Damage Control
How to fend off a bad Internet review

How to find a financial adviser you can trust

ICD-10 deadline extended to 2014
By the numbers? Not always

By RICHARD E. WALTMAN, MD

This is the era of medicine by the numbers. Third-party payers are now able to rank physicians by how many of the prescriptions they write are for generics, how many formulary medications they use, and how “cost-effective” they are. These agencies make yeo-or-nay decisions about our continued participation in their programs based solely on these numbers, never having fully evaluated the care we provide or ever seeing us work.

Our medical group has endless charts and graphs of physician “performance,” whether it be percentage of flu shots given, percentage of smokers counseled, percentage of cholesterol readings of less than 200 in patients, or number of patients whose heights are measured at least once a year. A physician can get a “grade” on more than 50 measures, and his or her yearly evaluation is largely based on the results. Even our annual quality bonus, initially intended to measure the quality of our work, now measures our numerical performances on several scales.

Drug companies know how much of one drug we use, and how much of another. They base their marketing to us on these profiles.

Even prospective patients now evaluate us by looking at our “scores” on various Internet services (see the articles beginning on page 20 for a detailed look at such physician ratings). And Medicare has initiated payments under the meaningful use program, yet another numerical scorecard on multiple criteria.

THE TRUE MEASURE OF A GOOD DOCTOR

But this is not the way we learned to evaluate our colleagues, nor is it the way we continue to evaluate them.

We look at the font of knowledge, work ethic, coping skills, collegiality, compassion, and caring.

In our training, our mentors were not the doctors who ordered the most prostate-specific antigen tests, but the ones who did the best work, the ones who cared most about their patients. That’s how I evaluated physicians in 1975, and that’s how I evaluate them in 2012.

But our informatics colleagues even have an answer for that. They say that performance on these numerical measures is a “marker” for overall performance. For as many times as I have heard that said, no one has ever been able to give me any proof of that statement. I don’t believe it, and I bet you don’t either.

My belief is that there are some great doctors out there with poor mammogram rates and that there are some whose care I would find not as good whose mammogram rates are high. I doubt there is a true correlation.

SCORES HELP GENERAL ASSESSMENT

I happen to get good grades on the measures I believe are important and perform less well on those I consider less important. So I get 100% on tobacco education and counseling and don’t do as well with getting LDL levels under 100. Frankly, they are not as big of a concern for me.

And I do think these measures are, for the most part, valid and fair—for a general assessment. But rightly identifying a great doctor is not quite as easy. That does not mean we can’t keep looking. I may not be able to define it, but to paraphrase what Judge Potter Stewart said about pornography, I know a great doctor when I see one.

Continued on page 9
Take charge of your online reputation
Excellent clinical care may not be enough to garner glowing online reviews from your patients, and such reviews increasingly are playing a role in the health of your practice. What matters most to patients may surprise you. Discover several steps you can take to avoid poor reviews or deal with them if they appear.

PAGE 20

PATIENT RELATIONS
20 Damage control
How to fend off a bad Internet review.
By Beth Thomas Hertz
21 Ratings especially important to PCPs
22 Complaints and solutions
23 The value of internal surveys
24 Relationships trump reviews, one physician says
25 How satisfaction surveys changed my approach
Assert influence where possible and hope for the best.
By Stephanie Weaver, MD
26 Realities present challenges
33 7 steps to managing anger in patients
Staff members are central to this proven technique. By David Zahanuk, MD, and Mark Terry
34 Additional tips for calming upset patients

Table of contents continued on page 4
Back Issues .......................... 218-740-6477
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Employee versus contractor
Considering a few points can help you determine whether to classify someone as an employee or as an independent contractor. Read up, because the wrong answer could have financial consequences.

PAGE 48
Continued from page 2

PATIENTS ARE’NT NUMBERS, EITHER

As do physicians, patients appreciate being treated as people, not numbers.

When my son Dan broke his wrist, he went to four orthopedic surgeons before agreeing to an operation. The first surgeon grabbed his hand as soon as he walked into the room and began his exam. The second one grabbed the x-rays and focused on the view box. The third surgeon spoke to me, not to my son. The fourth one began by asking my son how the team was doing and what the outlook was for next season.

That last one got the job, and the surgery went well. Twelve years later, my son is a successful indoor soccer goalkeeper.

I asked Danny what had influenced his decision. “Dr. Mason was interested in me; he cared. The other guys...they just saw me as a number.”

The author practices family medicine in Tacoma, Washington. From the Board columns reflect the opinions of the authors and are independent of Medical Economics. Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

ICD-10 COMPLIANCE DEADLINE NOW 2014

October 1, 2014, is the new proposed deadline by which practices and other relevant healthcare entities must use International Classification of Diseases, 10th Edition, diagnosis and procedure codes (ICD-10). The date was announced April 9 as part of a new proposed rule that the U.S. Department of Health and Human Services (HHS) believes will save healthcare providers and health plans up to $4.6 billion over the next decade.

HHS Secretary Kathleen Sebelius said the new rule would establish unique health plan identifiers under the Health Insurance Portability and Accountability Act of 1996 to cut red tape and reduce administrative costs. The rule proposes that health plans have unique identifiers of a standard length and format to facilitate routine use in computer systems, allowing provider offices to automate and simplify billing and other transaction processes, according to HHS.

The agency announced in February that it would postpone the date by which “certain healthcare entities” needed to file claims using ICD-10 but did not announce the revised date until April 9. The announcement extends the compliance date by 1 year.

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013, a delay of 2 years from the compliance date initially specified in the 2008 proposed rule.

“Many provider groups have expressed serious concerns about their ability to meet the October 1, 2013, compliance date,” the CMS announcement said. “The proposed change in the compliance date for ICD-10 would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to these new code sets.”


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Two tips for maintaining efficiency in your practice
I read with interest “The art of office triage” by George G. Ellis Jr., MD, FACP, in the March 10 issue. I am a family physician with many years of experience. I would like to add two suggestions that were very helpful to me in maintaining the efficiency of my office practice.

The first was to leave appointment times in the schedule open each morning and afternoon and not to fill those times until the day of the appointments. This allowed me to work in patients with acute problems who needed to be seen promptly. My practice was supposed to have a 45-minute gap in both the morning and afternoon schedule. In my experience, it was a rare occurrence when this did not fill.

The second was to have a brief meeting with the scheduler and the nurse just prior to starting the day to anticipate needs and look over and rearrange the schedule if necessary. Frequently, there were two patients back-to-back who would both require more than the allotted time. In that case, I would have the receptionist call and reschedule one of them, often for the last appointment in the morning or the last appointment of the day.

Joseph V. Cook, MD
Salt Lake City, Utah

Simple steps of selling to an insurance company
I loved the topic of Michael D. Brown, CHBC’s article “Sell to an insurance company? Why not?” (March 10 issue). Now I want to know: How do I contact insurance companies?

Sudeepa Gupta, MD
Rockville, Maryland

Response from Michael D. Brown:
Getting started selling to an insurance company is a three-step process. The first thing any potential buyer would want to know is the value of your practice. Tax returns, financials, profit-and-loss statements, accounts receivable, and a depreciation list are required to do this. Once the value is determined, the next step is to pursue the potential buyers. These could be junior physicians, hospitals, insurance carriers, or the competition. Each of these three to five buyers will require 3 to 5 hours of negotiation. The third phase of this process is to create a letter of intent and, ultimately, a buy-sell agreement.

We need to be partners
Mark W. Eulberg, MD’s belittling letter to the editor does no one in medicine any favors (“No, FP’s aren’t multispecialists,” [Talk Back], March 10 issue). I am a family physician (FP), and I consider myself a “specialist in the common problems.” I know my abilities and my restrictions. If a patient’s condition is beyond my ability to treat, I am the first to refer. No, I wouldn’t treat a patient with hypertension and diabetes who is in labor. However, there are many counties where obstetricians (OBs) are not to be found, and an FP may be the only game in town. You don’t always have time to transfer to where there is OB coverage. An FP can treat patients with strokes, Parkinson’s, or dementia. There aren’t enough neurologists in the entire world to treat all these patients.

While Dr. Eulberg may have witnessed FP’s getting into trouble, I have witnessed specialists who can’t see past their own specialty to consider the whole patient. I see them through thick and thin. I know the patient, their family, and friends. While I can’t do a patient’s coronary artery bypass graft (CABG), I am the one who controls their diabetes, dyslipidemia, and hypertension, therefore, potentially keeping them from needing a CABG.

Rather than impugning the FP’s value, I would suggest Dr. Eulberg work with them. We should be partners, not adversaries.

Leslie F. Stork, MD
Canyon Lake, Texas

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10 common privacy violations in the office setting you can avoid with care. SEE PAGE 37

Lee J. Johnson, JD HEALTH LAW ATTORNEY

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Proposed budget could worsen PCP shortage

As if your waiting room isn't crowded enough already, a new study predicts that the shortage of primary care physicians (PCPs) could be made even worse by President Barack Obama's proposed budget. Moreover, the increased shortage could be caused by the same measure that will cause an increase in demand for the services of PCPs.

In its fiscal 2013 budget proposal, the administration proposes saving $97 billion over 9 years by reducing what Medicare pays to train new doctors. The savings would help fund the expansion of healthcare coverage to as many as 32 million people who are uninsured now.

A Bloomberg Government study predicts that the cuts would cause hospitals to adjust their mix of residency slots to focus on the most profitable specialties. That would reduce in turn the number of PCPs, who will be in greatest demand under healthcare reform.

The Association of American Medical Colleges estimates that the training cuts would contribute to an overall shortage of 60,000 physicians by 2015.

Medicare provided about $9.5 billion to hospitals in 2010 to offset the costs associated with sponsoring residency programs in which graduate students train before going into practice for themselves.

The shortage of primary care physicians will become worse if a proposed 2013 budget is enacted, a new study predicts.

Is the Patient-Centered Medical Home (PCMH) model everything it's cracked up to be? It's too soon to know for sure.

That's the conclusion of a report published in the American Journal of Managed Care by research firm Mathematica and the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality. Authors analyzed 498 reports of previous studies and found most of them to be inconclusive, usually because they did not meet rigorous testing standards.

Those that did meet the standards showed some improvement toward the goals of increasing care quality, lowering costs, and improving the overall patient experience, the authors concluded, but they called for additional study.

Having computer access to your patients' test results means you are likely to order more imaging and lab tests, according to a new study in Health Affairs.

The study found that point-of-care electronic access to imaging results was associated with a 40% to 70% greater likelihood of an imaging test being ordered, and that surgeons and other specialists were more likely to order imaging tests than primary care physicians.

The findings contradict the assumption that computerized access to test results will reduce testing, a major part of the argument for electronic health records.

