

What Makes a 5-star Practice?

Chapter FastFACTS

- 1. A 5-star practice delivers evidence-based patient care; has a smooth-running, profitable operation; uses the latest technology; maximizes teamwork; communicates a caring attitude; and is patient centered.**
- 2. Having others verify your practice's excellence (e.g., through recertifications or NCQA recognition) is one way to ensure it.**
- 3. Administrative efficiencies, use of electronic tools, and frank talk with patients about payment can help practices meet financial challenges.**
- 4. Reducing patients' waiting time is critical for any practice aspiring to excellence.**
- 5. Top-tier physicians engage in self-assessment.**

Picture how this primary care physician's office works: Patients make their appointments after checking their doctor's schedule online. They mull over their options—a phone visit, an online cybervisit, or an office visit—knowing that an evening visit to the office is available. Maybe they e-mail or phone a triage nurse for advice. Before rushing over from work, they check the practice's Website to see if their doctor is running on schedule.

One patient who makes his appointment online attaches a digital picture of his rash. Both he and his doctor have already looked online at the already available lab report from the previous office visit to be prepared for an efficient encounter. When

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I have type 2 diabetes. This is...

my **24/7** glucose control

Model is for illustrative purposes only.

Indications and usage

Levemir® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information

Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Levemir® should not be diluted or mixed with

any other insulin preparations. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate- or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

*Whether these observed differences represent true differences in the effects of Levemir®, NPH insulin, and insulin glargine is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

For your patients with type 2 diabetes,
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Levemir® helps patients with diabetes achieve their A1C goal.^{2,3}

- 24-hour action at a once-daily dose^{4,5}
- Provides consistent insulin absorption and action, day after day^{4,6,7}
- Less weight gain^{8*}

To access complimentary e-learning programs,
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References: 1. Data on file. Novo Nordisk Inc, Princeton, NJ. 2. Meneghini LF, Rosenberg KH, Koenen C, Meilaniemi MJ, Lüddecke H-J. Insulin detemir improves glycaemic control with less hypoglycaemia and no weight gain in patients with type 2 diabetes who were insulin naive or treated with NPH or insulin glargine: clinical practice experience from a German subgroup of the PREDICTIVE study. *Diabetes Obes Metab* 2007;9(3):418-427. 3. Hermansen K, Davies M, Derezinski T, Ravn GM, Clauson P, Home P, for the Levemir Treat-to-Target Study Group. A 26-week, randomized, parallel, treat-to-target trial comparing insulin detemir with NPH insulin as add-on therapy to oral glucose-lowering drugs in insulin-naive people with type 2 diabetes. *Diabetes Care* 2006;29(6):1269-1274. 4. Klein O, Lyngre J, Endahl L, Damholt B, Nosek L, Heise T. Albumin-bound basal insulin analogues (insulin detemir and NN344): comparable time-action profiles but less variability than insulin glargine in type 2 diabetes. *Diabetes Obes Metab* 2007;9(3):290-299. 5. Phillis-Tsimikas A, Charpentier G, Clauson P, Ravn GM, Roberts VL, Thorsteinsson B. Comparison of once-daily insulin detemir with NPH insulin added to a regimen of oral antidiabetic drugs in poorly controlled type 2 diabetes. *Clin Ther* 2006;28(10):1569-1581. 6. Danne T, Endahl L, Haahr H, et al. Lower within-subject variability in pharmacokinetic profiles of insulin detemir in comparison to insulin glargine in children and adolescents with type 1 diabetes. Presented at: 43rd Annual Meeting of the European Association for the Study of Diabetes; September 17-21, 2007; Amsterdam, Netherlands. Abstract 0189. 7. Heise T, Nosek L, Ravn BB, et al. Lower within-subject variability of insulin detemir in comparison to NPH insulin and insulin glargine in people with type 1 diabetes. *Diabetes*. 2004;53(6):1614-1620. 8. Data on file. NDA21-536. Novo Nordisk Inc, Princeton, NJ.



Levemir®

insulin detemir (rDNA origin) injection



Please see brief summary of Prescribing Information on adjacent page.

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Levemir®

insulin detemir (rDNA origin) injection

Rx ONLY

BRIEF SUMMARY. Please see package insert for prescribing information.

