Small Group Implements Award-Winning DM Program

Disease management at Lake City Medical Center has not only resulted in significant improvement in patient outcomes, it has also earned the center an award for excellence from the American Medical Group Association. The four-year-old program in Lake City, Minn., engages the entire staff, from the eight-physician family practice’s president to its receptionists.

“When we started our disease management programs, some doctors and staff said they didn’t have the extra time it would take to ask questions of patients and mark up charts,” says Lori Scanlan-Hanson, the center’s quality and disease management strategies coordinator. “But the changes we’ve implemented spurred better outcomes. We’re successful because the staff sees the effectiveness of what they’re doing, especially when patients come to them and say ‘You saved my life.’”

Illness Prevention

Lake City is part of Mayo Health Systems in Rochester, Minn. The center began its Disease Management Strategies (DMS) program in 1998 after an examination of its records found that physicians were delivering and noting in charts only 50% of the preventive care services recommended for patients. At that time, Lake City physicians began planning to improve that figure, starting with an emphasis on preventive care.

The center’s clinical and support staff were aware of the potential for improved care that disease management can provide, says Scanlan-Hanson, and Mayo encouraged the development of a program by offering data collection software and educational materials. At the same time, the American Academy of Family Physicians in Leawood, Kan., had been urging its members to “participate in developing, implementing, and monitoring disease management programs whenever possible.”

“The heart of DM is preventing disease and intervening early with patients who have chronic conditions, such as asthma, diabetes, or congestive heart failure,” says David C. Kibbe, MD, chairman of Canopy Systems in Chapel Hill, N.C., a DM software company. Kibbe has written for the AAFP about the role of DM in family practice.

A successful DM approach requires “committed physicians, a willing and well-prepared staff, a structured process of change management, an organized approach to analysis, and a well-developed quality improvement system with the patient at the center of the process,” says Kibbe. “Because of their training and practice philosophy, family physicians should be able to implement DM as well as, or better than, anyone else.”

To some degree, the elements Kibbe describes were present at Lake City when Scanlan-Hanson and the center’s physicians began their efforts in 1998. The first step was the formation of a DMS coordination team, which included the clinic’s medical director, another physician, several nurses, and members of the support staff, including receptionists. “Having physician leadership at the table every meeting, leading the change, was critical right from the beginning,” says Scanlan-Hanson.

The first Lake City DMS program addressed tobacco use cessation, modeled on guidelines developed by the
Will Physicians Accept HMOs as Arbiters of Quality?

HMO executives and physicians view health care quality in remarkably dissimilar ways. Managed care executives tend to focus on outpatient care (including which procedures and treatments are necessary and whether physicians and other providers are following practice guidelines), and they want to ensure that physicians take appropriate steps to prevent disease. HMO executives believe the best providers of care are the physicians and hospitals that are cost effective and meet the criteria established by the National Committee for Quality Assurance, an HMO-accrediting organization. Physicians, however, tend not to use cost-effectiveness as a proxy for quality and may even disregard the importance of NCQA quality measures.

Many physicians believe that the best doctors practice in academic medical centers. For its publication, *America’s Top Doctors: The Best in American Medicine* (2nd edition, 2002), Castle Connolly Ltd., asked 250,000 doctors to whom they would refer patients for particular specialty-related problems. After reviewing the professional backgrounds of the 20,112 nominees, Castle Connolly editors and experts selected 4,254 as the nation’s top physicians. More than 90% of finalists were trained at top medical centers, practiced in academia, and were involved in clinical research.

To identify hospitals for “America’s Best Hospitals,” an article in the July 22 issue of *U.S. News and World Report*, editors at the magazine asked 3,060 board-certified specialty physicians to list five hospitals they considered the premier institutions in their specialty. The factors the physicians considered included volume of patients, mortality ratios, ratio of registered nurses to beds, and technologies offered. Most hospitals identified as the best performed a high volume of difficult and risky procedures. Experiences gained through doing a high volume of procedures and treating large numbers of patients with a given disease emerged as the leading indicator of quality.

The hospitals selected as meriting “acclaim for impressive quality and breadth of expertise” by US News were academic medical centers: Johns Hopkins Hospital, Baltimore; Mayo Clinic, Rochester, Minn.; Cleveland Clinic; Massachusetts General Hospital, Boston; UCLA Medical Center, Los Angeles; Duke University Medical Center, Durham, N.C.; University of California, San Francisco Medical Center; University of Michigan Medical Center, Ann Arbor; Barnes-Jewish Hospital, St. Louis; Brigham and Women’s Hospital, Boston; University of Washington Medical Center, Seattle; and New York Presbyterian Hospital, among others.

Until we can all agree on what constitutes the best in health care, physicians are not likely to accept HMOs as the sole arbiters of quality.
Skilled Telephone Staff Offer Groups Cost-Effective Practice Enhancements

With all the emphasis currently being placed on new technology to enhance quality of care and practice efficiency—such as electronic medical records, voice recognition software, and personal digital assistants—physicians may overlook how an “old” technology can benefit their practice. The telephone, when operated by a skilled receptionist, can help to improve the administrative quality of care provided in a practice by enhancing office efficiency and customer satisfaction without increasing costs. What’s more, acknowledging that the telephone receptionist fills an important position within the practice is a good way to retain and motivate qualified and experienced staff.

The pressure on physicians to increase productivity while maintaining quality of care can have a trickle-down effect throughout a practice. “With increasing demands on physicians’ time, staff must assume a greater role as representatives and communicators with patients and referral sources,” says Nancy Latady of Latady & Associates in Bedford, Mass., a strategic marketing consulting firm specializing in practice development. Skillful telephone service enhances overall practice efficiency and helps control costs by streamlining access to information and services, she says.