“Our findings should at a minimum raise questions about the whole idea that computerization decreases test ordering and, therefore, costs in the real world of outpatient practice,” says lead author Danny McCormick, MD, assistant professor of medicine at Harvard Medical School.
Patients undergoing elective coronary stent procedures are far less likely to be presented with alternatives to surgery than are prostate surgery cancer patients, according to one study. Nearly two-thirds of prostate cancer patients received surgery options, compared with 10% of coronary stent patients.

PATIENT COMMUNICATION

PATIENTS WANT MORE DISCUSSION OF ALTERNATIVES TO STENTING

Not enough of you are presenting your coronary stent patients with alternatives to the procedure, according to a new study.

The study in the Journal of General Internal Medicine surveyed fee-for-service Medicare beneficiaries who had elective coronary artery stenting in the last half of 2008. Only 10% said they were presented with an alternative to surgery as a serious option. Most (77%) reported talking with their doctors “a lot” or “some” about the reasons for the surgery, but only 19% reported talking about the drawbacks, and only 16% said they were asked about their treatment preference.

By contrast, 64% of patients who underwent surgery for prostate cancer reported having at least one alternative to surgery presented to them as a serious option.

STATE ROUNDUP

ILLINOIS CONSIDERING DOUBLING PHYSICIANS’ LICENSE FEE

The ILLINOIS state legislature is considering doubling the state’s annual physicians’ license fee—used to pay for regulatory enforcement of the profession—to $200. State health officials say the higher fees would allow the fund to stay out of debt and hire more staff. The Illinois State Medical Society opposes the hike, saying the state has used the license money for other purposes.

NEW HAMPSHIRE is the first state to get Medicaid grant money intended to keep patients out of nursing homes. The Centers for Medicare and Medicaid Services awarded the state $25.5 million over 3 years as part of the Balancing Incentive Program. The state and community health organizations will develop community-based care serving seniors and individuals with behavioral health needs and physical and mental disabilities. The grant’s goal is to strengthen the infrastructure of community-based care.

MEDICARE SUPPORT // BY THE NUMBERS

Percentage of groups that want to keep Medicare as it is.

- All Americans: 71%
- Democrats: 83%
- Independents: 71%
- Republicans: 53%

Source: Kaiser Family Foundation
We’ve all got a megaphone now,” says Mitch Rothschild, chief executive officer of Vitals, the company that owns physician-rating Web site Vitals.com, referring to the reach of such sites. “Doctors need to realize things have changed. Patients don’t just tell a few friends when they have a bad experience; they tell the whole world.”

And Vitals.com is just one of many physician-rating Web sites, such as DrScore.com, HealthGrades.com, and RateMDs.com, where patients go to spread the word. Even if most of the reviews a doctor garners are positive, a negative one can stand out painfully.

As more and more patients use the Web to get information about their healthcare, and more insurance companies and healthcare employers are surveying patients as part of their own internal review process, getting high satisfaction reviews from your patients has never been more important.

Although three-fourths of ratings and comments on Vitals.com are positive, most of the negative ratings reflect courtesy and professionalism of the office staff, Rothschild says. You can take several steps to avoid poor reviews or deal with them once they appear, say several experts in the field.

**Damage Control**

How to fend off a bad Internet review

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**LOOK AT THE SMALL PICTURE**

Daniel O’Connell, PhD, a psychologist who teaches at the University of Washington School of Medicine in Seattle, Washington, and has a consulting practice with physicians nationwide, urges his clients who get less-than-favorable reviews to avoid focusing on the entire review and instead only pay attention to the items that directly relate to them.

“Often only about three to nine items are actually rating the physician,” he says. “The others are related to things like parking.”

Christa Maruster, a patient satisfaction specialist at Sharp Community Medical Group in California, also encourages physicians not to take a bad review too hard.
“Don’t think you are horrible and that you should quit,” she says. “That is not what this is about.”

She compared a patient’s decision about whether to stay with a physician with his or her feelings about a favorite restaurant.

“It is not just the food that brings you back. It might be that there is a good waiter who remembers your name or your favorite drink. It might be the pleasant atmosphere. There are many factors,” she says. “If you have a busy practice, you are obviously doing something right, but patients want more. You need to give them that ‘extra’ that gives them a reason to come back and pay their co-pay again.”

Let the survey results show you how to deliver that extra, she says.

**STEPS TO TAKE**

O’Connell tells doctors to pay special attention to negative ratings on questions such as whether they clearly explain things to patients and whether patients are included in decision-making.

“Look at each item and ask yourself, if you were the patient, what would the doctor have to do differently to get you to give positive answers to these types of questions,” he says. “Diagnose why you got a low rating in these areas.”

For example, he suggests that if you score low on questions about whether you share a patient’s concerns and worries, ask yourself what you can do differently in the same amount of time to demonstrate that you care.

“Ask them questions such as, ‘What do you think is causing these headaches?’ or ‘Was there something special you wanted me to do today for you?’ or ‘What concerns you most about this problem?’” he says.

Being asked just three to five such open-ended questions will cause patients to rate a physician much higher in this area, O’Connell says.

“Too often, the physician takes over the interview too soon, asking, for example, ‘Do you get the headaches more in the morning or the evening?’ and not letting them answer your questions fully,” he says.

O’Connell also suggests that doctors set an “agenda” at the beginning of a visit.

“Most patients come in with two to four concerns, but the doctor jumps on what he sees as the chief complaint without pausing to ask about all of their concerns,” he says. “By asking up front if they have any other concerns, you are able to budget your time to address them all and don’t get unpleasant surprises at the end, when you think are you done.”

Another complaint that will lower a patient’s review is not fully explaining a medication you are prescribing. Patients want to know how to spell the medication so they can look it up on the Web, and they want to understand clearly why it is being prescribed, what the dosage is, how they will know whether it is working, and what side effects should concern them.

“You can cover all this in about 30 seconds and head off a lot of questions and dissatisfaction,” O’Connell says.

A final tip he offers to improve satisfaction ratings is to give patients a choice in their treatment plan.

“Give them two paths and ask which makes the most sense to them, and negotiate the best one,” he says. “Modern patients want to be included in the decision-making process.”

Kevin Pho, MD, an internal medicine physician who blogs at KevinMD.com and has written about patient satisfaction issues, says that including patients in the process also helps lessen the possibility that they will criticize you later for saying “no” to something they wanted but that you felt was not in their best interest—such as denying them pain medications that you believe are inappropriate or refusing to order tests that would cause unnecessary radiation exposure.

“A totally happy patient isn’t necessarily one who has received the best medical care,” Pho says.

**POWER POINTS**

Don’t respond to negative reviews. If posted information is unfair, ask the site to remove it.

Most patients give positive reviews, so ask your patients to review you.

Conducting your own patient surveys makes patients feel heard. Be sure to tell patients about practice improvements made based on feedback.

A blog or practice Web site will help you control your online presence.

**RATINGS ESPECIALLY IMPORTANT TO PCPs**

Online reviews may be even more important to primary care physicians (PCPs) than specialists, according to some associated with doctor-rating sites. Generally, patients have more latitude when selecting a PCP so may feel the need for assistance in making a choice, whereas their visits to specialists often are based on referrals.

Patients in general see PCPs more than other types of doctors, so existing patients have more on which to comment and potential patients have more reasons to search, according to HealthGrades.com spokeswoman Marsha Austin. Also, according to Austin and Mitch Rothschild, chief executive officer of the company that operates Vitals.com, relationships matter more in primary care than in other types of medicine because they tend to be longer-term.
“Often, only about three to nine items are actually rating the physician. The others are related to things like parking.”

—Daniel O’Connell, PhD

Indeed. John Swapceinski, co-founder of RateMDs.com, says that the two most common patient complaints posted on that Web site are having to wait too long in the office waiting room and feeling rushed by the doctor during the appointment. By addressing patient expectations in just these two areas, your satisfaction ratings will increase, Pho says.

CREATE A STRONG DIGITAL FOOTPRINT

“It is in every physician’s benefit to be in control of how they are defined online,” Pho says.

Listings such as those in LinkedIn or a Google profile are fairly easy to create, do not require regular upkeep, and, importantly, tend to appear higher in a Web search of a physician’s name than independent ratings sites. Having a blog or a practice Web site, although more time-consuming, will further help doctors control their online presence by giving them a more personal voice, he says.

Pho also recommends that physicians encourage their patients to post reviews about their experience at the office, possibly giving them cards at checkout that steer them to a particular site.

“Remember that most reviews are positive—probably 90%,” he says. “Ask more of your patients to rate you, and let the chips fall where they may. Most of [the reviews] will be good.”

O’Connell also advises encouraging patient reviews.

“It’s not cheating to encourage them to post a review about you if they have had a good experience. You aren’t telling them what to say,” he says. “Then maybe you have 11 reviews, instead of three, and if there is one bad one, patients get a more balanced view of you.”

Steven R. Feldman, MD, PhD, founder of DrScore.com and a physician practicing in Winston-Salem, North Carolina, agrees. Asking patients to post reviews “lets them know you appreciate them and trust their judgment,” he says.

“And it shows that you are trying to improve.”

RESPONDING TO BAD REVIEWS

If a patient does post a bad review about you on the Web, some sites will allow you to respond. Resist the urge to be defensive, however, several experts advised.

“Be empathetic,” O’Connell says. “Make it clear that you are sorry they are disappointed and that you take this very seriously, and state what you are doing about it.”

A few physicians have sued a site or a patient over a very defamatory review, but most experts recommend against doing so, because it is rarely successful. Also, news of the lawsuit will live online, possibly making you look mean-spirited for pursuing the patient, Pho says.

Far better is to ask the site owners to consider removing the bad review, particularly if the content is clearly an unfair attack, he adds.

Susan Shepard, RN, director of patient safety education for medical malpractice insurer The Doctors Company, advises physicians against ever suing. Instead, she says, “take the high road,” because it is difficult to prove any factual statements are incorrect, and opinions are just that—opinions.

Further, she suggests resisting the temptation to respond to bad reviews at all.

“Responding just keeps it going,” she says. “Getting into an argument online is always bad.”

Also, you may think you know who the criticizing patient is, but you could be wrong. Respond as if you are talking to them and you run the risk of violating patient privacy laws or further angering the person who actually wrote the review.

Instead, consider whether you can learn anything from what is posted, she advises.
“Patients are not always good judges of clinical skills, but they know how they felt,” Shepard says. “If they say, ‘He didn’t look up from his computer or tell me what he was doing,’ see what you can do to improve that.”

Feldman of DrScore.com adds, “When you get a negative review, consider it a gift. It helps you improve and give the best possible care.” Patients who believe you care are more likely to adhere to your treatment recommendations, he adds.