INDICATIONS AND USAGE

LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

CONTRAINDICATIONS

LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS

Hyperglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hyperglycemia may differ among various insulin formulations.

Glucose monitoring is recommended for all patients with diabetes.

LEVEMIR is not to be used in insulin infusion pumps.

Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted.

PRECAUTIONS

General

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

LEVEMIR should not be diluted or mixed with any other insulin preparations (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins.

As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia

As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions).

Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients' awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

Renal Impairment

As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

Hepatic Impairment

As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

Injection Site and Allergic Reactions

As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

Systemic allergy: Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Intercurrent Conditions

Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses.

Information for Patients

LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR "Patient Information" circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia.

Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

Laboratory Tests

As with all insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA_{1c} is recommended for the monitoring of long-term glycemic control.

Drug Interactions

A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of substances that may reduce

the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fibrates, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of *in-vitro* and *in-vivo* protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs.

Mixing of Insulins

If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in AUC_(0-2h) and C_{max} for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR was less than 50%.

LEVEMIR should NOT be mixed or diluted with any other insulin preparations.

Carcinogenicity, Mutagenicity, Impairment of Fertility

Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the *in-vitro* reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the *in-vivo* mouse micronucleus test.

Pregnancy: Teratogenic Effects: Pregnancy Category C

In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

Nursing mothers

It is unknown whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

Pediatric use

In a controlled clinical study, HbA_{1c} concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

Geriatric use

Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS

Adverse events commonly associated with human insulin therapy include the following:

Body as Whole: allergic reactions (see PRECAUTIONS, Allergy).

Skin and Appendages: lipodystrophy, pruritus, rash. Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

Other:

Hypoglycemia: (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

Weight gain:

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Studies

Treatment	# of subjects	Weight (kg)		Hypoglycemia (events/subject/month)		
		Baseline	End of treatment	Major*	Minor**	
Type 1						
Study A	LEVEMIR	N=276	75.0	75.1	0.045	2.184
	NPH	N=133	75.7	76.4	0.035	3.063
Study C	LEVEMIR	N=492	76.5	76.3	0.029	2.397
	NPH	N=257	76.1	76.5	0.027	2.564
Study D	LEVEMIR	N=232	N/A	N/A	0.076	2.677
	Pediatric NPH	N=115	N/A	N/A	0.083	3.203
Type 2						
Study E	LEVEMIR	N=237	82.7	83.7	0.001	0.306
	NPH	N=239	82.4	85.2	0.006	0.595
Study F	LEVEMIR	N=195	81.8	82.3	0.003	0.193
	NPH	N=200	79.6	80.9	0.006	0.235

* Major = requires assistance of another individual because of neurologic impairment

** Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself

OVERDOSAGE

Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid recurrence of hypoglycemia.

More detailed information is available on request.

Rx only

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he walks through the front door, he's greeted by a friendly, obliging staff that was expecting him. The office is clean and attractive. Parking was easy. The availability of WiFi means he can finish his work in the waiting room. A sign at the front desk states, "We appreciate the trust you put in us." He knows what he's expected to pay because the front desk has already precertified this visit with his insurance company; he had opted to remit his co-pay by securely entering his credit card information online when he booked the appointment.



“The only way you can be 5-star is if your patients think you are.... It would be unusual to achieve a 5-star rating if [the practice or the doctors] are not in tune with how their patients feel.”

Robert C. Scroggins, JD, CPA, CHBC
Principal and Management Consultant
Clayton L. Scroggins Associates Inc., Cincinnati

The wait is minimal, made even briefer by a helpful chat with a nurse educator who saw from the electronic scheduling-and-records system that even though he was here because of a rash, he was late in refilling his antidepressant prescription.

In the exam room, the doctor's electronic health record (EHR) signals that her patient is due for a colonoscopy and automatically generates a referral. It also displays the drug she prescribed for the same rash last year. She checks dosages and potential interactions on her smartphone while writing the script that is then automatically sent to the pharmacy.

The patient leaves with a written summary of the visit. If he misplaces that piece of paper, he knows he can check the same information online in his personal health record, which he can access through a secure portal at the doctor's Website. Later when he completes an online patient satisfaction survey, he says he trusts that the practice will never let him fall through the cracks, he likes the doctor's manner, and he is confident in her abilities and will follow her advice. He is satisfied that his experience was worth the time, effort, and money. And he feels better.

