to this demographic is totally different than it is for adult patients,” observes David L. Katz, MD, MPH, director of the Prevention Research Center at the Yale University School of Medicine. “Adolescents and young adults enjoy using their phones as a means of interfacing with their social world. The cell phone is a portal, and they don’t go anywhere without it. The appeal of that technology in the life of a teenager is very powerful, and using it to guide and cajole teenagers to take care of themselves is a great advance because that group is otherwise very tough to reach.”

David G. Marrero, PhD, professor of medicine at the Indiana University School of Medicine’s Division of Endocrinology and Metabolism, agrees. “In addition, adolescents have to make decisions about eating and activities that could have an impact on their glycemic control, but they don’t always have the resources

to make the best possible decisions,” he comments. In a recent study of the effectiveness of text messaging in helping adolescents manage their diabetes, nurses helped teenage patients make decisions about behaviors and therapeutic adjustments and could provide coaching in real time, so that acute complications could be avoided.

Furthermore, adolescents with diabetes often find that managing diabetes becomes a fight for control with their parents. “Adolescents want to be independent, but sometimes might make decisions that put their health in jeopardy,” Marrero says. “As a result, worried parents can become overly controlling, causing adolescents to resist and to even use their diabetes as a weapon. This creates tension and dysfunction in the relationship. Cell phone technology can alleviate this strain by offloading some of the vigilance to the health provider, thereby bringing comfort to parents in a way that is acceptable to the adolescent.”

—DJN

QUALITY IMPROVEMENT

Tests Help Identify Diabetes Patients at Risk

A minority patient in his 30s is referred to nephrologist Joseph Vassalotti, MD, at Mount Sinai Medical Center in New York City. He has a long history of poorly controlled diabetes, a major contributing factor in kidney disease, and hypertension. The patient is diagnosed with Stage 5 chronic kidney disease (CKD); he is in imminent need of dialysis or transplantation, though he did not know he had the disease.

“It is unfortunately a common scenario,” says Vassalotti, who practices nephrology part time while serving as chief medical officer of the National Kidney Foundation (NKF). “There were many missed opportunities to intervene in the years of this patient’s [diabetes] care.”

Slowing Disease Progression

Vassalotti and other nephrologists express nagging frustration at the number of end-stage renal disease (ESRD) cases they manage in patients with diabetes and other chronic conditions in which disease progression might have been delayed or contained at less dire stages. Ideally, primary care physicians would routinely screen all patients who have diabetes or other risk factors for



CKD with two simple lab tests: the microalbuminuria screen and the glomerular filtration rate (GFR). Once these patients had been screened, the clinicians would aggressively treat the chronic conditions that exacerbate CKD, potentially eliminating the need for dialysis or transplantation, Vassalotti says. When patients’ CKD reaches Stage 4, primary care clinicians would transition care to nephrologists.

“Nephrologists don’t have time to address early detection and treatment,” Vassalotti says. “We are focused on Stages 4 and 5, the CKD patient who requires hemodialysis.”

According to an article, “Identification and referral of patients with progressive CKD: a national study,” published in August 2006 in the *American Journal of Kidney Diseases* (Boulware LE, Troll MU, Jaar BG, Myers DI, Powe NR. *Am J Kidney Dis.* 2006 Aug;48(2):192-204), less than 20% of PCPs routinely screen patients with the most common CKD risk factors: diabetes and hypertension. Last year, Quest Diagnostics Inc., of Madison, N.J., reported that its own analysis of lab data showed that among 5 million patients only one in three patients with diabetes was tested annu-

INITIATIVES ALLOW PCPs TO SCREEN FOR CHRONIC KIDNEY DISEASE

Many efforts are underway to help primary care providers screen and treat diabetes patients for CKD. For example, at the American College of Physicians (ACP) annual convention held in Washington, D.C., in May of 2008, there were 12 seminars in nephrology, compared with only nine in 2000. The ACP journal *Annals of Internal Medicine* features five CME courses in nephrology. The *ACP Diabetes Care Guide* online includes a section on renal complications with links to courses and articles. However, a great boon to primary care-nephrologist relations is the naming of Jeffrey Harris, MD, a nephrologist in Winchester,

Va., as ACP president for 2008-09. Harris is believed to be the first renal specialist to lead the 125,000-member organization.

In addition, researchers reported in the July issue of the *Journal of the American Society of Nephrology* that a new laboratory test called urine neutrophil gelatinase associated lipocalin (NGAL) helps predict if patients will develop acute kidney injury (AKI). “As a stand-alone marker, urine NGAL performed moderately well in predicting ongoing and subsequent AKI,” says T. Alp Ikizler, MD, a researcher at Vanderbilt University.