**SEEK YOUR OWN FEEDBACK**
Shepard suggests doctors take that “learn from it” attitude a step further and ask patients to participate in a survey from the office via mail. Having them do so reduces the chances that patients will take their complaints to the Web, because they already believe they have been heard.

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**THE VALUE of INTERNAL SURVEYS**

Getting a high patient satisfaction rating can do more than boost your pride or impress patients looking you up online. In some cases, it can lead to more money in your pocket.

Sharp Community Medical Group (SCMG) is one of many employers, insurers, or other companies that give financial rewards to physicians who earn high satisfaction numbers.

SCMG is an association of primary care physicians (PCPs) and specialists in private practices in San Diego County, California. The network includes more than 200 PCPs and more than 500 specialists.

Christa Maruster, patient satisfaction specialist at SCMG, says the group sends out up to 50 patient surveys per month per physician with the goal of receiving at least 30 responses per physician within 12 months, to ensure statistical significance.

The company shares the results, unblinded, at quarterly meetings so everyone can see how they compare with their peers. Email bulletins and Web site postings regularly announce who scored at the 75th percentile level or higher. Quarterly trophies are given to high scorers.

Beyond recognition, however, doctors can earn incentives of up to 5% of their annual compensation from the medical group. The money comes from California’s “pay for performance” initiative, which is designed to improve patient care in the state.

To keep this experience a learning opportunity, high-scoring physicians are asked to share their best practices with their colleagues, many of whom are more willing to listen to a fellow physician than an administrative person, Maruster says.

Also, SCMG is working to post specific “blinded” patient comments on its internal Web site so physicians can get added insights into what helped a colleague earn a high score (this information is not visible to the public). Doctors already can access a secure site to check their patients’ blinded comments at any time.

Because all SCMG doctors own their practices, they are free to ignore the data and lose the financial incentives that are offered. Or they can listen to the feedback and try to improve.

Maruster is available to meet with physicians and office managers, if they wish, to brainstorm ways to improve any areas of weakness. They prepare a written action plan to help ensure accountability in the future. She often suggests training opportunities that are available to them as well. Although she cannot force them to go, she can offer incentives, such as a stipend and continuing medical education credits, for attending.

Some financial incentives also are available to physicians who improve low scores, even if they are still far from the top echelon, Maruster says.

Other opportunities for improvement that SCMG offers include participation in an 8-month program in which doctors with a variety of scores meet to talk and compare notes, and in-office visits by trainers who shadow the physicians for about 2 hours at a time. They offer brief feedback between visits and detailed reports afterward to suggest ways to improve.

“These programs are very helpful for all who want to participate in them,” she says. “We invest a lot in the people who want to do it, and they get a lot from it.”

Maruster says that when the group started using these surveys in 2005, many physicians were skeptical, in part because they suspected that only unhappy patients would participate, and so the doctors resisted participating in any improvement efforts.

Through the use of transparency in the reporting and public recognition for achievements, however, many are now participating willingly, she says.

“It was a long road to get to this point,” Maruster says.

Most physicians who are willing to listen to feedback and attempt changes will see improved survey results, she adds.

“Doctors see themselves as doing a good job if they spend a lot of time with their patients, and they say their other patients don’t mind waiting, but the surveys say otherwise,” Maruster says. “Patients are afraid to complain to a doctor’s face, but they will later once they are in the privacy of their own home.”

—Beth Thomas Hertz

*MedicalEconomics.com*
A negative online review can begin in your parking lot, swell up during a bad waiting-room experience, and end with a billing error. You could be left out of the equation altogether, yet the Web ensures that postings that cut like a knife remain long-associated with your practice.

The crux of the issue is that physicians today don’t have the time to develop personal relationships with patients, which allows small problems to fester and leaves personal relationships with patients, which today don’t have the time to develop long-associated with your practice.

"Let them know you welcome open communication," Shepard says.

Practices also can hire companies such as Press Ganey to conduct those surveys for them. The firm uses sophisticated research methodology to provide detailed reports to their clients that are tied to clinical data, says Patty Riskind, senior vice president of medical services at the company.

"Physicians are so data-driven that they really appreciate the validity of our results," she says.

Press Ganey has about 100,000 physician clients and about 2,400 hospital clients. (Please see “How satisfaction surveys changed my approach,” Page 25, for an inside look at one physician’s perspective on Press Ganey surveys.)

Shepard advises that physicians tell all patients about improvements that have been made due to survey feedback via a brochure, a letter, an email, or whatever vehicle they find most comfortable.

“If one person took the time to tell you something bothered them, other people will have thought that same thing, so communicate positive changes to everyone,” she says.

She also encourages doctors to let patients know that they welcome any feedback, not just via the surveys, by asking them to speak up if they have any problems with the practice. Just as patients are less likely to sue a physician if they think he or she cares, they are less likely to go public with complaints if they do not feel ignored.

“That doctor-patient relationship is always the key,” Shepard says.  

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Inappropriate behavior online can devastate your practice and your career. Learn the mistakes to avoid, according to state medical boards, at MedicalEconomics.com/onlinebehavior
How satisfaction surveys changed my approach

ASSERT INFLUENCE WHERE POSSIBLE AND HOPE FOR THE BEST

[By STEPHANIE WEAVER, MD]

What brings you to see me today, Mrs. Johnson? I asked the elderly lady sitting on my exam room table.

“Well, I have had this awful bronchitis for 2 days,” she coughed, “and I really need an antibiotic to get rid of it because my new grandbaby is coming to visit me tomorrow.”

I sighed, knowing that it was going to be a difficult visit with one of my more demanding patients. Mrs. Johnson (not her real name) had only been my patient for 6 months, but I already had realized that when she asked for something, she was not satisfied if she left without it.

And there was a new twist to satisfying Mrs. Johnson. I am an employee of a large healthcare organization that in January instituted reductions of the physicians’ salaries by up to $5,000 if their patient satisfaction scores fell below a national percentile rank of 50.

Because most patients like their doctors (why would they go to them otherwise?) physicians’ average patient satisfaction scores all cluster above 90% on the Press Ganey surveys that my organization uses. This reality means that a physician with an average score of 92% can have a national percentile rank of 30, whereas scoring an average of 94% can boost the national percentile rank to 70. Because the scores are an average of about 100 surveys per physician, over the course of a year, it’s also possible for a few really low surveys to pull the average down enough to change the national percentile rank from the top half of doctors nationwide to the bottom half.

TREND IS GROWING, ESPECIALLY AT HOSPITALS

Compensation being tied to patient satisfaction scores is likely to be a growing trend for physicians, at least for those affiliated with hospitals. The Patient Protection and Affordable Care Act of 2010 contains a clause that will tie a portion of hospital reimbursement to patient satisfaction scores starting in October if it remains unchanged after the Supreme Court ruling expected in June.

The patient satisfaction scores would be derived from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which has been randomly administered to hospitalized patients after their discharges since 2006. It includes 27 questions meant to measure patients’ perceptions of the quality of their care.

“So far, I have not been able to bring myself to beg for higher scores,” Stephanie Weaver, MD, says, “but I have tried to be more diligent in mentioning possible side effects, especially when prescribing new medications.”
Questions include whether patients would recommend the hospital to others, whether the area around their room was quiet, and whether the bathroom was clean. Reporting of the results of the surveys became mandatory in 2007 for hospitals to receive their full Medicare and Medicaid payments and were made available to the public in 2008.

In October, hospital diagnosis-related group payments are scheduled to be cut by 1%, and hospitals would have the opportunity to earn that 1% back by meeting quality standards (70% of the payment calculation) and scoring above the median on the patient satisfaction surveys (30% of the payment calculation). Hospitals have begun to implement programs to improve customer service ahead of the cuts, and some are tying bonuses for managers of staff departments to achieving patient satisfaction goals. Hospitals have the choice of administering the HCAHPS survey themselves or hiring an outside agency from the U.S. Department of Health and Human Services-approved list.

Administration of the surveys is not an inexpensive venture—it costs tens of thousands of dollars whether contracted out to companies such as Press Ganey or done in-house by the hospital. Hospitals have to hope to recoup the expense of administering the surveys by having high scores.

**SCORE DOESN’T NECESSARILY AFFECT COMPENSATION—YET**

So far, the Centers for Medicare and Medicaid Services (CMS) has not tied any financial incentives to outpatient patient satisfaction surveys, but the agency may do so in the future as part of the movement toward accountable care organizations. Also, many insurance plans are starting to discuss implementing different payment scales for physicians depending on their patient satisfaction scores.

Thus, some outpatient groups are starting to institute patient satisfaction surveys, and a few groups, like mine, are starting to tie a portion of physician compensation to their performance as measured by the survey (see “The value of internal surveys” within the article starting on page 20 for details on how one group uses surveys).

Surveys typically are administered to a random sample of patients after their visits and can be conducted by mail or telephone. Questions can cover several different aspects of the patient experience.

My healthcare organization’s survey covers the patient’s telephone contact with the clinic and the ease with which it was possible to obtain an appointment. Next, it asks about the wait time at the clinic and the performance of the support staff.

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**REFERENCE**

Then the survey asks about the patient’s experience with the physician, and it is specifically to these questions that doctor compensation is tied. The patients are asked about the physician’s friendliness and whether he or she explained the patient’s problem, expressed concern for the patient’s questions or worries, made an effort to include the patient in the decision-making process, provided information about medication side effects, provided instruction for follow-up care, and used clear language. The survey also asks how much time the doctor spent with the patient and asks about the patient’s confidence in the physician and the likelihood of the patient recommending the doctor to someone else.

**POWER POINTS**

Increasingly, physician compensation may be tied to patient satisfaction in groups, hospitals, and other environments.

The move toward accountable care organizations could see the federal government linking financial incentives to survey results.

Insurance companies are discussing implementing different payment scales based on scores.

Steps you take to improve the patient care you deliver also could improve how patients perceive and rate you.

Mrs. Johnson only wanted an antibiotic, but I recently had a 50-year-old patient with no cardiac symptoms or risk factors come for her annual physical with a request for me to order a “complete cardiac work-up,” including a stress test and carotid ultrasound imaging, because a friend of hers had recently had a heart attack. When I replied that her condition did not warrant that kind of testing, she became incensed and said that she had been paying thousands of dollars in insurance premiums and who was I to stop her from using some of that money. I hope she does not receive a survey.

Other patient demands that could be more difficult to refuse would be those for narcotics and other controlled substances. And some of my patients want to participate in the decision-making about their care by having me prescribe diet drugs that I believe are unsafe.

**BACK IN THE EXAM ROOM...**

So where does all of this leave me in my exam room with Mrs. Johnson? I put on my friendliest manner, take the full history of her illness, and then do a thorough problem-focused exam before saying, “So, are you concerned about needing antibiotics and being contagious? Fortunately, from what you have told me and your exam, it appears that your cough is being caused by a virus, and antibiotics don’t kill those. Viruses are less contagious after the first couple of days.”