Many would describe an exceptional 5-star primary care practice as one that balances top-notch, evidence-based patient care with a smooth-running, profitable operation employing the latest technology, making optimal use of teamwork, and communicating a caring attitude. A more skeptical view might be that, because no practice can meet everyone's needs all the time, a 5-star primary care practice is really one that has its priorities straight. Topping the list, perhaps, is a practice that has shifted from being doctor-oriented to patient-oriented.

This shift in orientation affects not only the daily routine of the practice, but even such details as location and availability of parking. A 5-star practice doesn't rent space in a building that patients dislike simply because the building is convenient for the doctors. And it doesn't refuse to offer evening hours simply because "that's the way we've always done it," ignoring the fact that it can be difficult for patients to leave their jobs during the normal workday.

The good news is that 5-star practices don't all have to look the same. The exceptional practice may be the 21st century equivalent of the old-fashioned doctor, making virtual visits online instead of housecalls and carrying a smartphone rather than a black bag. On the other extreme, an exceptional primary care group may be one that is just a small part of a giant, integrated, accountable, health organization.

How realistic is it to become a 5-star practice in 2010? And short of achieving that entire package, what really constitutes exceptional primary care? This issue of *Doctor's Digest* will show you what some practices are doing to take advantage of state-of-the-art information technology, to captain a ship that includes non-physician providers to extend the practice's breadth and depth, and to offer the caliber of service that patients now expect from everyone they do business with. Despite time pressures, costs, and the ever-present challenge of change, you, too, can start the process of becoming a 5-star practice.

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Time for Something Different

For Michelle A. Eads, MD, a family physician in Colorado Springs, Colo., the only way to work in a 5-star practice was to build one herself. Therefore, seven years ago Dr. Eads started her own solo practice with changes in mind. In her former 60-doctor group practice, she was always fully booked a month or two in advance, had to slog through mountains of paper charts unearthed from any one of 30 piles on various desks, and had to rush through appointments in order to earn enough to meet her high overhead and still make a living. “I couldn’t sleep at night because I couldn’t do a good job in this situation,” she says. “I wanted to try something completely different.”

Now she’s doing more with less staff. She and her medical assistant/front office person make liberal use of state-of-the-art health information technology (HIT) along with telephone calls, e-visits, and same-day appointments to provide 24/7 access to her much smaller panel of patients. The results, according to a profile of her “micropractice” on the Agency for Healthcare Research and Quality’s (AHRQ) “Innovations Exchange” Website, are “high levels of patient satisfaction, low patient turnover, improvements in outcomes for patients with chronic disease, and lower costs.”

It’s difficult to do what she did, Dr. Eads acknowledges. “But it’s so worth it. Patients are happy. Staff is happy. The doctors are happy. I am making less than I did in a group practice, but I am much less stressed out,” she says.

How to Have an Exceptional Office

Expert opinion supports her view. According to Steven R. Feldman, MD, a dermatologist at Wake Forest University in Winston-Salem, N.C., and founder of DrScore.com, an online physician rating service, one factor tends to determine patient satisfaction. By analyzing thousands of ratings from his Website over four years, he learned that the most important feature is neither “how long [patients] waited” nor “how much time the doctor spent with them,” but instead, “whether they felt they were seeing a caring, empathetic doctor.”

In determining what it takes to have a great primary care office, Dr. Feldman says the answer is obvious: “Set up your



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office to make sure patients realize that you are a caring, empathetic doctor.”

Next you need to make sure you've gotten that message across. “The only way you can be 5-star is if your patients think you are 5-star,” says Cincinnati-based practice management consultant Robert C. Scroggins, JD, CPA, CHBC, principal and management consultant, Scroggins Associates Inc. And the usual way to know is to ask them in a follow-up survey. “It would be unusual to achieve a 5-star rating if [the practice or the doctors] are not in tune with how their patients feel,” he points out.

Focus on the Consumer

A consumer-oriented practice recognizes the varying needs of different types of patients: What works for a primary care practice that generally sees young, healthy patients differs from what's needed for one that sees mostly older, sicker patients.