—MG

ally for microalbuminuria. This urine test for kidney damage is widely available and is a key indicator of CKD. The NKF and the American Diabetes Association recommend that all adults with risk factors for CKD receive annual microalbumin testing.

Part of the problem is training, says Andrew Narva, MD, director of the National Kidney Disease Education Program. Primary care clinicians, including nurse practitioners (NPs) and physician assistants (PAs), feel inadequately educated, and generally consider CKD to be a specialist disease, Narva adds.

Primary care clinicians misinterpret test results, underuse kidney protection medications such as angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs), and do not adequately control blood pressure, Narva says. In addition, they are unclear about recommendations and lack confidence in their abilities to manage patients with CKD successfully. Studies show they often believe a referral is necessary, he comments.

Expanding Screening

Contributing to the problem is the fact that patients feel fine in the early, most treatable stages of CKD, and visit providers only when the disease is advanced and options for intervention are limited. In addition, a vast number of uninsured patients with diabetes likely seek medical care only when it is needed, rather than seeking preventive care. A 2005 report by the National Institutes of Health revealed that less than one in 10 Americans with poor kidney function is aware of having weak or failing kidneys.

Even when patients are aware that their diabetes is a risk factor for CKD, they often do not take proper care of themselves. In addition to diabetes, risk factors for CKD include hypertension, cardiovascular disease, a family history of CKD, age greater than 60 years, or being of African American or Hispanic descent. Patients with diabetes or other

risk factors may have capable physicians, but they never see them, they don't follow up, and they don't take their medicines, Vassalotti says.

Getting Test Results

Another reason for a lack of early screening and treatment is that only half of all American diagnostic laboratories automatically estimate a patient's GFR from serum creatinine level. This test can be a significant indicator to a clinician receiving standard health panel reports if a diabetes patient is in early stages of CKD. Medicare pays \$11.83 for the panel and \$15.32 for the urine test to measure albumin. Both of these simple tests for markers of kidney damage and level of kidney function are required for a comprehensive CKD evaluation. All physicians, NPs, and PAs can order them, and they should be part of the regular care for patients with diabetes, experts say.

A number of initiatives are underway to encourage early detection and treatment of CKD. Most of these have been implemented since 2000, when the NKF announced its Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines. One of these initiatives is a push to require all American labs to calculate the estimated GFR (eGFR) from a patient's serum creatinine level.

Until 2002, it is likely that not a single American laboratory calculated patients' eGFRs, says Harvey Kaufman, MD, Quest's medical director. By now, however, 50% of American labs were calculating patients' eGFRs, according to surveys conducted by the College of American Pathologists, which represents the nation's largest laboratories. "It's not 100%, and that is the ultimate goal," Vassalotti says.

Creatinine Levels

Labs that currently calculate eGFR automatically when creatinine levels are measured include US Veterans Affairs laboratories (since 2003), Quest (since 2004), and Laboratory Corporation of America (since 2008). For diabetes patients using labs that still do not cal-

COMMUNITY GROUP PROMOTES GFR TEST

Among community groups working on early detection and treatment of CKD in patients with diabetes and other risk factors is the Niagara Health Quality Coalition, composed of employers, health plans, physicians, and hospitals in Buffalo, N.Y. In 2003, the coalition developed a plan to stave off or eliminate the need for dialysis while reducing costs and improving patient quality of life.

Three health insurers—Independent Health, Blue Cross and Blue Shield of Western New York, and Univera Healthcare—required that the region's laboratories calculate the estimated glomerular filtration rate (eGFR) from serum creatinine levels for all patients to improve identification and treatment of patients with mild to moderate kidney disease. The insurers then sent concise standards to primary care doctors on how to interpret and act on the lab findings, said Bruce Boissonnault, the coalition's president.

The coalition estimated that more than 20,000 out of 1 million residents of the region are likely to have kidney disease, but only 20 to 25 nephrologists practice there, making it imperative to involve primary care doctors in CKD detection and treatment.

All three plans sent letters to physicians instructing them on how to order lab tests correctly. The insurers created a patient education program to empower patients and families to take responsibility for their disease with weight management, compliance with medication orders, and physician appointments.

Since this program was implemented, officials at medical cooperatives in at least a half dozen cities have expressed interest in duplicating the program, Boissonnault said.

—MG

Continued on page 8

Continued from page 7

calculate eGFR, a user-friendly GFR calculator is available online from the NKF (at www.kidney.org). The cost to labs to create a computer program to calculate eGFR from creatinine is modest, Kaufman says. "It's hundreds or thousands, but not millions of dollars," he adds.

Rising Incidence

One day, diabetes patients will request their eGFR as they currently request high-density lipoprotein (HDL) and low-density lipoprotein (LDL) levels, but that day is not yet at hand. "Patients have such a low awareness of kidney disease that [patients with diabetes] are unlikely to come to their primary care doctors and ask, 'What is my kidney function?'" Vassalotti says. Moreover, primary care physicians spend on average only 16 minutes per visit, according to the October 2007 issue of *Health Services Research*.