We agreed that I would prescribe her some cough syrup with codeine (I made sure that I mentioned possible side effects) and that she could call me if she still had symptoms next week. She left looking, if not satisfied, at least not angry (for tips on how to manage angry patients, see “7 steps to managing anger in patients,” Page 33). Meanwhile, I crossed my fingers and hoped that if Mrs. Johnson was randomly selected to receive a survey, she would be fair. 

**LANGUAGE, ‘TEACHING TO THE TEST’ AMONG OPTIONS FOR HIGHER SCORES**

Some of my colleagues have advised me that I should start trying to “teach to the test” when seeing patients, to boost my scores. One doctor recommended ending every visit with, “If you can’t give me a perfect score on the patient satisfaction survey, let me know now.” He said that one of his friends who works at an automobile dealership boosted his customer satisfaction surveys using a similar technique.

Another colleague recommended using specific language from the survey when talking to patients. He advised using the phrases “I am addressing your concerns now” and “Let me tell you about this medicine’s side effects” with the hopes that patients will remember such comments when completing their surveys.

So far, I have not been able to bring myself to beg for higher scores, but I have tried to be more diligent in mentioning possible side effects, especially when prescribing new medications.

**PRESSURE MOUNTS TO MEET UNREASONABLE DEMANDS**

Some experts worry that as the practice of tying physician compensation to patient satisfaction becomes more widespread, doctors will be under more pressure to give in to unreasonable patient demands.
Introducing the power of the first and only ARB/chlorthalidone combination

STATISTICALLY SUPERIOR CLINIC SBP REDUCTION WITH EDARBYCLOR 40/25 mg VS BENICAR HCT® 40/25 mg AT WEEK 12\(^2,3\)

Mean clinic baseline: 164.8 mm Hg

- EDARBYCLOR 40/25 mg lowered trough SBP by 32.9 mm Hg vs 25.9 mm Hg with BENICAR HCT 40/25 mg as measured by ABPM (\(P<0.001\))
- 81.4% of patients on EDARBYCLOR 40/25 mg achieved target SBP/DBP <140/90 mm Hg vs 74.6% with BENICAR HCT 40/25 mg (\(P=0.021\))

*Study Design: A 12-week, randomized, double-blind, forced-titration, active-controlled study in patients (\(N = 1,071\)) with a mean sitting clinic SBP ≥160 mm Hg and ≤190 mm Hg. There was a 3- to 4-week washout period. The primary endpoint was reduction in clinic SBP.

IMPORTANT SAFETY INFORMATION

WARNING: FETAL TOXICITY
See full Prescribing Information for complete boxed warning.
- When pregnancy is detected, discontinue EDARBYCLOR as soon as possible.
- Drugs that act directly on the renin-angiotensin system can cause injury and death to the developing fetus.

- EDARBYCLOR is contraindicated in patients with anuria.
- Fetal Toxicity: Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. When pregnancy is detected, discontinue EDARBYCLOR as soon as possible. Thiazides cross the placental barrier and appear in cord blood. Adverse reactions include fetal or neonatal jaundice and thrombocytopenia.
**IMPORTANT SAFETY INFORMATION**

▼ In patients with an activated renin-angiotensin-aldosterone system (RAAS), such as volume- and/or salt-depleted patients, EDARBYCLOR can cause excessive hypotension. Correct volume or salt depletion prior to administration of EDARBYCLOR.

▼ Monitor for worsening renal function in patients with renal impairment. In patients whose renal function may depend on the activity of the renin-angiotensin system, treatment with ACE inhibitors and ARBs has been associated with oliguria or progressive azotemia and rarely with acute renal failure and death. In patients with renal artery stenosis, EDARBYCLOR may cause renal failure. In patients with renal disease, chlorthalidone may precipitate azotemia. Consider withholding or discontinuing EDARBYCLOR if progressive renal impairment becomes evident.

▼ EDARBYCLOR attenuates chlorthalidone-associated hypokalemia. Hypokalemia is a dose-dependent adverse reaction that may develop with chlorthalidone. Co-administration of digitalis may exacerbate the adverse effects of hypokalemia.

▼ Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving chlorthalidone monotherapy or other thiazide diuretics.

▼ Adverse Reactions (AE):
  - AEs that occurred at an incidence of $\geq 2\%$ of EDARBYCLOR-treated patients and greater than azilsartan medoxomil or chlorthalidone were dizziness (8.9%) and fatigue (2.0%).

▼ Elevations of creatinine ($\geq 50\%$ from baseline and $>\text{ULN}$) were 2% and were typically transient, or nonprogressive and reversible, and associated with large blood pressure reductions.

▼ Drug Interactions:
  - Renal clearance of lithium is reduced by diuretics, such as chlorthalidone, increasing the risk of lithium toxicity.
  - Monitor renal function periodically in patients receiving EDARBYCLOR and NSAIDs who are also elderly, volume-depleted (including those on diuretics), or who have compromised renal function due to potential reversible deterioration of renal function. NSAIDs may interfere with antihypertensive effect.

For further information, please see adjacent Brief Summary of Prescribing Information.

**INDICATION AND USAGE**

EDARBYCLOR is an angiotensin II receptor blocker (ARB) and a thiazide-like diuretic combination product indicated for the treatment of hypertension to lower blood pressure. EDARBYCLOR may be used if a patient is not adequately controlled on monotherapy or as initial therapy if multiple drugs are needed to help achieve blood pressure goals. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. There are no controlled trials demonstrating risk reduction with EDARBYCLOR, but trials with chlorthalidone and at least one pharmacologically similar drug to azilsartan medoxomil have demonstrated such benefits.

Control of high blood pressure should be part of comprehensive cardiovascular risk management, including, as appropriate, lipid control, diabetes management, antithrombotic therapy, smoking cessation, exercise, and limited sodium intake. Many patients will require more than one drug to achieve blood pressure goals.

EDARBYCLOR may be used with other antihypertensive agents.

**References:** 1. EDARBYCLOR Prescribing Information. 2. Data on file.

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Brief Summary of Prescribing Information for:
EDARBLYCIR (azilsartan medoxomil and chlorthalidone) tablets

WARNING: FETAL TOXICITY
See full prescribing information for complete boxed warning.
• When pregnancy is detected, discontinue EDARBLYCIR as soon as possible.
• Drugs that act directly on the renin-angiotensin system can cause injury and death to the developing fetus.

INDICATIONS AND USAGE
Edarbyclor contains an angiotensin II receptor blocker (ARB) and a thiazide-like diuretic and is indicated for the treatment of hypertension, to lower blood pressure.

Edarbyclor may be used in patients whose blood pressure is not adequately controlled on monotherapy.

Edarbyclor may be used as initial therapy if a patient is likely to need multiple drugs to achieve blood pressure goals.

Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. These benefits have been seen in controlled trials of antihypertensive drugs from a wide variety of pharmacologic classes including thiazide-like diuretics such as chlorthalidone and ARBs such as azilsartan medoxomil. There are no controlled trials demonstrating risk reduction with Edarbyclor.

Control of high blood pressure should be part of comprehensive cardiovascular risk management, including, as appropriate, lipid control, diabetes management, antithrombotic therapy, smoking cessation, exercise, and limited sodium intake. Many patients will require more than one drug to achieve blood pressure goals. For specific advice on goals and management of high blood pressure, see published guidelines, such as those of the National High Blood Pressure Education Program’s Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC).

Numerous antihypertensive drugs, from a variety of pharmacologic classes and with different mechanisms of action, have been shown in randomized controlled trials to reduce cardiovascular morbidity and mortality, and it can be concluded that it is blood pressure reduction, and not some other pharmacologic property of the drugs, that is largely responsible for those benefits. The largest and most consistent cardiovascular outcome benefit has been a reduction in the risk of stroke, but reductions in myocardial infarction and cardiovascular mortality also have been seen regularly.

Elevated systolic or diastolic pressure causes increased cardiovascular risk, and the absolute risk increase per mmHg is greater at higher blood pressures, so that even modest reductions of severe hypertension can provide substantial benefit. Relative risk reduction from blood pressure reduction is similar across populations with varying absolute risk, so the absolute benefit is greater in patients who are at higher risk independent of their hypertension (for example, patients with diabetes or hyperlipidemia), and such patients would be expected to benefit from more aggressive treatment to a lower blood pressure goal.

Some antihypertensive drugs have smaller blood pressure effects (as monotherapy) in black patients; however, the blood pressure effect of Edarbyclor in blacks is similar to that in non-blacks. Many antihypertensive drugs have additional approved indications and effects (e.g., on angina, heart failure, or diabetic kidney disease). These considerations may guide selection of therapy.

The choice of Edarbyclor as initial therapy for hypertension should be based on an assessment of potential benefits and risks including whether the patient is likely to tolerate the starting dose of Edarbyclor.

Patients with moderate-to-severe hypertension are at a relatively high risk of cardiovascular events (e.g., stroke, heart attack, and heart failure), kidney failure, and vision problems, so prompt treatment is clinically relevant. Consider the patient’s baseline blood pressure, target goal and the incremental likelihood of achieving the goal with a combination product, such as Edarbyclor, versus a monotherapy product when deciding upon initial therapy. Individual blood pressure goals may vary based on the patient’s risk.

Data from an 8-week, active-controlled, factorial trial provide estimates of the probability of reaching a target blood pressure with Edarbyclor compared with azilsartan medoxomil or chlorthalidone monotherapy.

Figures 1.a–1.d provide estimates of the likelihood of achieving target clinic systolic and diastolic blood pressure control with Edarbyclor 40/25 mg tablets after 8 weeks, based on baseline systolic or diastolic blood pressure. The curve for each treatment group was estimated by logistic regression modeling and is more variable at the tails.
For example, a patient with a baseline blood pressure of 170/105 mm Hg has approximately a 48% likelihood of achieving a goal of <140 mm Hg (systolic) and 48% likelihood of achieving <90 mm Hg (diastolic) on azilsartan medoxomil 80 mg. The likelihood of achieving these same goals on chlorthalidone 25 mg is approximately 51% (systolic) and 40% (diastolic). These likelihoods rise to 85% (systolic) and 85% (diastolic) with Edarbyclor 40/25 mg.

**CONTRAINDICATIONS**

Edarbyclor is contraindicated in patients with anuria (see Warnings and Precautions).

**WARNINGS AND PRECAUTIONS**

**Fetal Toxicity**

*Azilsartan medoxomil*

Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. Resulting oligohydramnios can be associated with fetal lung hypoplasia and skeletal deformations. Potential neonatal adverse effects include skull hypoplasia, anuria, hypotension, renal failure, and death. When pregnancy is detected, discontinue Edarbyclor as soon as possible [see Use in Specific Populations].