Saving Time
“Today, telephone receptionists serve what could be called a triage function,” Latady explains. “For example, rather than telling a caller that the doctor is not available or simply promising that the doctor or another staff member will return the call later, a well-informed receptionist can discern the focus of the call and, when possible, immediately connect the caller with the appropriate staff member who can handle the matter.”

Latady also says that by paying close attention to telephone customer service, physician practices can do a better job of retaining current patients and referral sources and attracting new ones. When patients and referral sources have a relationship with a practice, they remain with it and encourage others to join too. “Satisfied patients are the key to bringing in new patients—friends, family, and neighbors—through positive word-of-mouth,” she says. In fact, skilled, professional telephone staff can help a practice distinguish itself from its competitors, and standout practices capture market share, Latady believes. “It’s difficult to assess quality clinical care, but being known as a practice that has friendly, helpful, courteous staff helps to set a practice apart from the competition,” Latady notes.

Managing Expectations
The telephone receptionist also plays a key role in preparing patients for their office visit and in managing their expectations. “When the patient calls to schedule an office visit, the receptionist should explain to the patient what a given procedure will entail, identify any special preparations the patient must make for the visit, and explain how long the appointment and any follow-up results will take,” Latady suggests. “Warning patients about frustrating issues, such as leaving extra time to find a parking space, helps to empower patients by giving them some measure of control over their experience.”

Informing patients through skilled telephone answering techniques also can help to reduce the likelihood of litigation, says Latady. “Many malpractice issues result from a lack of or poor communication with patients, such as when patients are not told what to expect from a particular procedure or are not informed about likely outcomes,” Latady notes. “Giving patients clear and concise information and treating them with kindness and respect can go a long way toward reducing the risk of litigation. In other words, patients generally don’t sue physicians they like.”

Health care consumers are frequently surveyed about how satisfied they are with the quality of care they receive. By paying close attention to telephone customer service, physician practices can retain current patients and referral sources and attract new ones, experts say.

(Continued on page 4)
Surveys Measure Telephone Results

One way to determine the level of telephone skill among your staff is to survey patients’ attitudes, says Nancy Latady of Latady & Associates in Bedford, Mass., a consulting firm specializing in practice development.

“If your practice does patient satisfaction surveys, make sure you include a question about telephone customer service,” Latady adds. A less expensive but also less comprehensive method to assess customer service is for physicians to call their own practice. For such a first-hand assessment of how callers are treated, doctors also can ask a family member or friend, or hire a consultant to serve as a patient. Such assessments can be used to understand what type of impression the practice would leave with a first-time caller.

“Physicians also can enroll staff in telephone customer service training, and then write performance expectations into job descriptions,” Latady adds.

While telephone skills can help improve customer service and increase patient volume, using the telephone properly and triaging patients’ needs appropriately can also help to improve staff morale and retention. “Receptionists tend to come and go, and that can take its toll on a practice,” Latady observes. “If your staff members feel valued and happy, they’ll stay. That’s a plus for patient care.” —LGC

(Continued from page 3)

receive from physicians and other health care providers. Invariably, some of those questions involve the telephone service provided by the physician’s office staff.

Asking Questions
These questions often involve issues such as the following:

- When calling to schedule an appointment, is the line usually busy so that it takes several attempts for calls to be answered?
- If your call is answered promptly, are you forced to listen to a long series of menu options?
- Are you placed on hold for long periods of time before the telephone receptionist handles your call?
- Is the telephone receptionist courteous and helpful?

If the answers to such questions are negative, the health care consumer may be predisposed to be dissatisfied with other aspects of care provided by the physician practice. After all, when it comes to an office visit, the consumer’s interaction with the receptionist over the telephone is usually the first service the physician’s office provides.

In fact, that initial telephone call sets the tone for the patient’s experience with the physician and the practice, according to urologist Neil Baum, MD, a solo practitioner in New Orleans. “The telephone call is the first chance that the practice has to create a good impression,” says Baum.

Baum, an expert on practice management and marketing, has written two books about physician practice operations: Take Charge of Your Medical Practice...Before Someone Else Does It for You: Practical Practice Management for the Managed Care Market (Gaithersburg, Md.: Aspen Publishers, 1996); and Marketing Your Clinical Practice: Ethically, Effectively, Economically (Aspen Publishers, 1991).

Training Staff
Each telephone in Baum’s office has a small mirror attached to it so that staff can see what they look like as they speak on the phone. “The purpose of the mirrors is to encourage staff to smile as they talk to callers because a smile can be ‘heard’ on the other end of the line,” Baum says.

What’s more, Baum believes that good telephone skills help promote good patient relations. Every telephone receiver in his office has a sticker on it that says: “Telephone equals opportunity.” That message is a constant reminder that the telephone provides an opportunity to create a good, positive, first impression, he notes.

With this goal of creating a good first impression in mind, each member of Baum’s staff interacts with callers on the telephone by adhering to the following guidelines:

- Smile and be enthusiastic
- Identify the time of day and identify the practice
- State who you are
- Offer to be of service
- Use the caller’s name.

“Everyone likes to hear their name,” says Baum. “In my office, we try to customize the telephone calls we receive by encouraging our staff to use the caller’s name at least twice during the telephone conversation.”
Do You Need a New Phone System?

Some physician practices send the wrong messages if patients frequently get a busy signal when they call. If this is happening, the practice may need more phone lines. Also, many practices today are using automated telephone features, such as auto attendant, which automatically answers and directs calls to the proper individual, or voice mail.