Vassalotti acknowledges that primary care clinicians are constrained by the limited amount of time they have to spend with patients with diabetes, but adds that CKD patients and patients with risk factors such as diabetes "should be a physician's highest priority

because they have the highest risk of cardiovascular disease."

A crisis looms if PCPs don't take on the role of evaluating diabetes patients for early CKD diagnosis and treatment. In 2000, 398,000 people were treated with dialysis or transplantation for chronic kidney failure. By 2030, this number is expected to rise to 2 million, according to an article, "Testing for chronic kidney disease: a position statement from the National Kidney Foundation" in the *American Journal of Kidney Disease* (Vassalotti JA, Stevens LA, Levey AS. *Am J Kidney Dis.* 2007 Aug;50(2):169-80). Many of these patients will have developed CKD as a consequence of their diabetes. At the same time, the number of practicing nephrologists is expected to remain stable at 4,000, according to NKF estimates.

The estimated incidence of earlier stages of CKD in American adults was 20 million in 2000 and 26 million in 2007. There are currently no projections for future incidence of CKD, but Vassalotti expects the number will rise. The aging of the U.S. population and the obesity epidemic, coupled with the increasing incidence of diabetes, is like-

ly to increase the numbers of patients with CKD, he says.

Early detection and treatment of CKD in diabetes patients save lives, improve patients' quality of life, reduce the patient burden on nephrologists, and help cut costs.

Cutting Costs

A report by the United States Renal Data System in 2007 said Medicare pays \$68,600 annually to treat a patient on dialysis, or an estimated \$103,000 for a kidney transplant in the first year, and \$17,300 annually thereafter. Controlling diabetes and other chronic conditions that lead to CKD is significantly less expensive, even when the cost of years of medication is considered. In an article, "Slowing the progression of chronic renal failure: economic benefits and patients' perspectives." in the *American Journal of Kidney Disease* (Trivedi HS, Pang MM, Campbell A, Saab P. *Am J Kidney Dis.* 2002 Apr;39(4):721-9), researchers estimated the cost savings at \$18.6 billion over 10 years by postponing the need for dialysis. ■

—Reported and written by Maureen Glabman, in Miami.

LARGER LABS ROUTINELY REPORT eGFR

Labs that conduct the highest number of routine blood tests are more likely than others to report estimated glomerular filtration rate (eGFR), an important measure of kidney function that can identify early kidney disease, according to a survey funded by the National Institute of Diabetes and Digestive and Kidney Diseases, part of the National Institutes of Health. The work is reported in the October 2008 issue of the *American Journal of Kidney Diseases*.

The survey found that more than 86% of the highest-volume independent labs (those in the top 5%) and more than 55% of all labs in the top quarter of high-volume labs report eGFR, compared with only 24% of low-volume labs (those in the bottom quarter). The survey demonstrates room for improvement in making eGFR figures readily available to primary care providers who could be treating early chronic kidney disease (CKD), and possibly reducing their patients' risk for kidney failure, which results in the

need for dialysis or a kidney transplant.

While eGFR reporting is high among high-volume labs, reporting is relatively low overall (38%), particularly by labs in physicians' offices (26%) and low-volume independent labs (39%). On the positive side, the survey found that about 67% of labs that report eGFR do so routinely, without providers needing to ask for the result.

The survey also found that nearly 40% of labs are reporting eGFR values above the cutoff of 60 milliliters per minute per 1.73m² (an estimate of body surface area used to calculate eGFR levels).

The National Kidney Disease Education Program (at www.nkdep.nih.gov) has more information on estimating and reporting GFR and its importance in detection and treatment of CKD.

—MG

Q&A

Can Telehealth Improve Care for Patients with Chronic Illness?



Randy Moore, MD, MBA, is chairman and chief executive officer of American TeleCare, Inc. (ATI), a telehealth technology company. A diplomat of the American Board of Internal Medicine, he has held a variety of clinical, administrative, and teaching positions at the University of Minnesota Medical School. In this interview with Editor-in-Chief Richard L. Reece, MD, Moore shares his perspectives on the role of telehealth in meeting the challenges of managing chronic illnesses such as diabetes.

Q *Dr. Moore, you've written that the costs of chronic illnesses represent one of the biggest threats to health care reform. What do you mean?*

A Chronic illnesses account for about 75% of total U.S. health care expenditures. Looking ahead, the challenge of caring for people with chronic conditions looms large. By 2020, the number of Americans with one or more chronic disease will climb to about 157 million. That is when the shortage of physicians in the United States will reach 200,000 and when the shortage of registered nurses could top 340,000. In addition, the Medicare trust fund could be broke by then.