**Chlorthalidone**

Thiazides cross the placental barrier and appear in cord blood. Adverse reactions include fetal or neonatal jaundice and thrombocytopenia.

**Hypotension in Volume- or Salt-Depleted Patients**

In patients with an activated renin-angiotensin system, such as volume- or salt-depleted patients (e.g., those being treated with high doses of diuretics), symptomatic hypotension may occur after initiation of treatment with Edarbyclor. Such patients are probably not good candidates to start therapy with more than one drug; therefore, correct volume prior to administration of Edarbyclor. If hypotension does occur, the patient should be placed in the supine position and, if necessary, given an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further treatment, which usually can be continued without difficulty once the blood pressure has stabilized.

**Impaired Renal Function**

*Edarbyclor*

Monitor for worsening renal function in patients with renal impairment. Consider withholding or discontinuing Edarbyclor if progressive renal impairment becomes evident.

*Azilsartan medoxomil*

As a consequence of inhibiting the renin-angiotensin system, changes in renal function may be anticipated in susceptible individuals treated with Edarbyclor. In patients whose renal function may depend on the activity of the renin-angiotensin system (e.g., patients with severe congestive heart failure, renal artery stenosis, or volume depletion), treatment with angiotensin-converting enzyme inhibitors and angiotensin receptor blockers has been associated with oliguria or progressive azotemia and rarely with acute renal failure and death. Similar results may be anticipated in patients treated with Edarbyclor [see Use in Specific Populations].

In studies of ACE inhibitors in patients with unilateral or bilateral renal artery stenosis, increases in serum creatinine or blood urea nitrogen have been reported. There has been no long-term use of azilsartan medoxomil in patients with unilateral or bilateral renal artery stenosis, but similar results are expected.

**Chlorthalidone**

In patients with renal disease, chlorthalidone may precipitate azotemia. If progressive renal impairment becomes evident, as indicated by increased blood urea nitrogen, consider withholding or discontinuing diuretic therapy.

**Hypokalemia**

*Chlorthalidone*

Hypokalemia is a dose-dependent adverse reaction that may develop with chlorthalidone. Co-administration of digitals may exacerbate the adverse effects of hypokalemia. Edarbyclor attenuates chlorthalidone-associated hypokalemia. In patients with normal potassium levels at baseline, 1.7% of Edarbyclor-treated patients, 0.9% of azilsartan medoxomil-treated patients, and 13.4% of chlorthalidone-treated patients shifted to low potassium values (less than 3.4 mmol/L).

**Hyperuricemia**

*Chlorthalidone*

Hyperuricemia or frank gout may be precipitated in certain patients receiving chlorthalidone or other thiazide diuretics.

**ADVERSE REACTIONS**

The following potential adverse reactions with Edarbyclor, azilsartan medoxomil, or chlorthalidone and similar agents are included in more detail in the Warnings and Precautions section of the label:

- **Fetal toxicity** [see Warnings and Precautions]
- **Hypotension in Volume- or Salt-Depleted Patients** [see Warnings and Precautions]
- **Impaired Renal Function** [see Warnings and Precautions]
- **Hypokalemia** [see Warnings and Precautions]
- **Hyperuricemia** [see Warnings and Precautions]

**Clinical Trials Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Edarbyclor has been evaluated for safety in more than 3900 patients with hypertension; more than 700 patients were treated for at least 6 months and more than 280 for at least 1 year. Adverse reactions have generally been mild and transient in nature.

Common adverse reactions that occurred in the 8-week factorial design trial in at least 2% of Edarbyclor-treated patients and greater than azilsartan medoxomil or chlorthalidone are presented in Table 1.

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Azilsartan medoxomil 20, 40, 80 mg (N=470)</th>
<th>Chlorthalidone 12.5, 25 mg (N=316)</th>
<th>Edarbyclor 40/12.5, 40/25 mg (N=302)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dizziness</strong></td>
<td>1.7%</td>
<td>1.9%</td>
<td>8.9%</td>
</tr>
<tr>
<td><strong>Fatigue</strong></td>
<td>0.8%</td>
<td>1.3%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Hypotension and syncope were reported in 1.7% and 0.3%, respectively, of patients treated with Edarbyclor.

Study discontinuation because of adverse reactions occurred in 8.3% of patients treated with the recommended doses of Edarbyclor compared with 3.2% of patients treated with azilsartan medoxomil and 3.2% of patients treated with chlorthalidone. The most common reasons for discontinuation of therapy with Edarbyclor were serum creatinine increased (3.6%) and dizziness (2.3%).

The adverse reaction profile obtained from 52 weeks of open-label combination therapy with azilsartan medoxomil plus chlorthalidone or Edarbyclor was similar to that observed during the double-blind, active controlled trials.

In 3 double-blind, active controlled, titration studies, in which Edarbyclor was titrated to higher doses in a step-wise manner, adverse reactions and discontinuations for adverse events were less frequent than in the fixed-dose factorial trial.

**Azilsartan medoxomil**

A total of 4814 patients were evaluated for safety when treated with azilsartan medoxomil at doses of 20, 40 or 80 mg in clinical trials. This includes 1704 patients treated for at least 6 months, of these, 588 were treated for at least 1 year. Generally, adverse reactions were mild, not dose related and similar regardless of age, gender and race.

Adverse reactions with a plausible relationship to treatment that have been reported with an incidence of ≥0.3% and greater than placebo in more than 3300 patients treated with azilsartan medoxomil in controlled trials are listed below:

**Gastrointestinal Disorders:** diarrhea, nausea.

**General Disorders and Administration Site Conditions:** asthenia, fatigue.

**Musculoskeletal and Connective Tissue Disorders:** muscle spasm.

**Nervous System Disorders:** dizziness, dizziness postural.

**Respiratory, Thoracic and Mediastinal Disorders:** cough.

**Chlorthalidone**

The following adverse reactions have been observed in clinical trials of chlorthalidone: rash, headache, dizziness, GI upset, and elevations of uric acid and cholesterol.

**Clinical Laboratory Findings with Edarbyclor**

In the factorial design trial, clinically relevant changes in standard laboratory parameters were uncommon with administration of the recommended doses of Edarbyclor.

**Renal parameters:**

Increased blood creatinine is a known pharmacologic effect of renin-angiotensin aldosterone system (RAAS) blockers, such as ARBs and ACE inhibitors, and is related to the magnitude of blood pressure reduction. The incidence of consecutive increases of creatinine ≥50% from baseline and ≥0.5ULN was 2.0% in patients treated with the recommended doses of Edarbyclor compared with 0.4% and 0.3% with azilsartan medoxomil and chlorthalidone, respectively. Elevations of creatinine were typically transient, or non-progressive and reversible, and associated with large blood pressure reductions.

Mean increases in blood urea nitrogen (BUN) were observed with Edarbyclor (5.3 mg/dL) compared with azilsartan medoxomil (1.5 mg/dL) and with chlorthalidone (2.5 mg/dL).

**DRUG INTERACTIONS**

*Edarbyclor*

The pharmacokinetics of azilsartan medoxomil and chlorthalidone are not altered when the drugs are co-administered.

No drug interaction studies have been conducted with other drugs and Edarbyclor, although studies have been conducted with azilsartan medoxomil and chlorthalidone.

**Azilsartan medoxomil**

No clinically significant drug interactions have been observed in studies of azilsartan medoxomil or azilsartan given with amlopidine, antacids, chlorthalidone, digoxin, fluconazole, glyburide, ketoconazole, metformin, pioglitazone, and warfarin. Therefore, azilsartan medoxomil may be used concomitantly with these medications.
Non-Steroidal Anti-Inflammatory Agents including Selective Cyclooxygenase-2 Inhibitors (COX-2 Inhibitors).

In patients who are elderly, volume-depleted (including those on diuretic therapy), or who have compromised renal function, co-administration of NSAIDs, including selective COX-2 inhibitors, with angiotensin II receptor antagonists, including azilsartan, may result in deterioration of renal function, including possible acute renal failure. These effects are usually reversible. Monitor renal function periodically in patients receiving Edarbyclor and NSAID therapy.

The antihypertensive effect of Edarbyclor may be attenuated by NSAIDs, including selective COX-2 inhibitors.

Chlorthalidone

Lithium renal clearance is reduced by diuretics, such as chlorthalidone, increasing the risk of lithium toxicity. Consider monitoring lithium levels when using Edarbyclor.

USE IN SPECIFIC POPULATIONS

Pediatric Use

Safety and effectiveness of Edarbyclor in pediatric patients under 18 years of age have not been established.

Neonates

Neonates with a history of in utero exposure to Edarbyclor

Geriatric Use

Chlorthalidone is excreted in human milk. Because of the potential for adverse effects on the nursing infant, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pregnancy

Azilsartan medoxomil

Mutagenesis: Azilsartan medoxomil, azilsartan, and M-II were positive for structural aberrations in the Chinese Hamster Lung Cytogenic Assay. In this assay, structural chromosomal aberrations were observed with the prodrug, azilsartan medoxomil, without metabolic activation. The active moiety, azilsartan, was also positive in this assay both with and without metabolic activation. M-II was also positive in this assay during a 24-hr assay without metabolic activation.

Azilsartan medoxomil, azilsartan, and M-II were devoid of genotoxic potential in the Ames reverse mutation assay with Salmonella typhimurium and Escherichia coli, the in vitro Chinese Hamster Ovary Cell forward mutation assay, the in vitro mouse lymphoma (tk) gene mutation test, the ex vivo unscheduled DNA synthesis test, and the in vivo mouse and/or rat bone marrow micronucleus assay.

Impairment of Fertility: There was no effect of azilsartan medoxomil on the fertility of male or female rats at oral doses of up to 1000 mg azilsartan medoxomil/kg/day (6000 mg/m² [approximately 122 times the MRHD of 80 mg azilsartan medoxomil/60 kg on a mg/m² basis]). Fertility of rats was also unaffected at doses of up to 3000 mg M-I/kg/day.

PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information).

Tell patients that if they miss a dose, they should take it later in the same day, but not to double the dose on the following day.

Pregnancy

Tell female patients of childbearing potential about the consequences of exposure to Edarbyclor during pregnancy. Discuss treatment options with women planning to become pregnant. Tell patients to report pregnancies to their healthcare providers as soon as possible.

Symptomatic Hypotension

Advise patients to report light-headedness. Advise patients, if syncope occurs, to have someone call the doctor or seek medical attention, and to discontinue Edarbyclor.

Renal Impairment

Inform patients that dehydration from excessive perspiration, vomiting, or diarrhea may lead to an excessive fall in blood pressure. Inform patients to consult with their healthcare provider if these symptoms occur.

Renal Impairment

Inform patients with renal impairment that they should receive periodic blood tests to monitor their renal function while taking Edarbyclor.