“If you think you have outgrown your current phone system, call your local phone company and ask for a needs assessment,” says Randall S. Shulkin, vice president of health care management at MedSolve.com, a physician practice consultant in Norwalk, Conn. “It can tell you how many calls the practice is missing because of busy signals.”

The phone company also will provide details on the volume of calls the practice receives and the duration of calls. This information can help physicians determine how many lines are needed and what kind of phone system to use.

“The next step is to sit down with your staff and solicit their input, and observe how staff members handle calls,” Shulkin recommends. Physicians will want to know if new telephone features help receptionists make better use of their time. Practices may want to consider individual voice mail boxes for each physician, a box where patients can leave a message for prescription refills, or a box that patients can access, with an assigned and secure identification number, for recent test results.

When evaluating needs, consider adding enough modem lines so that faxes can be sent via computer, which can save staff time. Preformatted form letters and memos can be faxed directly from word processing programs, also reducing staff time and increasing the professional presentation. Take into account increasing demands for e-mail and Internet research. Try to think ahead by planning for future telephone needs.

“You want to buy a system that is going to serve you for the next five to 10 years,” says Shulkin. “You also want to be certain that the system you purchase allows for service, training, and ongoing education.”

One important suggestion: “If your practice does use an auto attendant to answer the phone, give callers the immediate choice to press ‘0’ or ‘star’ to speak to a real person in the event of a medical emergency,” says Shulkin. “Don’t make the emergency option last in a long list of choices.”

—LGC

In addition, the staff in Baum’s office is trained to give patients clear, concise directions to the practice, and they have information on Baum’s credentials and areas of interest and expertise so that they can answer any frequently asked questions. “For example, if a patient calls with a specific urological problem, particularly if it is in my area of expertise, my staff offers to send copies of journal articles I have published on the subject and directs the patient to our Web site if he or she has Internet access,” Baum explains.

Increasing Motivation

Skilled, knowledgeable telephone receptionists play an important—but sometimes overlooked—role in a practice. “Telephone receptionists are a key link in a practice’s chain of service,” says Suzanne O’Connor, RN, MS. “Practices have to respect the importance of the job and its difficulty. If patients are frustrated or angry, it is the telephone receptionists who hear their complaints; if patients are satisfied and pleased, it is the doctor who gets the accolades.” O’Connor is president of Health Care Satisfaction a consulting firm in Andover, Mass., that specializes in providing telephone training and interpersonal skill building to increase patient and staff satisfaction.

Like Baum, O’Connor believes that practices should value their telephone receptionists and acknowledge their contributions to the practice. “The callers the receptionists are servicing are not customers calling to order an item from a mail-order catalog,” O’Connor explains. “They are often patients who are ill, who are in pain, or who are frightened. Any one of these factors can make a person feel angry or upset. It takes skill and training to handle these types of callers successfully, and physicians who have such staff also have a valuable asset.”

Baum agrees, saying, “I tell the staff who answer the phones in my office that they are the most important people in the practice because they have a chance to make or break the attitudes of patients toward the practice. I emphasize this point at staff meetings, at performance reviews, and at any other opportunity I have to interact with them about the importance of the telephone.”

—Reported and written by Lisa Gilson Clancy, in Hopkinton, N.H. Additional reporting and editing by Paula Grant, in Lincoln, Va. More information on quality improvement is available on our Web site (see page 16).
This question is one of many posed in the Visible Fairness Project, an 18-month study sponsored by Sacramento Healthcare Decisions, a nonprofit organization in Rancho Cordova, Calif., that seeks to increase public participation in improving health care policy and practice. A report about the project, Cost-Effectiveness as a Criterion for Medical and Coverage Decisions: Understanding and Responding to Community Perspectives, is available online (at www.sachealthdecisions.org).

Seeking Fairness

For the report, researchers considered the role of all participants in health care, including physicians and other providers, purchasers, consumers, and the media. The report makes recommendations on how these parties can work together to respond openly and realistically to the tension that exists between what consumers want from health care and what purchasers are willing to spend. The researchers’ aim was to understand and respond to one specific dimension of the cost equation: the role of cost-effectiveness as a criterion in treatment and coverage decisions, says Marjorie Ginsburg, the organization’s executive director.

The researchers attempted to answer these questions: What constitutes a beneficial intervention and who decides? How much better must an intervention work to be considered meaningful? And, how much is too high a cost relative to the benefit?

For the project, the researchers sought to:
1. Determine how physicians perceive and implement cost-benefit trade-offs and how they communicate them to patients
2. Identify the principles, values, and processes that consumers believe are most important for physicians and other providers to consider when comparing different treatment costs and benefits
3. Increase the visibility of cost-benefit dilemmas through the mass media and in professional and consumer publications
4. Prepare recommendations, based on consumer and physician perspectives, on how cost-effectiveness issues can be addressed
5. Demonstrate a model for integrating consumer and physician views based on constructive collaboration

With these objectives in mind, Visible Fairness held discussions with physicians and consumers and conducted surveys to gather information about what each side views as the most important issues related to cost-effectiveness. A group of physicians from different specialties helped to develop a questionnaire that was sent to 1,000 physicians, and 52% responded.

The results of the survey show that although physicians support the use of cost-effectiveness in principle, there was no consensus about how to apply it in practice. The responding physicians said societal pressures and patient expectations were the biggest barriers to practicing cost-effective medicine. The frequency with which patients insist on care that is not cost-effective varies considerably, and physicians differ in their responses when it happens, the respondents said. They also voiced a high level of support for evidence-based practice guidelines to help them make decisions about cost-effective care.

To gather opinions from consumers, the researchers held a series of small group discussions with Sacramento-area residents. The groups discussed various issues in health care, such as how physicians make decisions at the bedside, the use of practice guidelines, and population-based coverage decisions.