So we face the prospect of more and more patients with increasingly complex and intense care needs, a shortage of clinicians to care for them, and uncertain funding. If we do not get chronic care management right, we cannot make effective use of resources, and we cannot control costs. For health system reform to succeed, we need to do both of those things.

Q *Seventy-five percent is a huge share of health expenditures. How do we get some focus on the problem of chronic disease?*

A We need to zero in on those patients with the highest burden and complexity of disease and the highest level of risk. Think 5/55. The top 5% of patients with the highest clinical complexity—and often multiple chronic conditions—utilize 55% of all health

“A team that blocks an exacerbation of diabetes today is more effective than a team that must use all the resources of the ER and intensive care to rescue the patient from an advanced deterioration tomorrow.”

Randy Moore, MD, American TeleCare Inc.

care dollars. For this 5/55 group, the right care is routinely delivered too late, or not at all.

This is because health care in the United States has evolved to react to episodic, acute illness and injury. To care for the 5/55 population, we still rely on emergency rooms (ERs), inpa-

tient services, and skilled nursing facilities. We rescue patients after exacerbations of chronic disease. We have not developed the capacity to leverage the expertise of physicians and establish high-value, patient-centered care to proactively manage patients with chronic disease and complex clinical problems.

Ambulatory care remains stubbornly episodic, discontinuous, and disjointed. By default, reactive acute care interventions are required and apply the most expensive expertise and resources to rescue patients after they have become gravely ill.

Q *So how do we ensure that patients with chronic disease receive the care that they need?*

A When patients with chronic disease and complex medical problems have office visits, they can get the routine care they need, and that's important. When their conditions deteriorate and they are admitted to a hospital, they generally have access to the essential expertise and get the care they need—despite the overcrowding seen in most ERs. What's missing? We need to keep 5/55 patients connected to the right clinical expertise in between office visits in order to avert the medical crises that land them first in the

ER and then in the hospital.

Q *That's what you refer to as “consumer-centric care continuums.”*

A Yes. When 5/55 patients get sustained access to the right care delivered with the right expertise and the right resources at the right time, chances are that outcomes will be good

Continued on page 10

Continued from page 9

and costs will be controlled. For that to happen consistently, patients must be at the center of high-value expert care teams that stay connected with them. Patient-centered care connections have to be supported by an ongoing flow of information to monitor patients, track the implementation of their care plans, educate patients and guide their self-care, and support timely clinical decision making.

Q *Is that where telehealth technology comes into play?*

A I have to give you a “yes, but” answer. The right technology is important and necessary, but it is not sufficient. It has to be used to implement new systems of patient-centered, connected care continuums. It must be used to establish and maintain ongoing monitoring of patients at home, timely detection of potential acute events, and prompt intervention by care teams with the requisite knowledge and skill to attain positive clinical, health status, and financial outcomes. We call this solution “advanced care management.”

Q *What are the elements of this approach?*

A A complete solution set includes clinical and operational re-engineering, operations support, clinical management program portfolios, associated business and financial models, and enabling telehealth technology.

For example, for congestive heart failure (CHF) patients and others at

high risk for readmissions, we’re working with integrated health systems, their physicians and their home care divisions to build care teams, re-engineer clinical processes and operational workflow, introduce best practices, and implement telehealth systems that boost and extend clinical team efficiency and effectiveness. This enables the expertise that resides within these health systems to be delivered to patients wherever and whenever they need it, and they are achieving substantial reductions in readmission rates.

Q *How would the approach we’re discussing apply to diabetes?*

A First of all, let’s recognize that health systems and large group practices don’t have the operational capacity, change management capabilities, or resources to do everything we could do for everyone. So shouldn’t we focus first on where we can get the biggest clinical and financial results?

We have to segment the diabetes patient population. Start, for instance, by targeting those whose level of kidney disease puts them at highest risk for kidney failure. We identify the endocrinologists with proven expertise and competence in holding off kidney failure and dialysis: those specialists who understand the nuances of genetic factors and metabolic abnormalities that define Type II diabetes for specific patients. We undertake clinical and operational re-engineering, develop a

clinical management program, and provide operations support—including telehealth—to connect the highest-risk patients with expert-led care teams capable of keeping them out of the hospital and delaying the necessity of dialysis for as long as possible.

The health system saves from \$5,000 to \$10,000 per patient for every month we can delay dialysis. And we give those patients that many more months living with a higher quality of life. With such savings, health systems can reinvest those savings to build up the capacity in primary care to focus on patients at lower risk levels.