Gout

Have patients report gout symptoms.

Distributed by Takeda Pharmaceuticals America, Inc.

Deerfield, IL 60015

For more detailed information, see the full prescribing information for EDARBYCLOR at www.edarbyclor.com or contact Takeda Pharmaceuticals America, Inc. at 1-877-825-3327.

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December 2011

AZC066 R1

L-LXAC-1211-2

[33x-448]eGFR 30-60 mL/min/1.73 m

[33x-432]eGFR <30 mL/min/1.73 m

[33x-424]Safety and effectiveness of Edarbyclor in patients with severe renal impairment

[33x-415]Edarbyclor

[33x-265]age or older); 5.7% were 75 years and older. No overall differences in safety or effectiveness of Edarbyclor in patients with severe renal impairment.

[33x-183]Edarbyclor

Geriatric Use

Neonates with a history of in utero exposure to Edarbyclor

Geriatric Use

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December 2011

AZC066 R1

L-LXAC-1211-2

[33x-440]2

[124x-445]2

[126x-448]) renal impairment.

[233x-440]) or moderate

[290x-103]All other trademark names are the property of their respective owners.

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December 2011

AZC066 R1

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[33x-440]2

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[233x-440]) or moderate
All physicians—and their employees—know them: patients who react to problems with anger and other negative emotions. In these instances, front-office staff are usually the first line of defense. They’re often busy handling multiple duties, however, and just want to get past the angry person and on to the next task. Instead of deflecting or defusing the anger, this attitude often intensifies it.

What can you do to help staff deal with hostile patients? A technique with the acronym RAPSAND is a creative way to handle the emotional components of a conflict. When emotion is high, logic is low; when logic is high, emotion is low. RAPSAND is designed to raise logic and help keep emotions in check.

Like any training, RAPSAND is most effective if it’s practiced on an ongoing basis. Use role-playing during staff meetings, and eventually everyone will
get a chance to play both the difficult patient and the staff member who is trying to manage the difficult patient. Feedback from other employees during this process provides some of the best training.

The purpose of RAPSAND is to build “emotional muscle” in your staff members—and like any other muscle, it responds best to regular use. At the same time, staff training, if it solves a real problem or raises the staff’s level of competency, is a potent tool for increasing staff retention and motivation.

REMEMBER THIS ACRONYM
RAPSAND, as the acronym indicates, consists of seven elements.

R  Re-establish rapport

Emotional conflict, by definition, is adversarial; rapport has broken down. To re-establish rapport, use a combination of empathetic statements and body language.

The empathetic statement—for example, “I understand,” “I can see why you’re concerned,” or “I can see why you feel that way”—tells the patient that the staff member agrees that the problem is important. It further validates that staff members are there to take care of the problem.

During an emotional confrontation, the natural reaction of many front-desk staffers is to fold their arms, lean back in their chairs, and speak softly. These reactions often are the worst things to do, however.

A more effective response has been suggested by psychologist Albert Mehrabian’s 7%/38%/55% rule. According to Mehrabian, communication generally consists of 55% body language, 38% tone of voice, and 7% what is actually said. As such, train your staff to mirror the angry patient’s body language and tone of voice. That is, move closer to them, tilt your head forward, and speak in similar volume.

Just be careful that a conversation doesn’t escalate into a full-blown shouting match. That’s not the intention. The aim, rather, is to set the stage for a solution.

P  Problem

Before you can solve a problem, you need to verify what it actually is. Not only does this effort become part of the yes momentum—“Do I understand this correctly? Is this the problem?”—it involves the patient in problem-solving. Addressing a problem without including the patient in the process tends to make the patient feel as if he or she is being marginalized, that he or she is just being pushed through the system.

Train your staff members to take notes while they’re asking questions. Their doing so conveys the impression that the problem is being taken seriously. Instruct staff to ask for clarification (“Please tell me one more time exactly what the problem is”) and provide confirmation by repeating what the patient has said (“Just to be sure I understand correctly...”).
Solution

Ideally, solutions to front-office problems should be part of your practice’s policies and procedures. If your practice routinely solves problems on the fly, policies and procedures probably need to be strengthened or fine-tuned.

One approach, if front-office staff members are unsure of the correct solution, is to designate a go-to person in the office who has the authority to solve the problem. Typically, this person is the office manager. Having a go-to person not only eliminates guesswork, it takes the staffer out of the hostile environment while a peace plan is put in place.

Ask permission to solve the problem

Having come up with a plan, the next step is to ask the angry patient’s permission to solve the problem. The staffer might say, “Okay, the problem is a billing issue. What we’re going to do is re-file the claim with different modifiers. We’re going to hold off on processing your bill until we hear back from the insurance company. Is that okay?”

The idea is to make sure the patient is in full agreement. If the patient isn’t in full agreement, then the staffer should discuss the problem again with the office manager or other go-to person.

Next step

After getting permission to solve the problem, the staffer should explain to the patient what happens next. For instance, in the case of re-filing a claim, the staffer might say, “We’re going to re-file this claim. This will take about a week. If you don’t hear from us by Friday, call me. I’m the person who will take care of this.”

Knowing who will handle a problem—and how to contact that person—assures the patient that he or

The purpose of RAPSAND is to build ‘emotional muscle’ in your staff members—and like any other muscle, it responds best to regular use.”
ANGRY PATIENTS

she won’t have to constantly repeat the situation and chain of events over and over to different people. It also solidifies the idea that someone is there to help.

**Document**

Provide the patient with something in writing—either printed or handwritten—that describes the problem, the solution, who’s in charge of solving the problem, and what the next step will be. It gives the patient, when he or she cools down, a chance to review the solution, and it assures him or her that a staff member intends to see the solution through to the end.

**CONTROL THE SITUATION**

Of course, not every patient can be calmed down. Some people are just chronically angry, and that anger may not have much to do with the stated problem. Perhaps a patient’s health concerns are making him or her angry, or medication is causing him or her to feel irritable.

Ultimately, the only person staff members can control is themselves, but by using RAPSAND, they are controlling the situation, which will go a long way toward defusing negative circumstances and allowing everybody to focus instead on good medicine.

David Zahaluk, MD, top, a family physician in Dallas, Texas, is a practice optimization expert and the author of The Ultimate Practice Building Book. Mark Terry is a freelance writer in Oxford, Michigan, who specializes in medicine, health, and biotechnology. He is the co-author of 31½ Essentials for Running Your Medical Practice. Send your feedback to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.

**Survey: ICD-10 readiness even worse than expected**

If you’re relieved that the compliance date for adopting ICD-10 might be delayed for your practice, you’re not alone. Survey results released by the Workgroup for Electronic Data Interchange (WEDI) on March 19 revealed that much of the industry will not be able to meet the original October 1, 2013, compliance date.

In February, Health and Human Services (HHS) Secretary Kathleen G. Sebelius announced that HHS would postpone the date by which “certain healthcare entities” needed to file claims using ICD-10. HHS has not yet announced a new date, indicating that the entities will receive more time.

Since 2009, WEDI has been conducting ICD-10 readiness surveys to measure industry compliance progress. The organization also acts as an adviser to HHS regarding health data policy issues. WEDI’s assessment is derived from survey responses collected from more than 2,600 providers, health plans, and vendors. Based on the premise that impact assessments and other key milestones should have been completed in 2011, survey results show that the industry is falling behind with ICD-10 compliance.

For example, although one-third of providers expected to begin external testing in 2013, another 50% responded that they did not know when testing would occur. In addition, most health plans do not expect to begin external testing until 2013, and 25% of health plan respondents are less than halfway through their assessment of ICD-10 readiness.
Correct patient privacy and confidentiality violations

How easy is it to violate patient privacy and confidentiality in a practice setting? Very easy. Such violations usually are unintentional and occur because of a preoccupation with the task at hand.

The concept of privacy and confidentiality is basic to medicine. It is often violated, however, thereby exposing physicians to legal, Health Insurance Portability and Accountability Act (HIPAA) and moral concerns.

KEEP IT CONFIDENTIAL

Confidentiality means that you cannot share a patient's information with any other person in either verbal or written form. Information learned during the course of treatment that is material to that treatment is protected by confidentiality laws. Disclosure of such information could be construed as a breach of a patient's privacy.

Doctor-patient privilege means that a patient's information is protected and cannot be obtained by any third party. Although you own the records, the patient owns the privilege. A patient must waive the privilege before you can release records or discuss his or her case with others.

A patient, rightfully, does not want or expect his or her personally identifiable health information to be shared with others. But in your office, you never know who is listening. It could be a friend, a relative, or a reporter. If a patient authorizes a third party to be present, however, then the privilege regarding that third party is waived.

Patients have the right to sue you if you violate their privilege and they are damaged as a result. In one example, a patient's employer heard from a physician that an employee had AIDS and, as a result, fired the employee/patient. The doctor was sued and lost.

KNOW THE LAW

Federal HIPAA laws are superimposed on state confidentiality laws. Federal laws usually supersede state laws, but state law still may prevail if it is more strict.

HIPAA protects all personally identifiable health information. It includes all information that identifies, or could reasonably be used to identify, a patient regardless of medium employed. Although originally envisaged as a regulator of electronic health records (EHR), it applies to paper records and verbal communication as well.

HIPAA allows the transfer of personally identifiable health information without a patient's consent in three circumstances: for treatment, payment, and healthcare operations.

Although HIPAA regulations often are burdensome, they help clarify some issues for physicians. Before HIPAA, patients had no specific waiver that allowed physicians to share information, yet good practice and avoidance of malpractice dictate the abundant sharing of information. This conundrum for the physician is now resolved.

HIPAA also adds more penalties. Patients can still sue, but they can also complain to the federal government. The government can investigate and can impose fines.

COMMON VIOLATIONS

Privacy lapses may be intentional or unintentional. Most lapses are avoidable with care. They are often the result of preoccupation with other tasks at hand. Privacy comes up in all aspects of patient care, from making the appointment through the office visit, testing, and/or surgery. No areas of an office are exempt from possible violations.

Many inadvertent and often seemingly harmless violations of patient privacy occur in the office setting on a day-to-day basis. Some of the causes of those violations:

Office design. Privacy should be a concern as you plan the design of your office. It is common to sit in a doctor's office and hear everything the physician is saying to the patient in the next room, either through the wall or a door that is left open.

New facility. If you are just starting a practice or moving into a new facility, make it a priority to ensure confidentiality at all times. When building a new office, bring up the topic of privacy during the design stage. It is much easier to plan ahead than correct a problem later.

For example, when I (Dr. Weinstock) had an office in a hospital-built medical building, during the construc-

POWER POINTS

Physicians have a legal and moral obligation to protect patients' privacy.

Physicians and their staff inadvertently violate patients' privacy every day.