Many of the participating consumers accepted cost-effectiveness as a reasonable criterion but most had trouble balancing the roles of the consumer wanting the best care possible and their own concern about the rising cost of care. Many of the consumers believed that the patient and
doctor should be partners in decision-making about treatment choices and that consumers need to take more responsibility in their role as health care recipients.

After reviewing the responses from physicians and consumers, the researchers concluded that, generally, cost-effective care is determined by the patient’s knowledge and understanding of the complexities of care and the physician’s ability to communicate effectively and sensitively. When comparing the responses from the two groups, the researchers found some degree of agreement on several key issues. For example, the physicians and consumers said they understand and accept the benefits of managing costs; view guidelines as helpful to the care process; and believe that cost-related discussions should not occur between physician and patient. “The reality is that both physicians and consumers don’t want to talk about money at the bedside. It’s about care. Bridging this dynamic within a cost-effective practice is tough.”

—Marjorie Ginsburg, Sacramento Healthcare Decisions

Coverage Details
Conversely, patients and physicians disagreed about the role of third parties that issue coverage denials. Physicians viewed some third-party health plan denials as useful in preventing treating physicians from having to say “no,” thereby ensuring their role as a patient’s advocate. Consumers, however, believe that health plans should not override a physician’s decision, nor should they pressure doctors to say “no.”

The results of the physician survey and the discussions with consumers indicate that both groups have adapted well to the unprecedented levels of change in health care. In general, consumers today seem to understand the complex issues related to cost containment in health care. “Consumers are more ready for managed care than we think,” says Ginsburg. “They feel strongly about these issues and do not want their options limited.”

After weighing the issues from the consumers’ and physicians’ perspectives, the researchers developed six strategies for participants in the health care system: physician organizations, health plans and insurers, employers and purchasing cooperatives, consumer organizations and the media, researchers and other non-aligned groups, and stakeholders working collaboratively.

Physician organizations should improve communication with patients, incorporate consumer concerns within care processes, and explore the value of cost-effectiveness in medical practices, the researchers say. What’s more, physicians should develop some criteria they can use to assess cost-effectiveness, and they should not simply “blame the health plan” when treatment is denied.

Health plans and insurers should provide ample information about the plan’s decisionmaking processes, assess physician use of clinical guidelines, bring members into the decisionmaking process more effectively, and make clinical guidelines compatible with consumers’ priorities, the researchers say.

Educate and Collaborate
Employers and purchasers should educate employees about the issues related to cost-effectiveness and let employees get involved in choosing health plans.

The media should provide objective information, encourage open debate, and address consumer responsibility.

Researchers, philanthropic foundations, and other nonaligned groups should continue to pursue research on health policy and clinical effectiveness, and produce journals and conferences on cost-effectiveness in health care.

Stakeholders working collaboratively should seek to foster systemwide cost-effectiveness by encouraging a broad range of standards, including developing consistent messages for consumers, promoting a unified approach to quality measurement, and reporting and collaborating on new models of health care coverage.

At the heart of Visible Fairness Project is the emphasis on collaboration and consumer involvement in reducing health care costs, a task that Ginsburg acknowledges can be difficult. “The main thing we have learned from this project is that there isn’t one single answer,” she comments. “There’s nothing so clean as to say, ‘If we could fix this, then the rest would fall into place.’ It doesn’t work like that. You have to work on one sphere of influence at a time to create change.”

—Reported and written by Felicity John Odell in San Francisco. More information on quality improvement is available on our Web site (see page 16).
Database Allows Independent Study

Rheumatologists and their patients could benefit from the compilation of long-term data in a national registry that could be used to analyze the outcomes of various drug therapies. A new organization, called the Consortium of Rheumatology Researchers of North America, in Albany, N.Y., is developing such a database to collect data on comparative treatments and outcomes.

CORRONA includes a group of experienced clinical investigators who are in community practices and academic medical centers nationwide. “Our goal is to create and sustain the best clinical database on patients with rheumatic diseases in the world,” says Joel M. Kremer, MD, a rheumatologist with the Center for Rheumatology in Albany and president of CORRONA.

Disease Evolution
The database includes data on patients with rheumatoid arthritis, psoriatic arthritis, osteoarthritis, and osteoporosis. Data are collected on patients with rheumatoid arthritis every three months; on the other patients, data are collected every six months. “This ongoing data collection will enable participants to see how these diseases are evolving options—make a national database such as CORRONA particularly important. “Before CORRONA, there was no national database that could be used to collect drug safety and efficacy data in a prospective manner on all the drug therapies in use,” Kremer notes. “The postmarketing surveillance executed by an individual pharmaceutical company is limited to its own product.”

Furthermore, because postmarketing surveillance depends heavily on voluntary reports by physicians, information on the safety and efficacy of drugs in widespread use is incomplete. “In the drug approval process, the U.S. Food and Drug Administration typically looks at the experience of a few hundred patients on a therapy,” says David Ridley, MD, a rheumatologist with St. Paul Rheumatology in St. Paul, Minn. “After the FDA gives methotrexate,” says Ridley, who, along with his partner in St. Paul Rheumatology, participates in the CORRONA data collection effort. “Now there are a number of alternative therapies, some that may be better than others. We will get a lot more information about their safety and efficacy if we can analyze data from a cohort of 50,000 patients with various levels of disease activity than we can from an individual drug study involving less than 1,000 patients.”

Enrollment in the data collection effort is ongoing; Kremer hopes to have 40 sites enrolled by late fall. “It will take a while before the database is large enough to inform large studies,” he says. “But by the end of the year, we will have a very respectable database.” This spring, more than 1,000 patients were included in it.