Q *Do you mean rather than having a medical home for all patients with diabetes, are you envisioning sort of advanced medical homes for those at highest risk?*

A Yes. The National Coalition on Care Coordination refers to them in this way. It’s the only way medical homes can achieve clinical results big enough to generate net savings.

Q *Can you provide another example of how your model might be used?*

A Sure. Let’s consider transplant care. Transplant surgeons have extraordinary clinical expertise with strong teams built around them. Consider how we might leverage that expertise and extend the teams to provide more high-value, high-impact connected care: a complete pre-transplant care protocol

CEO OFFERS INNOVATIVE APPROACH TO REIMBURSEMENT

Randy Moore, MD, MBA, the chairman and CEO of American TeleCare, Inc. (ATI), has a surprising opinion about reimbursement for telehealth. He believes that to achieve the outcome-improving and cost-controlling benefits of telehealth, we should not pay for it as a stand-alone technology.

Long experience with introducing promising technologies into fee-for-service systems suggests to Moore that reimbursing physician practices that adopt telehealth technology will lead to predictable results. TeleCare pioneered the development and deployment of telehealth-supported solutions.

“If telehealth becomes another covered service to which all

patients are entitled, patients will demand it, and we’ll provide it, and bill for it. Costs will go up,” says Moore. “If we use telehealth to just substitute \$50 video visits for \$100 office visits, a tsunami of demand will wash away potential cost savings.”

Instead, Moore advocates pay-for-performance alternatives that center on patient outcomes. “Rather than paying for the process of providing telehealth as a convenience for all patients, we should pay for the results that it can help achieve with segmented high-risk patient populations for whom it will yield the highest value,” he says.

—RLR

ADVANCED CARE MANAGEMENT ALIGNS WITH N3C SUCCESS FACTORS

In March, the New York Academy of Medicine and the National Coalition on Care Coordination (N3C) assessed the attributes of models of care that have the potential to decrease rates of hospitalization and improve outcomes for Medicare beneficiaries with chronic illnesses. In a report on the assessment, *The Promise of Care Coordination*, the authors identified six critical success factors that distinguish effective care models. The Advance Care Management (ACM) model developed by the medical technology company American TeleCare reflects these elements.

N3C Critical Success Factors	ACM Key Attributes
Targeted care	Care is focused on those patient populations at highest risk
In-person contact	Continuing personal contact with caregivers via televisits supplements and complements home care and office visits
Timely information	Care includes ongoing monitoring of physiological data and patient-reported health status information
Close interaction between PCP and care coordinator	Care teams collaborate
Staffing skills and continuity	Care team expertise is matched to individual patient's needs; continuity of care is maintained in the care team
The services provided include patient assessment, care planning, monitoring, patient education, enabling self-care, medication compliance, and social support	Includes all required services

Source: American TeleCare Inc., Minneapolis, 2009

that coordinates outpatient care. Telehealth-enabled interdisciplinary transplant teams provide ongoing clinical evaluation of people awaiting transplants, which is complementary to the care provided by their primary physicians; maintain their health status; and keep them ready for transplant. Then they provide a post-transplant program for when the patient returns home, to support the patient and the primary care physician. In this way we leverage the expertise of the transplant team and maintain a continuum of connected care, pre- and post-transplant. It makes

sense to have an interdisciplinary care team that knows all about these patients to establish and maintain a continuum of connected care in support of primary care physicians.

Q *What's the real difference between this approach and those that have fallen short?*

A We are on the inside of the care process. We partner with health systems and their physicians to develop care teams and deliver a new level of advanced care management. In contrast to disease management, we're trying to bring expert, physician-led

team care to patients when and where they need it. A team that blocks an exacerbation of diabetes today is much more effective and efficient than a team that must use all the resources of the ER and intensive care to rescue the patient from an advanced deterioration tomorrow.

Q *Payers and health plans have devised special programs to deal with high-cost illness. Why haven't these programs been effective?*

A The inherent problem is in the design of prevailing approaches to managing the 5/55 group. Programs like case management and disease management are applied as supplements to the care process in order to patch gaps in our disjointed health system. They are external and only minimally coordinated with physician practice. They aim to augment and affect the management of patient care from outside the care process itself.

They do not fundamentally change the basic way in which the direct care of 5/55 patients is organized and delivered. We have yet to get deep, lasting change to take root.

Q *What about the medical home concept? Medical homes are designed to change primary care physician practice for patients with chronic disease.*

A The critique of the concept of the medical home in the National Coalition on Care Coordination report seems right on target to me: the medical home is not targeted. The eligibility criteria in the Medicare medical home demonstration project are so broad that participating physician groups will get monthly fees for almost all their Medicare patients.