The possibility of a privacy lapse in the practice setting exists at every level of patient care.
“If you look around your office with an objective and perceptive view, you probably will spot potential privacy hazards.”

...tion phase I mentioned the concept of sound transference and confidentiality and was assured it would be adequate. When construction was finished however, it was possible to stand in one room and hear the conversations in the adjoining rooms. Attempts were made to soundproof rooms late in the design process, with minimal success. The use of a music system helped significantly, but occasional loud conversations could be heard.

**Reception.** When your practice receives phone calls for appointments, prescription renewals, or test results, your receptionist should be aware of patients who are nearby and might hear these conversations. Try to avoid discussing diagnoses if others might hear. Be careful to avoid using your patients’ names on the phone.

**Telephone calls.** Although doctors and staff should take phone calls in a secure area, they rarely do. Physicians rarely take care to avoid private conversations, because they don’t have time to leave the room. Phone calls require care when you are in a room with a patient, however. Excuse yourself and take the call in your office or a secure area.

Usually, however, a physician walks out of the room, leaves the door open, and carries on a conversation that patients and others in the office can hear. Some people have naturally loud voices. If you do, then take your phone calls in an insulated area or try to speak quietly.

**EHRs.** If you step out of the exam room to speak to someone, don’t leave on the EHR computer that’s in the room. Doing so makes it possible for your patient to look at the previous patient’s (or any other patient’s) information.

**Contacting patients.** Ask your patients how they want to be contacted or notified about appointments or test results. Do they prefer fax, e-mail, text, or phone? Ask patients to sign a form that gives you permission to notify them via the media of their choice.

Sometimes, messages end up in the wrong hands. Take precautions to safeguard the confidential material contained in medical documents. Make sure you have your patient’s correct contact numbers. Request that you be notified immediately if a document arrives at the wrong place. Include a warning. As an added precaution, ask the recipient to call your office and verify that he or she received the information.

**Staff discussions.** Staff members often will come into your exam room to give you test results for another patient. Instead, they should write this information on a note that they hand you or ask you to leave the room to hear what they have to say.

**Non-medical discussions.** Don’t spend “down” time talking about patients. Also do not talk about golf, investments, and other topics that might upset patients or staff. Some doctors have a rule that personal phone calls from family members are put right through. If you have such a policy, consider the effect of such conversations on the patient sitting there.

If a partner or colleague is not being discreet, you have an obligation to bring this up to the physician who is doing the talking. Point it out, because usually people are not aware of how loud they speak or that they are discussing inappropriate topics.

**Sign-in sheets.** Sign-in sheets can be another breach of confidentiality. In most offices and in many hospitals, these sheets are left out in the open. This practice enables all patients to see who visited the office earlier in the day. Some offices cover up the previous patients’ names, but usually it is still possible to read them.

**Identifiable equipment.** Equipment, samples, and prescriptions may be left out in the office and marked with a patient’s name. For example, an allergist may leave vials of injectables in boxes labeled by patient for use on that day, but they can be seen by all the other patients in the office.

**BE PROACTIVE**

You should not violate patient confidentiality. Be proactive to avoid potential problems. If you look around your office with an objective and perceptive view, you probably will spot potential privacy hazards. Get together with your colleagues and staff to try to correct any potential privacy breaches.

Consider the ethical and legal concerns of confidentiality and privacy in all situations. Adherence should be automatic. Privacy protection can and should be habit-forming.

Johnson is a health law attorney in Mt. Kisco, New York. Weinstein is on the faculties of the Northeast Ohio Medical University, the Charles E. Schmidt College of Biomedical Science at Florida Atlantic University, and the University of Miami Leonard M. Miller School of Medicine. Law Consult deals with questions on common professional liability issues. Unfortunately, we cannot offer specific legal advice. If you have a general question or a topic you would like to see covered here, please send it to medec@advanstar.com. Also engage at www.twitter.com/MedEconomics and www.facebook.com/MedicalEconomics.
5010 enforcement discretion date extended

Q: Our office is still having difficulty getting our claims processed under version 5010. What can we do?

A: First of all, let me reassure you that you are not alone, and the Centers for Medicare and Medicaid Services (CMS) has heard the complaints from the provider community.

As a result, CMS announced, in a press release dated March 15, that its Office of E-Health Standards and Services (OESS) has extended the 5010 enforcement discretion date an additional 3 months to June 30. That means that during this time, the OESS will not initiate enforcement action against any covered entity that is not compliant under the Health Insurance Portability and Accountability Act (HIPAA): Accredited Standards Committee (ASC) X12 version 5010, National Council for Prescription Drug Programs Telecomm (NCPDP) D.0 and NCPDP Medicaid Subrogation 3.0.

As you know, the OESS already had given an extension until March 31 for the 5010 conversion. Although the CMS press release reports that “health plans, clearinghouses, providers, and software vendors have been making steady progress” (see chart below), they are continuing to see challenges that are hindering the implementation.

To help overcome these issues and challenges, OESS has implemented the following additional assistance so that transition statistics reach their expected 98% by the end of June:

- The OESS (by itself and in partnership with Medicare fee-for-service [FFS], Medicaid, and several industry groups) will offer expanded technical support to overcome the remaining obstacles. Details of this support have not been published yet.
- Medicare FFS will continue to offer educational provider calls regarding the 5010 conversion issues.
- Medicare administrative contractors (MACs) will continue to work closely with clearinghouses, billing vendors, and healthcare providers who need help submitting or receiving

<table>
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<tr>
<th>Entity</th>
<th>5010 implementation success</th>
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| Medicare fee-for-service (FFS)   | **PART A**: more than 70% of claims
                                            **PART B**: more than 90% of claims |
| Commercial plans                 | Reporting similar numbers as Medicare FFS. |
| State Medicaid agencies          | Showing progress (no specific percentages reported). Some have made full transition. |
| Covered entities                 | Reporting similar progress as state Medicaid agencies. |

How to refine your version 5010 conversion

After you finish your office upgrade to version 5010, you must ensure that your claims are being submitted and paid properly.

Look for a reason
If you are experiencing an increase in claim rejections or denials, review your claims closely to determine the reason. It’s possible that insufficient or incorrect data are being provided to meet the version 5010 standards. Payers have a part in correcting this issue, because forwarding, converting, or formatting data can result in rejections or denials, so talk with the payer(s) involved.

Check the address
If you are having issues with your non-electronic funds transfer (EFT) payments, formatting of your provider billing address could be the culprit. The provider’s full nine-digit (not five-digit, as previously allowed) ZIP code is required for the billing address. If your practice is submitting the incorrect billing address, your non-EFT payments or explanations of benefits (EOBs) may be mailed to the wrong location. Review your EOBS and claims regularly to identify any address issues, and, if any are found, verify with the specific payer enrollment department(s) that your billing address is correct.

Monitor claims
You might have formatting discrepancies with your trading partners (such as payers or clearinghouses) that can result in rejected claims. Interpretation of the new standards might be different for your trading partners than for your office, so coordinate with the partner to determine gaps or discrepancies in claims submissions by monitoring claims that are automatically transferred between payers.

Get the facts
Be proactive and review the version 5010 section of the ICD-10 Web site (www.cms.gov/ICD10/11a_Version_5010.asp) to find fact sheets and the latest news regarding the version 5010 upgrade.
5010-compliant transactions (If you are having difficulties with your MAC, contact Karen Jackson at Karen. Jackson1@cms.hhs.gov).

- CMS’ Medicaid staff will continue to work with their respective state Medicaid programs to resolve remaining problems. If you are experiencing Medicaid 5010 claim processing problems, you are encouraged to send your information to Medicaid5010@cms.hhs.gov.

OESS expects that transition statistics will reach 98% industry-wide by the end of the enforcement discretion period. The 5010 conversion is complex, requiring cooperation from payers, vendors, software companies, and providers. To meet this goal, everyone is going to need to work together to resolve any remaining problems.

**IMPLEMENTATION DATE FOR ICD-10 TO BE DELAYED**

**Q:** We heard that we might not be converting to ICD-10 on the original date. Is that true?

**A:** The Centers for Medicare and Medicaid Services (CMS) issued on February 16 a press release announcing that the U.S. Department of Health and Human Services (HHS) intended to delay the ICD-10 implementation date, originally scheduled for October 1, 2013. HHS Secretary Kathleen Sebelius gave this explanation for the delay: “We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to re-examine the pace at which HHS and the nation implement these important improvements to our healthcare system.”

Sebelius then announced on April 9 that compliance for ICD-10 will be delayed 1 year, to October 1, 2014, as part of a proposed rule that aims to simplify certain Patient Protection and Affordable Care Act administrative provisions.

Healthcare professionals and national organizations, including the American Health Information Management Association (AHIMA), had publicly voiced opposition to the delay and concern that the message could be misinterpreted by the provider community as a reason to interrupt their ICD-10 implementation progress.

AHIMA had asked CMS to issue a clear statement indicating that ICD-10 conversion efforts should not be halted while HHS reviewed its timeline. According to AHIMA and an Edifecs poll of senior healthcare professionals (www.edifecs.com/downloads/EdifecsSurvey-ICD10Delay.pdf), the delay in implementing ICD-10 could lead to:

- **Lost resources.** Healthcare providers have invested resources over the past 3 years to review their systems and train staff.
- **Increased costs.** Healthcare providers and plans will expend more money to maintain two systems (ICD-9 and ICD-10), personnel transition training costs will increase, and more resources will be needed to repeat some implementation activities.
- **Lost jobs.** To prepare for the transition, healthcare entities have hired additional staff members whose jobs will be affected.

**Slowed provider readiness.** Delay in the ICD-10 implementation date would not result in improved readiness because budget and staff resources would be reassigned to more urgent tasks.

Other organizations however, such as the American Medical Association and the Medical Group Management Association (MGMA), oppose the transition to ICD-10 until HHS has a thorough understanding of the significant impact it will have on the provider community.

MGMA offers seven recommendations that involve:

- extensive cost/benefit analysis;
- pilot testing;
- analysis of overlapping initiatives;
- evaluation of additional code set approaches such as improving ICD-9 or mandating only inpatient use of ICD-10;
- staggered implementation dates, with clearinghouses and insurers first and providers at least a year later;
- development of a single set of ICD-9/ICD-10 crosswalks; and
- certification of insurers, clearinghouses, and practice management/billing software.

Although the implementation date has been delayed, the effort required to be ICD-10-compliant is significant, and practices cannot afford to be idle.

For more information about how to prepare for ICD-10, see the Practice Management Q&A column on page 46.
Why join a hospital-owned practice?

Q: I am considering joining a hospital-owned physician practice and want to make an informed decision if I decide to make this change. What traits should I look for in successful hospital-owned physician organizations?