CORRONA includes long-term data gathered from both patients and physicians. To foster the collection of data, the project provides monetary and other incentives. Physicians are paid for each form they complete, and they receive electronic data summaries on their patients, which they can use to pursue their own analyses.

“Other databases covering rheumatic diseases include data input primarily from patients,” Kremer says. “We wanted to create a data collection process that is user friendly for both the physicians and the patients. We also wanted to provide incentives to the rheumatologists such that they would want to participate and would continue to participate over time.”

“Before CORRONA, there was no national database that could be used to collect drug safety and efficacy data in a prospective manner on all the drug therapies in use.”
—Joel M. Kremer, MD, CORRONA

around the country in real time,” says Kremer. “We will be able to determine numerous outcomes, such as drug toxicities, hospitalization rates, adverse event rates, and comparative lab values.”

Particular aspects of the rheumatology specialty—including complex diseases and a variety of treatment options—are not suitable for a national database such as CORRONA. “We did a statement as to the drug’s safety and efficacy, no formal effort is made to find out whether that drug is truly safe and efficacious in practice.”

More formal collection of drug performance data is needed given the number of new rheumatology therapies developed in recent years. “Until five years ago, all we had was a statement as to the drug’s safety and efficacy, no formal effort is made to find out whether that drug is truly safe and efficacious in practice.”

(Continued on page 9)
The difficulty has always been convincing them that it was worthwhile to spend time collecting data.”

**Improving Care**

Participating rheumatologists are contributing to the understanding of rheumatic diseases. Also, by completing the data collection forms, they can provide a better level of care to patients, says Kremer. “The data collection forms are thorough and inclusive; in fact, they supply the rheumatologists with all the information they need moving forward in the treatment of their patients,” he adds. “Collecting these data is good for patient care, particularly for patients who have complex diseases and are on a number of different drug therapies.”

The form is efficient, user friendly, and streamlined, Kremer explains. “The CORRONA sponsors spent a lot of time developing the form,” he says. “It is very important for the doctors to have a form that works well, that they can complete efficiently, and that gives them a sense that they are doing something that is worthwhile for their patients. These qualities make the form a useful tool for rheumatologists aside from the fact that it is contributing to a database. The form sells itself because rheumatologists recognize that using it is an efficient way to collect and summarize data about their patients and it enables them to get a much better understanding of the evolution of multiple simultaneous events in complex patients.”

The form collects the patient’s diagnosis, the rheumatologist’s estimation of the severity of the disease, and the disease activity. For patients with rheumatoid arthritis, the form asks for a 28 joint count. “This count is essentially from the shoulders to the knees,” explains Kremer. “Experienced rheumatologists are able to do it very quickly.”

The form also asks the rheumatologist to indicate with “yes” or “no” if a patient has been hospitalized, has developed a comorbidity, or has had a new x-ray or bone densitometry scan, and whether the rheumatologist has ordered new laboratory tests. “If the answer is no to all of these items, the form is complete,” Kremer says. “If the answer is yes, the rheumatologist provides further information by, for example, indicating the outcome of the lab tests.”

The form includes a modified version of the Health Assessment Questionnaire (HAQ) and the Short Form 36 (SF-36), questionnaires completed by patients that yield data on functional ability and quality of life. “These data are used to judge long-term effectiveness of drug therapy.”

“Some patients may seem to be managing well based on the data from their x-rays and joint exams, but they may be significantly deteriorating on their disability questionnaire, indicating that their therapy may need to be adjusted. This additional information helps to enable me to offer better care to each patient.”

—David Ridley, MD, St. Paul Rheumatology

The form collects the patient’s disability questionnaire, indicating that their therapy may need to be adjusted. This additional information helps to enable me to offer better care to each patient.”

—David Ridley, MD, St. Paul Rheumatology

form helps both me and my patient focus our visit,” he explains. “As a result, the visit is more appropriate and more efficient because we are directly addressing the patient’s problem instead of peripheral issues that may not be related to the patient’s condition. The form is particularly helpful in treating patients who tend to be diffuse in their questions.”

After completing the form, the rheumatologists fax it to CORRONA’s central database. All the data submitted by the rheumatologists are sent back to them via computer.

(Continued on page 12)
The heart of DM is preventing disease and intervening early with patients who have chronic conditions, such as asthma, diabetes, or congestive heart failure.”

—David C. Kibbe, MD, Canopy Systems

Promoting Improvements

Lake City’s DMS interventions begin with a flowsheet, prepared by a medical center receptionist the afternoon before a patient’s scheduled appointment. The sheet prompts physicians and nurses to complete the necessary preventive care services. Notations are made on the form, which is displayed in the patient’s chart. The flowsheets are frequently revised to make them as uncomplicated as possible, says Kim Anderson, communications coordinator and a member of the DMS team.

The DMS program also includes pressure monitoring; scheduled tetanus, influenza, and pneumonia inoculations; lipid, colon cancer, and cervical cancer screenings; mammograms; and hemoglobin A1c blood sugar level monitoring. It continues to use ICSI guidelines. “We also developed our own processes and forms, and expanded and adjusted them after learning what worked as we went along,” Scanlan-Hanson explains.

Recognizing the value of the center’s DM programs, and particularly a depression management program, the AMGA in Alexandria, Va., named the center a 2002 Acclaim Award honoree, which includes a $10,000 educational grant. “This program is an example of what can be accomplished by a small medical group committed to improving the overall health of its patients,” says David Fisher, AMGA president. “Disease management is a proven effective means of improving outcomes.”

Depression Checklist

The PHQ-9 is a checklist for nine symptoms. It asks questions related to how often a patient has been bothered by feelings of hopelessness or failure, suicidal thoughts, or other symptoms of depression. It also asks how difficult these problems make it for the patient to work, do chores at home, or get along with others.