For example, the internal medicine practice of Grace E. Terrell, MD, redesigned the progress note for patients over age 60. Dr. Terrell practices part-time in a three-internist, four-nurse practitioner office in High Point, N.C., while also serving as president and CEO of 300-doctor Cornerstone Health Care. When an elderly patient comes in, Dr. Terrell explains, the nurse automatically selects a special “geriatric note” form in the EHR. That note prompts a series of extra questions specifically aimed

at seniors—essential questions often forgotten in a busy primary care practice. For instance, is the patient being assessed for risk of falling? What is his social situation? What is his diet?



“We have found that [patients] really don’t like to talk about Aunt Effie’s gout every time they come in. They don’t like talking about the same stuff they talked about last time. What patients tell us is that the most meaningful time they spend with the doctor, the better.”

**Terry McGeeney, MD, President
CEO, TransformMED**

Stamps of Approval

According to Dr. Terrell, one way to ensure that you’re a 5-star practice is to have others verify it. To get objective confirmation, Cornerstone spent the time to work through the physician practice recognition processes of the National Committee for Quality Assurance (NCQA).

Some say that to be 5-star, you need to prove you’re involved in continuous quality improvement, whether by completing medical board certifications and recertifications, racking up NCQA recognitions, or garnering top rankings on online consumer rating sites. A 2009 Survey of Health Care Consumers by the Deloitte Center for Health Solutions found, for instance, that more than half of Americans (57%) said they would use quality rankings to compare doctors and hospitals in their community.

‘Can Do’ Staff

Others say a 5-star practice, regardless of what outside stamps of approval it has garnered, is one that hums along smoothly and has the right staff doing evidence-backed, outcome-oriented work. And that starts with an overall positive attitude permeating the practice. A truly exceptional practice knows how to say ‘yes’ to the patient, which often involves turning a ‘no’ around, Mr. Scroggins explains. “When they call at 8 a.m. saying, ‘I really have this problem and I need to see the doc today,’ instead

of the staff saying, ‘No, I can’t get you in,’ there is more room to say, ‘Yes, we can see you.’ Or ‘I can’t schedule you today with Dr. Jones, but I can schedule you with Mary Johnson. She’s our nurse practitioner,’” he says.

Here’s where staffing becomes critical. “You want someone answering the phone who likes to smile,” Mr. Scroggins says. You want someone doing checkout who’s used to asking for money. Healthcare consultant James A. Muschler, president of the Itasca, Ill.-based ARSI Group, recommends that medical offices hire staff with banking and loan-officer experience, people who aren’t squeamish talking about money.

It’s important for physicians to know how their receptionists treat patients. From the patient’s perspective, a bad experience with a rude or unskilled receptionist is the same as poor medical care from the physician. When Kelli Ward, DO, a family physician in Lake Havasu City, Ariz., was designing a new office, for instance, she moved her desk into the center between her nurses’ station and the front desk. That way, she can hear everything that goes on and can monitor how staff do their jobs.

A 5-star practice attitude extends to the physician’s bedside manner. “[Unhappy patients] aren’t usually talking about the fact that the doctor gave them the wrong antibiotics. They talk about the bad bedside manner,” says Lori J. Heim, MD, president of the American Association of Family Physicians (AAFP). That means physicians can’t let administrative hassles or a bad day impinge upon human interaction, she says.

The Bottom Line Matters

To call yourself a 5-star practice, you must be both “patient-centric” and financially viable (see “The Importance of Self-Pay

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and Collections,” p. 20, and “How to Lower Your Overhead Costs,” p. 23). The need for administrative efficiency can’t be overstated in today’s era of shrinking reimbursements and government and public scrutiny of healthcare costs. According to data from last fall’s Medical Group Management Association



“Doctors often know what they should do, but it’s not being executed. The really top-notch physicians are the ones who engage in self assessment. They are not afraid to ask their peers how they are doing, to measure their practice, and get involved in cycles of improvement.”

Eric S. Holmboe, MD

Senior Vice President, Chief Medical Officer
ABIM, Philadelphia

(MGMA) meeting, total operating costs for medical practices have risen more than 40% since 2001, exceeding a 24% rise in the Consumer Price Index over that same period. Meanwhile, the association reported a 7.8% decline in practice revenue per full-time group practice physician in 2008.