The concept spreads too few resources too thinly rather than concentrating on the segment of patients at highest risk. And even with the fees, it's unrealistic to expect primary care practices to have the time, capability, and resources to manage and coordinate the care of the most complex patients, especially those with the very highest levels of disease burden. ■

EHR Helps Physician Practice Cut Errors and Delays

Palm Beach Obstetrics & Gynecology, PA, offers an excellent example of a medical group that achieved outstanding success by implementing an electronic health record (EHR) system. As a result of installing an EHR in 2006, the group streamlined workflow, increased revenue, reduced its staffing needs, improved billing and coding, and eliminated a significant amount of overtime.

The group's effort earned it a Davies Award from the Healthcare Information and Management Systems Society (at www.himss.org) last year. The practice has offered routine women's health care services for 15 years. At the time of its award application, it had six providers, working from two offices and four hospitals in Palm Beach, Florida.

Setting Goals

When Palm Beach Obstetrics & Gynecology decided to adopt an EHR, it laid out a number of business objectives that the physicians hoped the new system would help them to achieve. Of major importance on this list were the goals of:

- Eliminating the need to look for charts
- Eliminating errors in reviewing labs and radiology reports
- Reducing delays in obtaining and acting on patients' results
- Eliminating incomplete documenta-

tion for billing

- Making clinical information accessible on nights and weekends
- Improving internal communication.

Other goals included decreasing the need for human resources dealing with medical records, decreasing the amount spent on office supplies, increasing physicians' productivity through connectivity while working at hospitals, and decreasing paper waste.

The staff at Palm Beach determined that implementing the EHR all at once would not work for the practice. Obstetrical responsibilities and ongoing crises made shutting down the entire practice impractical. Likewise, a lengthy decrease in productivity would lead to an extended decrease in revenue that the physicians believed they could ill afford. Instead, management opted for a phased-in approach to implementation.

Selecting a System

The managing partner and the office administrator at Palm Beach were responsible of evaluating and implementing the EHR. After reviewing various systems, they decided to adopt an EHR from Greenway Medical Technologies. Greenway Medical EHR



systems are certified by the Certification Commission for Health Information Technology (CCHIT), whose goal is to set benchmarks for EHR functionality and to approve and rate various products, so that physicians and medical practices will be informed about which EHR systems provide necessary functions and features. "Choosing a certified product was extremely important to us since it meant that the software provides a comprehensive list of features reviewed and certified by an impartial professional organization," the group said in its application for a Davies award.

The Greenway system includes the following features:

- Secure, password-protected access to data

PALM BEACH OB-GYN GROUP'S EHR BRINGS COST SAVINGS

Among the benefits that Palm Beach Obstetrics & Gynecology realized through implementing an electronic health record (EHR) were significant cost savings.

The total investment in the system was \$277,532, including \$70,932 for the purchase and upgrading of hardware, \$82,000 for license fees, and \$15,000 for training, among other costs.

Total savings after implementation were \$126,000 for the year, including \$95,000 in decreased overtime and the elimination of two and one half staff positions; \$31,000 in savings on supplies, printing, and postage. After totaling these savings and adjustments, the practice concluded that the EHR produced a total of \$409,941 in increased income in fiscal 2007.

- Tracking of patients within the practice
- Patient medical histories
- Automatic calculation of level of care provided
- Billing available in real time to check-out and billing departments
- Tools to track visits, ultrasounds, lab work, consultations, and problem lists.

Further, the system can communicate with other computer systems on site and off. It can receive lab and pathology reports and place them in patient charts, and send EHR documents to other providers, hospitals, or insurers. Tablet computers connect wirelessly so that providers can take notes in real time during patient visits. Docking stations were installed in the doctors' offices and nurses' stations, enabling the providers to type notes as needed. Scanning stations enable old paper records to be scanned, along with consent forms and records from other practices. Once scanned, these images can be added to each patient's electronic record.

Staff training began the week before the go-live date. Ten computer terminals were set up, and staff members took a variety of courses, depending on each staff member's individual responsibilities. Training was arranged in such a way that all staff members had time to work with a few patients per day, to keep the practice from having to stop seeing patients. Training materials were available on compact disks and on the Greenway's Web site. During training, the physicians identified super-users within the practice who were proficient enough to help users who were having trouble with the system.

Phasing in an EHR

The EHR went live in April 2006. For the first three months, the staff used only the billing, collections, and scheduling portions of the EHR. Because the billing software Palm Beach had been using before EHR adoption had been becoming increasingly deficient in its capabilities compared with the prac-

tice's needs, the billing functionality of the EHR proved to be the easiest and quickest to implement fully.

In the first phase of implementation, providers decreased their work loads so that they were seeing only three to five patients per half-day. During this phase, all notes made during patient visits were made on the EHR. Billing was still done on paper during this phase, and lab results, hospital records, and radiology reports were reviewed on paper. While adjusting to the EHR, the staff used electronic record keeping causing staff to fall behind after only a few patients and switch back to paper record keeping. The practice scanned certain records and stored them electronically, while paper records filed by physicians still uncomfortable with the EHR continued to be filed in the usual manner.