Next, the patient’s physician addresses the issue of depression, usually by prescribing an antidepressant and sometimes referring the patient to a therapist. To monitor patients’ progress, the center maintains a registry of depressed patients.

Since its implementation, the DMS team tracked symptoms in 170 patients in the depression registry and measured improvements over six-month periods. “Patients enrolled in the registry were more likely to show improvement in symptoms compared to a control population,” says Scanlan-Hanson. She monitored patients’ charts each month and compiled reports at three months and six months. After six months, more than 50% of the patients in the registry demonstrated a reduction in depression symptoms, as measured with the PHQ-9.

Another program on depression was developed by Witt and went even further than the DMS screening and produced better results. In this second program, Witt and other staff distributed educational materials related to antidepressant medications and a self-management program that contained individual goals set by the patient and Witt. The educational materials explained what patients could expect...
from their medication and a time-frame for anticipating relief.

“Usually physicians would give patients their medications and briefly describe what to expect, then tell them to call if they experienced any problems or weren’t feeling better,” says Witt. “I would go over the materials with the patient and schedule a follow-up appointment to see how things were going.”

At the follow-up appointment, usually two weeks after the initial appointment, Witt and the patient would discuss self-management goals. “We would discuss getting more exercise, perhaps taking some time away from the job or family, whatever the patient thought might help relieve the depression,” he says.

The DMS team tracked Witt’s patients and determined that a higher percentage of patients improved within a single year than patients seeing the other five physicians. “Among the patients in Dr. Witt’s program—about 60 patients—some 82% experienced symptom relief,” says Scanlan-Hanson. “We sent those numbers to the Institute for Healthcare Improvement’s national collaborative breakthrough program and then decided to expand the program to the entire registry, which we’re doing this year.”

Data Reporting

IHI, based in Boston, uses information gathered from medical groups throughout the country as part of its health care improvement collaborative program. Data is disseminated by IHI, which encourages participants to communicate and share their experiences.

In addition to expanding depression management, Lake City is planning to implement diabetes management, with an emphasis on weight management. “We’re using ICSI guidelines to consider an expansion of our diabetes treatment programs through an intensive chronic care model,” says Scanlan-Hanson. “Our pilot weight management groups will be patients with diabetes. Through this effort we’ll learn about weight reduction incentives; the proper use of group patient visits; and how to integrate the options of weight checks, glucose monitoring, and the reinforcement of diabetic behavioral management.”

While adding programs on depression and weight management, the center also is working to inform area residents about its preventive care programs. “When we go to discuss health care within our community, we have preventive health materials to hand out,” says Scanlan-Hanson. “If it’s flu season, we discuss the importance and availability of flu shots. We also discuss important public health issues, such as antibiotic resistance, and encourage people to use our walk-in clinic.”

In January 2000, Lake City Medical Center opened a walk-in preventive care clinic that provides free blood pressure, blood sugar, and cholesterol level screenings. It also provides immunizations to students for $10. A registered nurse runs the clinic and sees about 60 patients a month even though the clinic is open only two days a month.

“The walk-in clinic has proven to be one of our most important preventive care initiatives,” Scanlan-Hanson explains. “Patients who historically resist going to the doctor, particularly older men, will come to the clinic, maybe because it’s free and it doesn’t involve a complete physical. Then, if we discover something, like a high cholesterol level, they’re usually willing to come back for a regular visit. Also, if we do determine they have high cholesterol, Medicare or Medicaid will cover treatment.”

Quality Checks

The nurse in the clinic affixes stickers to patients’ charts so physicians can track immunizations and other treatments provided there. “This simple tool, no more than sheets of self-sticking labels with places to fill in dates and immunization lot numbers, is a way to disseminate information and track the number of total shots given.”

“The entire medical staff meets to review quality data. Team members and other staff receive compensation for time spent attending meetings and training sessions. Everyone is rewarded in one way or another.”

—Lori Scanlan-Hanson, Lake City Medical Center

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on quality improvement is available on our Web site (see page 16).
Optimizing Care

A rheumatologist can also group his or her patients by diagnosis or by treatment to determine patterns in care. “Group practices can compare their improvement in disability among similar patients on different DMARDs,” suggests Kremer. “The analysis would reveal the difference in disability among similar patients on various DMARDs.”

Similarly, rheumatologists could also compare x-ray data, lab values, the incidence of opportunistic infections, and liver enzyme abnormalities among patients on different DMARDs or DMARD combinations. Then, if necessary, they could change their practice patterns or the drugs they prescribe based on these data.

“There are so many potential combinations of clinical data that can be analyzed using CORRONA,” asserts Kremer. “The database allows us to go beyond the realm of anecdotal impressions—the art of medicine that we all currently rely on. Rheumatologists are limited only by their imaginations in developing different analyses. Any academic or epidemiological interest in rheumatic diseases can be pursued using this database.”

“CORRONA is more than just descriptive; rheumatologists can also actually interact with the database to create their own analyses.”

—Joel M. Kremer, MD, CORRONA

Advancing Science

Another value of the database is that it will allow researchers to advance the science of rheumatology. “When we aggregate all the data centrally within CORRONA, the database sponsors will then use those data to create abstracts and manuscripts on issues that are relevant to the clinical care of patients with rheumatic diseases,” says Kremer.

In addition, pharmaceutical companies will be able to lease access to the data for studies. “Pharmaceutical companies would be able to have access to data that are processed by CORRONA’s full-time biostatistician; they would never access the raw data,” Kremer explains.