“If, from a business standpoint, you aren’t being run very efficiently, you will be hampered from being able to do some of the other stuff clinically that exceptional practices want to do,” says Steven Waldren, MD, director of the AAFP Center for Health Information Technology. These efficiencies range from skillful billing, coding and documentation, to understanding your accounts receivable, payer mix, and claim rejection rates. This means adroit use of electronic tools like instant messaging to cut down on waste and inefficiency and automatic time stamps to track and identify delays, bottlenecks, and rework.

For some, the answer to the financial challenge in providing exceptional primary care is more integration, particularly if it allows them to concentrate on the “5% of patients who incur 50% of the cost,” according to Alan S. Kaplan MD, vice president and chief medical officer with the Iowa Health System. An

exceptional practice, he says, is one that “can move from good to excellent in chronic care management.” (See “Different Models for Excellence: Ensuring 5-Star Care,” p. 24.)

The Team Approach

It’s essential for a top-performing primary care practice to have a modern, comprehensive EHR (often referred to as an electronic medical record or EMR), experts say, but it’s also crucial to recognize that technology alone is never enough. Teams of providers are vital to any exceptional primary care practice.

“I may have disease-registry capability in my EMR, and my system is so smart that it tells me what I should do when patients visit me,” Dr. Kaplan says. “But that doesn’t mean I have an advanced medical team and can coordinate a dietician, a PharmD, or anyone else the patient needs to keep them out of the ER.”

Richard J. Baron, MD, an internist in Philadelphia, says he can’t imagine providing top-quality primary care without nurses and mid-level providers. “Team-based care is a survival strategy and a very patient-friendly and patient-centered strategy” that intersects with everything from efficiency and patient service to payment, he says. “If I am the only person who can do X, Y, and Z for patients, I’m going to be a bottleneck. I will slow down the process of care. People experience delays trying to work through me. When I can sufficiently activate a team, people will get what they need more quickly and more reliably.”

Minimal Waiting

A rule of thumb is that a 5-star practice has done away with unnecessary waiting; some practices have even eliminated the waiting room—a room with no other function but to park people. “When people feel an office wastes their time, they are less likely to follow up on preventive screening, and they are less likely to follow up on chronic disease management,” says L. Gordon Moore, MD, a family physician in Seattle and founder of the Ideal Medical Practices movement.

A quality primary care practice has to create enough “breathing room” to allow its providers to do all they need to do for patients while staying on time. The options, he says, are either “shrinking the population to match the capacity of the team or

The Importance of Self-pay and Collections

As deductibles and co-pays rise, you're likely to see more self-pay. And more self-pay means that primary care practices, in order to stay afloat and have money to invest in the kinds of facilities, staff, technology, and processes that make them exceptional, need to have excellent billing and collections procedures.

"I don't want to sound like a huckster only concerned about money, but a couple hundred \$25's a week adds up," says H. Lee Adkins, DO, a family physician and geriatrician in solo practice in Ft. Myers, Fla. "I have been able to survive, where a lot of guys down here have not, because I am doing something right."

Dr. Adkins was forced to address collections head on because he practices in an area where out-of-state snowbirds fill waiting rooms in the winter, returning north afterward. "If you don't have a rigorous procedure at the front when the patient is in the office, you invariably collect less," he says. "The collections effort is extremely difficult when people owe you \$25 and they go back to Wisconsin."

Consultants say a 5-star practice collects as much money as possible up front by doing the following:

- **Learn to accept cash.** Preauthorize debits. Give discounts for cash—on the self-pay portion only.
- **Take all credit cards.** Mr. Muschler says that practices should renegotiate the fee their bank charges them for accepting credit cards. While many practices pay banks 5% to 7%, "we have found that 1.7% to 2% is obtainable," Mr. Muschler says. "It is easily negotiable just by asking for it."
- **Outsource your "first-party pre-collect calls"** to experts who are good at asking for money.
- When you call to remind patients of scheduled appointments, **remind them to bring their co-pay**, too. Better yet, says Michael La Penna of the Grand Rapids, Mich.-based healthcare consulting firm, The La Penna Group Inc., collect that co-pay over the phone in advance by asking patients for their credit card number, just as one does to hold a hotel reservation.
- **Bill everything everyday.** "Nothing should wait around," according to Mr. La Penna.