In the second phase of implementation, all new patients being treated at the practice began to be entered directly into the EHR, without ever being recorded in paper records. There was a two-day period during which trainers worked with staff who were having difficulty making the switch to the EHR. In addition, all lab results, hospital records, and radiology reports were scanned during this time and placed into patients' electronic files.

Challenging Implementation

This part of the implementation was the most challenging aspect of the process. "Practice employees and providers were stressed by the rapid changes," the staff said in its Davies Award application. "In addition, practice revenue dropped due to the decrease in productivity and transient increase in overhead. The initial surge in data entry meant the temporary addition of one employee and an increase in overtime." Because the physicians and staff were at different levels of expertise with the EHR, only about half of all charts were being recorded electronically, requiring many providers to work overtime to complete their patients' notes.

AWARD FOSTERS EHR ADOPTION

The Healthcare Information and Management Systems Society (at www.himss.org) awards the HIMSS Davies Award annually to medical practices that exhibit excellence in the implementation of health information technology in general, and of electronic health record (EHR) systems in particular. Each year the society bestows awards in four categories: public health, organizational, ambulatory, and community health organizations. The applications of practices that have been given the award can be found on the HIMSS Web site, and provide excellent examples of how a wide variety of practices have improved efficiency as a result of implementing EHRs.

—RD

In the third phase of implementation, trainers again spent two days working with the Palm Beach staff. The connections for lab and pathology reports were implemented, reducing the workload of the scanning team. And, providers were encouraged to go live with record keeping and billing.

By November 2006, practice revenue returned to normal levels, and staff were becoming more proficient and comfortable with the EHR. Workflow was running efficiently in all areas. But at this time, about 30% of visits were still recorded in paper charts, creating a confusing and inefficient system.

As a result, management established a deadline of January 2007 for full implementation of the EHR. The creation of the deadline encouraged staff members who were still having difficulty with the new system to seek needed training, and despite a small amount of stress, the final phase of implementation was completed on target and the transition to full EHR utilization occurred smoothly. ■

—Associate Editor Rev DiCerto.

Report Outlines Need for Disability Insurance

A recently released report, *Physician's Guide to Purchasing Disability Insurance*, by Michael Reiman, a financial planner and founder of Reiman Financial in Dallas, contains important advice for physicians. The report is available online (at www.reimanfinancial.com).

An overview of the factors that a physician should consider when shopping for disability coverage, the report begins with a Physicians' Checklist of items to keep in mind when reviewing various plans. It answers a number of important questions, such as these:

- How much disability insurance will a physician need?
- What different contracts are available?
- What levels of coverage should physicians consider?
- What factors can change over time?
- What types of problems can such changes cause?

Filling the Gaps

For physicians seeking to avoid the most common pitfalls, Reiman describes the various benefits and features of disability policies. "A disability policy will pay you a monthly benefit if you become disabled from an illness or an injury depending on what your contract defines as a disability and the exclusions in your contract," the report

says. "The provisions of your contract may depend upon your specialty... For example, surgeons and dermatologists are in different classes. Some classes will not be eligible for certain features and the premium will vary according to the class."

It's important to note that policies vary greatly in terms of how they define a disability, and, depending on the definition, benefits can be reduced or denied.

The report explains the own-occupation definition of total disability. A policy that provides own-occupation coverage will provide benefits if the physician becomes disabled and is unable to perform the duties of his or her specific occupation. Own-occupation policies are more costly than other types of disability insurance. But Reiman states that the added protection is worth the additional expense to the insured, and advises all physicians to seek own-occupation coverage.

Also physicians should purchase policies that provide lifetime benefits, if such policies are available. Lifetime benefits are becoming increasingly difficult to find and policies typically stop providing benefits when the insured reaches the age of 65 or 67. In addition, policies that provide lifetime own-occupation benefits are rarer still, he explains.

"Normal life expectancy extends well beyond age 65," the report says. "If you

were to become disabled early in your career and live to your life expectancy, you would be without benefits for many years if you failed to purchase a lifetime benefit." Only two insurers are offering disability policies with lifetime benefits for physicians, Reiman adds.

Features to Consider

Whenever possible, physicians should seek non-cancelable and guaranteed-renewable policies. As long as the insured continues to pay the premium, the insurer cannot change or cancel such policies, meaning the original provisions and premium-payment schedule of policies like these cannot be altered, he explains. With a non-cancelable and guaranteed-renewable policy, the physician can lock in the provisions and cost of the contract.