To illustrate: A pharmaceutical company may pose a question, which is then analyzed and answered by the biostatistician. “Then, if the company wants to create an abstract or go public in any domain within the database it has mined from the database, it has to supply the information it wishes to publicize to our biostatistician, who checks it for accuracy,” says Kremer. “Only after approval can the pharmaceutical company publicly state that the CORRONA data reveal a certain finding.”

By leasing access to the database, CORRONA sponsors hope to realize sufficient revenue to fund comparative studies of different DMARDs. “Such comparative studies are currently difficult to execute, given that drugs are owned by different pharmaceutical companies, which fund most drug therapy research,” Kremer notes. “Typically, it is not on the agenda of a particular pharmaceutical company to compare its branded product with a competitor’s branded product.”

The CORRONA sponsors are also interested in funding trials of combination therapies. “These types of independent comparative drug studies could inform optimal drug therapy decisions and would be in the best interest of patients with rheumatoid arthritis,” Kremer concludes.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. For information on participating in the CORRONA database, readers may contact Kremer by e-mail at jkremer@joint-docs.com or call Kim Hinkle, CORRONA project coordinator, at 518/533-1326. More information on disease management is available on our Web site (see page 16).
Solo Physician Finds Success
Balancing High Tech, High Touch

James Dykes, MD, is a family practice physician in Durham, N.C. He attended Duke University Medical School and completed a three-year family practice residency with the Mountain Area Health Education Center in Asheville, N.C. This interview is one of a series by Editor in Chief Richard L. Reece, MD, on issues confronting physicians in private practice.

**Q:** Why did you decide to become a solo practitioner?

**A:** When I started practicing medicine, I worked with the National Health Service Corps in an underserved area of North Carolina, which included two years of working as the doctor on Ocracoke Island off the coast of North Carolina. About 600 residents inhabit the island year-round, but in the summer the population swells to almost 3,000. Being the only doctor there, I got a great sense of what it is like to be an old-fashioned, solo community doctor. I liked it.

**Q:** What kind of practice are you now trying to achieve?

**A:** I am interested in having a traditional family practice that makes time for the patients it serves. The basic principles of my practice are to serve the patient with both my head and my heart, that listening is a fundamental requirement for good patient care, and that I should therefore allow adequate time for listening carefully. I view patients as equals who have a right to participate as full partners in medical decisionmaking.

I’ve learned to schedule an average of 10 patients a day and to give each patient as much time as he or she needs. Rather than having several examination rooms occupied, I focus on only one patient at a time. This strategy allows me to give each person my full attention. I escort each patient to the examination room and back to the reception area when our visit is complete. Since I do not work with a nurse, I also obtain vital signs and draw blood. This personal style of care is very satisfying and seems to be appreciated by my patients.

**Q:** How can you make your practice economically successful by seeing only 10 patients a day?

**A:** By managing overhead! When I started my practice, I did not want to go into debt. I used about $10,000 in savings to purchase new medical equipment and office furnishings for a very small office. My building was only 850 square feet: just room enough for two exam rooms, secretarial space, a waiting area, and a bathroom. For the first nine months, I did not hire support staff. My wife volunteered as a part-time receptionist. I still work with only one office assistant. Debt and office overhead often pressure physicians to see more patients and to push themselves harder. I started small and debt free and just let the practice build in a natural way.

**Q:** One trend today is toward boutique, luxury, and concierge practices, in which doctors ask for an annual fee per patient and in return provide their undivided attention to their patients. But yours is not that type of practice, is it?

**A:** No. I have no annual fee. My practice is purely fee for service. But I am aware of the trend toward boutique practices, and I certainly understand why these practices are growing. Physicians are frustrated and want to spend more time with their patients. They want to have a sense that they are doing high-quality work. Physicians also have a tremendous desire to be independent of managed care and insurers that are threatening their autonomy and quality care. Patients are also frustrated because they want more of the doctor's attention.

**Q:** How do you handle managed care and Medicare patients?

**A:** I have never participated in managed care. The role of gatekeeper does not fit with my values and ethics as a physician. I believe that it is my job to serve the patient. As a gatekeeper, it seems that my job would be to serve the insurance companies. Furthermore, I do not believe that a gatekeeper system is the best way to save medical costs.

(Continued on page 14)
Rather, I believe that cost reduction is best accomplished by forming trusting relationships with patients. I have patients who have managed care insurance through their workplace, which they view as a safety net. However, they are willing to see me out of network because of the relationship that we have formed and value.

I participated in Medicare until February of this year, when I decided to opt out. It was beginning to feel too much like managed care. I’m still waiting to see just how that decision affects my practice.

**Q:** What benefits do you derive from using computers in your practice?

**A:** Family physicians need to be able to access up-to-date information both for day-to-day patient care and to provide handouts for patient education and guidance. Medical knowledge is changing quickly, and our understanding of the ways in which natural and complementary therapies figure into health care is evolving. As a result, I wanted a computer in my office to access the Internet and the resources available there. I have also found that an important but time-consuming aspect of a medical practice is creating progress notes and medical records. I was eager to find a way of keeping my notes that would be efficient, enjoyable, and organized.

**Q:** You spend at least an hour with each patient, and conduct a lengthy interview to get to know them better. You have also implemented electronic medical records. Do you find those two approaches compatible?

**A:** Absolutely. The electronic medical record is just another tool to serve the patient better. It helps me document the office visit quickly and get prescriptions and reports done efficiently. It organizes information more effectively. All of the benefits serve the patient’s needs.

Combining high tech with high touch has made my practice more fun. I have found that whenever I take care of my own needs (for example, by introducing some enhancement into my practice that makes work more enjoyable), I’m more interested in my work, happier to be at the office, and more emotionally available to my patients.