- When hiring for the check-out position, **consider people with loan-officer banking experience.** “It’s not an emotional experience for them to talk about and ask for money,” Mr. Muschler says.
- **Have paperwork on hand,** including hardship forms as recommended by your legal and tax advisors, to allow patients to formally request charity care. “If people cannot pay, there is no reason to force them to pay because you won’t get it, and it’s bad for business,” Mr. Muschler points out.

Given today’s technological capabilities, with most insurance companies offering free, real-time online claims adjudication for the vast majority of claims, plus the ability to preauthorize credit cards and debit accounts, no primary care practice can be top-tier without restructuring its revenue cycle, practice management consultants say.

“To be a top-2% practice, you need to focus on upfront conversations with your patients about payment,” says Mr. Muschler of the ARSI Group. “In general, most physicians spend 80% of their time talking to the patient about money after the account becomes delinquent.” A rule of thumb, he says, is that 5% of money not collected at the time of service will never be collected. In addition, he says, U.S. Department of Commerce statistics show that once a bill is overdue by 60 days, on average, “that patient is now delinquent with 13 other creditors. The practice will now be competing with 13 other people for the limited resources of that patient.”

Dr. Adkins has learned from how the big-box stores are running their retail clinics. He posts a fee schedule online and in the office, and goes over it with patients when they call to make an appointment. Patients are instructed to come in a half-hour early so that the staff can verify insurance online before seeing the doctor, a system that automatically calculates the patient’s co-pay so the patient can’t ask to be billed “after insurance pays.” He offers cybervisits, too: Patients input their credit card number, pay \$35, and have minor conditions taken care of without coming to the office.

He has hired front-office staff who are “tough” about asking for and collecting money. And he views his job as backing up his staff in this work: He walks all patients to the front after their visit and talks directly to the checkout person.

increasing the capacity of the team.” Better yet, Dr. Moore argues, 5-star practices do both: They use state-of-the-art information technology to increase productivity and efficiency while expanding access and reach, and also decrease the size of their per doctor-patient panels. “You can’t solve the problem if you have too many patients and not enough time,” he says.

Although reducing waiting is essential for any practice aspiring to the 5-star level, this alone doesn’t guarantee quality. A study published Feb. 28, 2007, by *BMC Health Services Research* examined the relationship between patient waiting time and willingness to return for care with primary care physicians. The authors concluded that “shortening patient waiting times”—if done at the expense of face-to-face time with the physician—“would be counterproductive.”

Even the amount of time spent with physicians isn’t the complete answer. Patients want to be recognized and valued, Dr. Heim says, “but they don’t want to spend an hour.”

Terry McGeeney, MD, president and CEO of TransformMED, an AAFP affiliate that helps physicians with practice improvement, says, “We have found that [patients] really don’t like to talk about Aunt Effie’s gout every time they come in. They don’t like talking about the same stuff they talked about last time” or having to say the same thing to the medical assistant, to the nurse, and again to the doctor. “What patients tell us is that the more meaningful time they spend with the doctor, the better,” he says.

Ethical and Charitable Considerations

While some contend that a top practice is one that makes the most money or provides the best value or customer experience, others say that such practices are those that have figured out how to treat all comers regardless of ability to pay while still staying in business. That’s not an easy proposition in today’s economic climate, one that promises to remain tricky to navigate despite the latest stab at health reform. A study released in September 2009 by the Robert Wood Johnson Foundation and the Center for Studying Health System Change found that “fewer than six in 10 physicians (59%) provided charity care in 2008,” defined as free or reduced-cost care to financially needy patients. In fact, some practices contend that in order to be top quality, they have had

How to Lower Your Overhead Costs

Beef up collections processes. Collect more when patients are in the office to reduce the effort and expense of trying to collect later.

Renegotiate rent or move. One person's bad economy can be another's gain. Mr. Muschler of The ARSI Group says that a number of shopping plazas that have lost tenants recently are particularly interested in renting to medical offices and may end up reducing your current rent by 25% or even 50%. "Even a solo doctor will see 50 patients in a day. In a small plaza ... that is like a small anchor store. A lot of plazas are giving discounts for physicians who ask for them to move them into their plaza and away from the medical building," he says.