One of the most important features of any disability policy is the residual disability rider, which will cover a physician for loss of income, time, and duties due to illness or injury and pay a proportional benefit if the physician becomes partially disabled but can still work. This feature is important because residual disabilities are more common than total disability, Reiman comments. There is much variation in how residual disability is defined and how benefits are calculated.

A recovery benefit is described as

PHYSICIANS SPEAK OUT ON 'MEANINGFUL USE'

In two years, physicians will start getting Medicare and Medicaid incentives for engaging in "meaningful use" of electronic health record (EHR) systems. The question many are asking is what constitutes "meaningful use." In the EHR Meaningful Use Physician Study, Nuance Communications, Inc., of Boston, surveyed more than 1,000 physicians and found that 90% of respondents want

EHRs that allow faster, real-time access to medical records. Also, 83% want more complete patient reports and faster communication with other providers, and 79% want improved documentation based on a point-and-click system. More information on physicians' opinions as surveyed by Nuance is available online (at www.nuance.com/healthcare/ehr-meaningful-use-study/).

one that allows the insured physician to rebuild his or her income after recovering from being disabled. A recovery benefit is paid once the physician returns to full-time work, assuming there has been a continuous loss of income, the report says.

Looking Forward

For residents and fellows, the report suggests that they seek future insurability options. Such options give the insured the ability to increase coverage as his or her income rises. A future insurability option is subject only to financial underwriting, as opposed to medical underwriting. Physicians who qualify financially for these options can purchase additional coverage annually without proof of medical insurability. "This is a key issue as it allows you to lock in your current health status," Reiman explains.

Physicians can protect their disability benefits from inflation by seeking out insurance that includes a cost of living adjustment rider. When a disability is incurred, these riders cause monthly payments to increase to compensate for changes in the cost of living; but the rate at which they change varies depending on a number of factors.

Under certain circumstances, the elimination period (period of time between incurring a disability and the initiation of payments) can be waived. This process is referred to as

presumptive disability. "For example, if the insured lost sight in both eyes or the use of two limbs, then the elimination period would be waived from the date of the loss," the report states. Such provisions vary from one contract to another. Physicians also should seek a recurrent disability provision. Such a provision waives the elimination period when a related disability recurs following recovery from a period of disability, such as a relapse of an illness or a related re-injury of a limb.

Choosing Wisely

Reiman closes the report with a few words on how to make the best decision about disability insurance. He suggests that physicians check the financial ratings of any insurance companies under consideration.

The report lists Weiss Ratings (www.weissratings.com), A.M. Best (www.ambest.com), and Standard and Poor's (www.standardandpoors.com) as reliable sources of ratings and suggests that a rating company should have high marks from at least two of these sources to be worth considering.

When seeking coverage, physicians should not rely on a group policy, because such coverage may not be adequate. These plans often define disability narrowly and have more exclusions and limitations, the report concludes. ■

—Associate Editor Rev DiCerto.

HERE'S HOW TO PROTECT YOUR ONLINE IMAGE

In a recent report, *How Healthcare Providers Can Protect Their Image Online*, the Web site, CheckMD offered physicians advice on how to minimize or counter the effects of negative reviews on social networking Web sites, blogs, and sites that rate providers. CheckMD.com is a Web site for consumers and providers that physicians can use for online marketing, to connect with consumers, and post information about their practices. The site notes that as of June, 61% of adult Americans reported getting advice from online sources, many of which were consumer-oriented rating sites and blogs. Among the suggestions the site offers are these:

- Establish a presence on a review site, maximize that presence, and create an awareness of your presence online by announcing it to patients and the local media
- Avoid being argumentative in any discussion with patients
- Hire a public relations consultant if necessary.

The report is available on the CheckMD site (www.checkmd.com/index.php/researchinformation/research-physician.html).

BOOK ADVISES PROVIDERS TO ENGAGE PHYSICIANS

A new book, *Engaging Physicians: A Manual to Physician Partnership* (Fire Starter Publishing, 2009, ISBN: 978-0-9840794-0-7) provides advice to physicians and managers of health care organizations about how to initiate change in their businesses. "Physician involvement is a proven predictor of success for an organization's change efforts," says Stephen C. Beesom, MD, the author of the book. Beesom presents a comprehensive program designed to build loyalty and avoid adversarial relationships. He also identifies nine stages in the partnership process as follows:

1. Creating and communicating organizational vision and goals
2. Developing accountability for performance
3. Establishing physician confidence and trust
4. Building physician leadership
5. Training physicians
6. Measuring physician performance
7. Implementing physician behavioral standards
8. Managing the disruptive physician, and
9. Recognizing physicians.

DIABETES OPTIONS.net



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

Name: _____

E-mail: _____

DIABETES PRACTICE OPTIONS™

August 2009



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

Provided as a
professional
courtesy by



novo nordisk®