**Q:** How did you implement an EMR in less than six months?

**A:** I give special thanks to Ken Kawamoto, a medical student at Duke University who devoted many hours to this project. His enthusiasm was the catalyst I needed.

We looked at the natural flow of my practice and built the technology around the pattern we saw. I normally do the patient interview in my private office and then do a physical exam in the exam room. The patient and I then return to my office to summarize findings and outline a treatment plan. As Ken and I looked at that workflow, it became clear that I would need a computer with Internet access on my desk and a smaller, portable computer in the examination room. There has been a computer in the front office for billing, accounting, and scheduling for some time. But because phone messages are handled in the front office and I wanted the messages forwarded to me in a timely, paperless way, the three computers needed to be networked together.

As a result, the network we put together is simple and straightforward. I purchased the hardware through local computer vendors and mail order. Ken and I initially put the system together, but as it turned out, we needed some outside technical assistance to complete the project.

**Q:** What was the cost of this new EMR system?

**A:** We set up this system for less than $10,000, the hardware and software combined. The hardware includes two desktop computers, a flat screen monitor (the only thing that is visible on the desk in my private office), a small laptop computer with a docking station that is connected to the network through a wireless card, and a router. I chose electronic medical record software called SOAPware from Docs Inc., in Springdale, Ark., which was relatively easy to install and learn. It is also very affordable, and not too costly to buy phone and e-mail support for a year. It’s also easily customized, and the upgrades come quarterly. The system suits my needs perfectly.

**Q:** Do you plan to incorporate other new technologies?

**A:** I’m interested in all new technologies that can make my practice more efficient and fun. For example, I have a handheld computer that I have been using for years. I’m fascinated with how these technologies can support patient care. However, as a solo practitioner whose income is calculated after overhead is subtracted, I will always have to pay attention to the cost.

**Q:** Do you plan to communicate with patients by e-mail?

**A:** Yes. I already use e-mail in my practice. It is convenient and avoids the “phone tag” phenomenon.
I’ve found e-mail to be particularly helpful for mailing information to patients regarding their health, and I’ve also found on the Web several sources for excellent patient handouts, such as www.OneMedicine.com. For instance, I recommended to a patient whose liver enzymes were slightly elevated that she begin taking some milk thistle extract. Since she had some questions about the supplement, I got her an excellent handout regarding milk thistle’s benefits and usage. Though I have not yet begun doing e-mail consultations for a fee, I think it could be a valuable service for my patients. I am exploring this possibility.

Q: Do you have any ancillary sources of revenue, such as a laboratory or an x-ray machine?
A: I have an office lab so that I can do urine analyses, hemocrits, and other work. That’s about it. We send most of our diagnostic lab work to a local reference laboratory.

Q: How do you attract new patients and market your services?
A: My practice has primarily grown through word-of-mouth referrals. Patients, who are happy with the care they received, refer their friends and family. My practice has grown naturally in this way.

Q: Do you think that the current sharply rising health care costs will have an impact on your practice, since you aren’t involved in managed care and no longer accept Medicare patients?
A: Yes, undoubtedly these forces are and will impact my practice. Even though I have not participated in managed care plans, they now dominate the insurance market and all physician practices are affected by them. When I started my practice in 1987, more than 75% of practices were fee for service. Now that percentage has dropped to 7%. The number of patients who can afford to pay for health insurance that allows physician choice seems to be dwindling. Also, insurance policies are paying less and less for the physician services of “nonparticipating” physicians. Managed care has failed to bring down the costs of health care, but it has succeeded in alienating doctors and patients.

I certainly hope we will see a change in my lifetime. Listening to patients is cost effective and will reduce the costs of health care. But it takes time to listen. We have to have a medical system that places value on that face-to-face time and will pay for it.

Q: What are your thoughts on the need for health care reform? What about universal coverage?
A: We have never been in greater need of reform or universal care. I would love to see a health care system that allows patients to choose their doctors and creates a climate in which doctors can once again have the time to know their patients well. Trusting partnerships are necessary for healing. Kindness is essential. Wouldn’t it be wonderful to envision a health care system that was founded on these values and was available to everyone? I believe a system of self-directed, tax-deferred medical savings accounts might be the best way to pay for such a system.

Q: You graduated from Duke and you practice almost in the shadow of the school. How does that environment influence your practice?
A: It influences my practice in a very favorable way. I received an invaluable medical education from Duke and continue to benefit from its proximity. For example, I have the opportunity to teach the Duke medical students who rotate through my office. They are a joy to work with, and seem to be very hungry to see a style of medicine that emphasizes high touch and high tech. They see a doctor who is happy, who laughs a lot, who hugs his patients and gets hugs from them, and who acknowledges that he does not know all the answers. Answers are less important really, than listening.

My students know—and we all know—how important listening is. But my students see how deeply it changes the doctor-patient encounter such that, in some sense, healing begins right in the room. There’s something about listening that is miraculous. In part, I learned that as a Duke medical student. It’s nice to have the opportunity to pass it on.

Q: How has your practice lifestyle affected your personal lifestyle?
A: I am pleasantly surprised about the personal and professional successes I have had with this simple practice at a time when many doctors are feeling so discouraged and burned out and are working harder to make ends meet.

As a physician, I need to take care of myself and keep my life in balance in order to serve my patients well. “As a physician, I need to take care of myself and keep my life in balance in order to serve my patients well.”

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As a physician, I need to take care of myself and keep my life in balance in order to serve my patients well. If we push ourselves too hard, we may push our staffs and our patients too hard as well. By creating time to relax and retreat, I’m just happier. I have created a level of prosperity that is not just financial; it is emotional and spiritual as well.

—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).
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