Invest in technology. Richard Boss, MD, a family physician in Fremont, Mich., says that putting in an EHR has more than paid for itself in four years, simply in terms of looking at the number of medical records staff the group now needs to employ. The 21-provider group "had 14 medical records technicians in August 2006, each costing approximately \$40,000 a year for wages and benefits. Today we have four. Each year we save 10 times \$40,000. That's \$400,000 a year in savings for our practice. And our entire system cost us \$400,000," he says.

Hold on to good employees. Treat your productive employees well. How expensive is it to pay taxi fare home when staff work late or have anniversary lunches? And, consultants say, if you do lose a worker, consider whether you would be better served by hiring two part-timers instead. You may save on salary and benefits while being able to staff early-morning, evening, or weekend hours better. Also, look at salaries; if they are too low to be competitive in your community, you will lose employees.

Ask employees for money-saving ideas. They often have them; and reward employees for good ideas.

to become cash-only, dropping their insurance contracts partially or entirely, and limiting themselves to patients who can afford them. For example, Dr. Eads accepts no insurance although she helps people fill out reimbursement forms.

Other primary care physicians struggling with how to treat people in need have opted for different solutions. Family physician Susan P. Osborne, DO, in Floyd, Va., for instance, has named her office "The Barter Clinic" and exchanges medical care for everything from tilework at her home to venison. Dr.

Different Models for Excellence: Ensuring 5-star Care

During the last health reform go-round, the buzzword was integration. The only way to be a 5-star primary care practice, people were saying, was to be part of a large, integrated health system. However, during this current round of Health Reform 2.0, the thinking is that all top primary care practices need not look the same.

Maybe they will be **patient-centered medical homes**, as promoted by a collaborative made up of the nation's largest primary care medical societies, large insurers, health systems, and self-insured corporations. Medical homes may be small independent practices "virtually" linked together in a "medical neighborhood," or they may be large multispecialty groups integrated with big health systems.

Or perhaps exceptional practices will be "**micropractices**," small, independent ones modeled on the old-time doc-of-all-trades style of yesteryear but brought into the 21st century by extensive use of information technology. Some micropractices are casting themselves as "Ideal Medical Practices," a model promoted by family physician Dr. Moore and others.

Still others may be a new breed of **company clinics**, designed not just to take care of workers injured on the job or to reduce costs for self-insured companies, but also to provide better-quality primary care than employees and their families are able to access today.

Ward in Arizona merged her practice recently with a community health center. Dr. Baron in Philadelphia advocates that physicians accept global payments from payers or health system employers as the only way to free them from the constraints of practicing fee-for-service medicine.

Asking the Hard Question

A primary care physician who wants to achieve the 5-star level should review the practice's willingness to ask itself how it can be better. (See "Online Doctor Rating Likely Here to Stay," p. 26.) Some fascinating new research into practice improvement, in fact, shows that top-tier physicians—the ones who provide the best quality care as measured by national quality measures—are those who aren't afraid to question whether they're doing the best they can in delivering care to their patients.

"The only way you can identify a knowledge-performance gap is to assess," explains Eric S. Holmboe, MD, an internist who is

Or will top practices look like **retail clinics**? Younger patients are flocking to clinics in big-box stores and pharmacies. More than a quarter of consumers surveyed in 2009 by the financial and consulting firm Deloitte said they “would be likely to use a retail clinic if they could be seen immediately rather than wait up to a week to see a doctor in a doctor’s office” or if it “cost 50% less than seeing a doctor in a doctor’s office.” Some large health systems—from Mayo to Intermountain Healthcare—are becoming believers in this model, opening retail clinics of their own.

Many experts, however, still contend that a top primary care practice will have to be part of something bigger. Integration—whether actual or virtual—is probably going to be key.

An individual practice may be excellent “in the sense that they have high patient satisfaction, great throughput, high productivity, happy employees, meeting quality indices, and all the things we consider practice excellence today,” Dr. Kaplan says. “But that in no way tells us for sure that their chronic care patients get better care coordination. That doesn’t measure how many times their chronic care patients are in the emergency department or mixed up about their medications. It just means that when they come in, they really like their doctor, and the doctor is documenting her quality metrics really well.”

senior vice president and chief medical officer at the American Board of Internal Medicine (ABIM) in Philadelphia. “Doctors often know what they should do, but it’s not being executed. The really top-notch physicians are the ones who engage in self-assessment. They are not afraid to ask their peers how they are doing, to measure their practice, and get involved in cycles of improvement.”

That is, in part, why most board recertification programs are now requiring physicians to prove they’re thinking about practice improvement—and not just assuming they are doing everything well. In fact, says Vincenza Snow, MD, director of clinical programs and quality of care at the American College of Physicians (ACP), one of the chief lessons learned from quality



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improvement programs like ACP's "Closing the Gap" is that "just getting doctors to the point of saying I want to be a 5-star practice—just getting to the point of recognizing that I could do better—is a huge step" toward getting there.

"We are finding that a lot of practices, as soon as they hear the words 'quality improvement,' immediately become defensive," Dr. Snow says. "'What do you mean I need to improve my quality? I do provide high quality care.' They think they have standard processes in place to help them achieve their goals," whether it's regularly measuring hemoglobin A1C for diabetic patients or offering flu shots to seniors. "But they don't. They

Online Doctor Rating Likely Here to Stay

A patient looking for a 5-star doctor still asks friends and acquaintances for recommendations just as in the past. The only difference is that "word of mouth" can include online ratings, and today the community of friends can be virtual.

A 2009 Survey of Health Care Consumers by the Deloitte Center for Health Solutions found that 30% of consumers reported comparing doctors before choosing one in the last 12 months, up from 23% answering a similar question the year before. And these consumers said they considered "independent health-related Websites" as trusted a source of information about healthcare providers as medical associations.

A Google search turns up scores of online doctor-rating sites, from *RateMDs.com*, *ratemydoctor.net*, and *ratemydm.ca* to *Drscore.com* and <http://www.angieslist.com/angieslist/>, some independent and some insurance company sponsored.

"Nothing helped me more than learning [from reviews] that [patients] thought I wasn't a caring doctor," Drscore.com's Dr. Feldman says. "I care tremendously, but I wasn't communicating that. I was treating patients efficiently and correctly, but the patient didn't see that. The patient saw me as not spending any time with them, not doing a thorough examination."

Online rating services like his offer doctors this kind of actionable patient satisfaction feedback on an ongoing basis, not just during the weeks their office or health system surveys satisfaction. Drscore.com, for example, allows doctors to look at their detailed ratings for free, and they can sign up to use the Website as their office's patient satisfaction survey service, which then gives them detailed reports. About a thousand physicians use the four-year-old service, Dr. Feldman says.

can't tell you why they did well on some measures and poorly on others," she says.

She offers herself as an example. As an internist who lives and breathes quality improvement, teaching others systems and techniques, she thought her practice's immunization rate would be near perfect. "That was until I did a chart audit. It was nowhere near 90%. I am now doing the [ACP Closing the Gap] immunization program myself," she says. She points out her own first step toward becoming a 5-star practice: adding an immunization reminder to her chart's front sheet.

Angie Hicks, the founder of Angie's List, one of the largest providers of consumer reviews on all types of service providers—from building contractors and plumbers to doctors and hospitals—says doctors should embrace these ratings sites, not only because they can understand what patients are saying about them, but also because it gives them a chance to right a perceived wrong and try to turn an unhappy customer into a satisfied one.

"You have to realize that no matter how good you are, you are not going to please everyone all the time," she says. "And in many ways, people can learn more about you when something doesn't go quite right and you worked to rectify it." Angie's List doesn't allow anonymous reviews, and that allows service providers to post responses alongside the review. Angie's List routinely collects between 10,000 and 15,000 healthcare reports a month on physicians, hospitals, pharmacies, and health insurance companies.

"If you see a list of reviews and they are all glowing, then you have to wonder if they are all real," she says. "If you have one complaint and 20 good reviews, that is pretty good."

Doctors should realize, too, she says, that "not everybody who reviews a healthcare provider is complaining. ... We get a higher percent of positive reviews than we get negatives." And the average rating for doctors who have 20 or more ratings on DrScore is nearly 9 (out of 10), Dr. Feldman notes.

Doctors who have required patients to sign waivers to keep them from posting online reviews about their care are only harming themselves, Dr. Feldman contends. "The idea that you are going to hide what a great job you do is just totally counterproductive. It looks as if you have something to hide."