A: First, ask the hospital or health system representative to describe the support or management team that is tasked with the physician group’s success. Are the physicians organized as a “real” group, or is it more like a conglomeration of physicians functioning independently? Successful physician organizations are well-defined, and have organizational charts and clear reporting relationships. Ask for sample monthly reports that are given to the physicians. Successful groups provide regular reports that track important key indicators that are relevant to the compensation model.

Also ask to see the business plan or reason for the development of the physician group. Look for health systems that are developing physician groups for more than defensive reasons. Also, the hospital’s strategy must match your healthcare philosophy and beliefs. Because most hospitals and health systems now employ physicians, it is vital that you find an employer that matches your culture and needs—if you choose to seek employment. Moving into employment is a major step and involves detailed research and consideration of the hiring organization. It might turn out to be a short-lived situation without careful study.

Compensation models are simple, numerical formulas that allocate revenues and expenses. The difficulty arises in implementing the plans to fit the group’s culture, personality, practice style, mission, and business plan. The art in designing the compensation plan is accurately reflecting the behaviors the group wants to reward to achieve its business goals. The wrong plan can cause a group to stagnate and put disincentives in place to keep physicians from taking risks or taking care of certain patients. Groups that have a strong culture of sharing and measure key success indicators can maintain all-equial compensation models.

THE BEST COMPENSATION MODEL IS ONE DESIGNATED FOR A SOLO PRACTICE

Q: We are a large, single-specialty group interested in revising our compensation model. Can all-equial salary models work between partners?

A: Physician compensation always is the most difficult area for partners to agree on. There is neither a right answer nor a uniform formula or model that always will work. The best, time-tested compensation model guaranteed to work is the solo practitioner model: revenue minus expense equals physician compensation.
Q: Why do some hospitals’ chief executive officers (CEOs) refer to employing physicians as a curse and others as a blessing?

A: Employing physicians is a direct response to decreased physician profits (take-home pay) and healthcare reform. Some healthcare systems have created detailed strategies to engage physicians and develop networks and continuums of care. Time will tell whether these plans are the correct strategies to fulfill the missions of the healthcare systems. Systems that have a concrete plan to develop, refine, and engage their physician organizations, however, tend to be more successful, and CEOs believe as though the employment model is a blessing.

The curse pertains to the financial issues and promises that were made in the course of recruiting physicians and practices that are no longer sustainable on their own. Most hospital-employed physicians require an investment of $60,000 to $240,000 each per year. The investment is a combination of employment contracts, infrastructure issues, poor reimbursement, and lack of a well-defined strategy.

Changing employment status from a “curse” to a “blessing” is a difficult transition that requires identifying poor performance, changing compensation models, and changing course (that is, changing some promises that were made in initial recruitment discussions) to ensure the survival of all parties.

Hospital being willing but not compelled to buy the services from the physician.

In essence, hospitals are under constraints through a variety of rules, regulations, and compliance issues to not overpay for reasons other than market value of services. The rules are designed to protect the community and patients from a hospital paying higher than market rates to obtain physician referrals or procedures. Fair market value typically is determined by a third party or a hospital’s compliance department. Available physician compensation survey data are used for a physician specialty. Examples of survey data include those from the Medical Group Management Association and Sullivan Cotter & Associates, Inc.

PHYSICIANS, MANAGERS, AND CODERS SHOULD PREPARE NOW FOR ICD-10

Q: ICD-10 is coming. When do I need to start preparing for the change in coding?

A: Although the kick-off for this large-scale change in coding to the 10th revision of the International Classification of Diseases (ICD-10) was planned for October 1, 2013, the Centers for Medicare and Medicaid Services (CMS) recently announced that it has pushed back the deadline. Regardless, this issue is one that should not be taken lightly by any medical practice. CMS maintains that once it settles on a go-live deadline, ICD-9 codes will not be accepted.

With this in mind, we strongly recommend physicians, office managers, coders, and IT support staff begin preparing for ICD-10 immediately. Approach the project as you might a clinical situation: perform an assessment, plan, and get started right away.

ICD-10 will require more in-depth knowledge of anatomy and physiology, so it is important to develop a baseline for your staff members in these areas. Evaluate their knowledge through a variety of assessment tools, such as the ones found at the American Health Information Management Association Web site.

Assess your own documentation by obtaining a gap analysis of current documentation versus the documentation requirements of ICD-10. This analysis should be performed by a certified coder, using a combination of chart reviews and determination of overall use of “non-specific” diagnostic codes assigned by the physician.

Finally, assess your practice software. It is important to ensure your practice management/electronic health record software vendor has made all the necessary upgrades to support ICD-10 by January 1, 2013.

(For another viewpoint on ICD-10 implementation, see www.MedicalEconomics.com/ICD-10waiting.)
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Part-time associate should be classified as employee

Q: I have been treating the part-time associate in my practice as an independent contractor for the past 2 years, but my accountant suggested that she should be classified as an employee instead. I don’t want to make the change because of the additional payroll taxes. Do I have to reclassify her?

A: If the physician works for you regularly, then it is safer and more appropriate to treat her as an employee, rather than as an independent contractor. Your accountant, lawyer, and other outsiders, by contrast, are more appropriately treated as independent contractors.

When someone’s work is under your control, and the person works in your office and provides regular ongoing services, you are required to treat that person as an employee by withholding income taxes and matching payroll taxes. Further, if you treat her as an independent contractor and she fails to pay her taxes, you can be held liable for those taxes.

OPERATING MEDICAL PRACTICE AS CORPORATION REDUCES AUDIT RISK

Q: Am I more likely to be audited if I operate my practice as a professional corporation or as a sole proprietorship?

A: Over the years, physicians operating under a sole proprietorship have been considered the “bigger fish in the sea” when they have net income of $150,000 to $250,000. Their audit risk has been approximately 5%, which is much higher than the national average.

By contrast, a professional corporation with gross revenues of less than $1 million is considered a “small fish” and has an audit risk of approximately 1%, which is about the same as the overall population. Starting in April, however, the Internal Revenue Service (IRS) will be performing random audits on about 2,500 small corporations around the country so that it can update the secret formulas used to select which returns to audit. The IRS will be examining tax returns from the 2010 corporate year.

S CORPORATION PROFITS MUST BE TAKEN IN THE FORM OF SALARY

Q: I operate my practice as an S corporation and was told I am permitted to take income out as profits before taxes, rather than as wages. Is this true?

A: You are required to take out a reasonable salary as W-2 wages and pay payroll taxes. If you take out less and call it “profits,” the Internal Revenue Service (IRS) can recharacterize the distributions, and you may be also subject to interest and penalties. The IRS knows that this misclassification occurs frequently and continues to be on the lookout for it.

DON’T WAIT TO BEGIN MAKING WITHDRAWALS FROM INHERITED IRA

Q: My father passed away in 2002 and left me his individual retirement account (IRA). I have not made any withdrawals from it and was told recently that I should have. Is that true? What should I do?

A: The information you received is correct. You were required to start withdrawals either by the year following your father’s death or to take all of the funds out within 5 years of his death. You need to get caught up by withdrawing all of the distributions you should have taken from the time of his death through today.

Your next step should be to file Form 5329 with the Internal Revenue Service (IRS) for each year of withdrawal you missed, and request a waiver of the 50% excise tax. The IRS will waive the requirement only if you can prove that you missed those distributions due to reasonable error and that you are taking reasonable steps to fix it.
Your financial adviser must put your interests first

Last month Greg Smith, an executive with the investment firm Goldman Sachs, wrote an op-ed for the New York Times in which he announced his resignation and offered scathing criticisms of his former employer. Among other reasons for resigning, Smith felt many of his former colleagues were not acting in the best interest of their clients. “It makes me ill how callously people talk about ripping their clients off,” he wrote.

Smith’s article serves as a wake-up call to both Wall Street and Main Street about the responsibility of financial professionals toward their clients’ interests. The problem is that many—although certainly not all—financial salespeople are compensated based on the fees and commissions they generate. This is true across the board, from the largest wealth management firms to independent financial advisers and brokers.

THE VALUE OF FIDUCIARY RESPONSIBILITY

So how do you determine who is best-suited to manage your wealth? Smith does not use the word “fiduciary” in his article, but it is a vital concept for today’s investors. According to a study our firm conducted, fewer than 2,500 of the more than 1 million people who call themselves financial advisers are registered fiduciaries, meaning they are legally bound to act in the best interest of their investor clients.

When confronted with a range of titles, be it financial adviser, consultant, or wealth manager, how can you be sure the person you hire always will be acting on your behalf? What makes the question especially confusing is that some brokers will say they are able to act as both fiduciary and salesperson, seamlessly alternating between each role (typically depending on which role pays the most) without taking 100% fiduciary responsibility 100% of the time. So how can you know whether an adviser who says he or she is acting as your fiduciary is looking out for your best interests, rather than merely trying to sell you the latest financial product?

HOW TO PROTECT YOUR FINANCIAL INTERESTS

Here are three steps you can take to ensure that your financial adviser is acting solely in your best interest:

- **Require all financial professionals working for you to sign a fiduciary agreement.** Each adviser must be willing to sign a “fiduciary oath” stating that the advice he or she provides is in your best interests—even if those best interests are not in line with their best interests (meaning the advice won’t necessarily yield the greatest amount of money for them). Ask your attorney to draft such an agreement, and have it notarized.

- **Ask the financial professional how he or she is compensated.** A true fiduciary will not accept any fees (beyond the standard advisory fee). That means no referral fees, commissions, or rebates of any kind.

- **Thoroughly vet the advisers you hire.** Ask for references, then ask the references to assess the adviser’s performance—whether he or she is an honest, competent, professional investor and money manager. If your adviser is honest but not competent, he or she eventually will send you to the poorhouse. If your adviser is competent but not honest, he or she will part you from your money. Look for an individual or firm with at least 10 years of performance that has been reviewed by an independent accounting firm.

These simple steps will show who is truly willing to act as your fiduciary and look out for your best interests, come what may.
C. diff infections primarily start in healthcare settings

Nearly all Clostridium difficile infections (CDIs) are related to healthcare settings where predisposing antibiotics are prescribed, according to the Centers for Disease Control and Prevention (CDC). From a surveillance program of eight geographic areas in 2010, the CDC identified 10,342 CDIs; 94% of these were related to healthcare exposures. Of these, 75% had their onset outside of hospitals, including recently discharged patients, outpatients, and nursing home residents. Seventy-one hospitals from three states participating in prevention programs that focused primarily on infection control strategies were able to reduce the incidence of CDIs by 20% over 21 months. The CDC says that healthcare exposures are potentially preventable by reducing unnecessary antibiotic use and by interrupting patient-to-patient transmission of C. difficile.

Stroke, atrial fibr rates higher with rheumatoid arthritis
BMJ. 2012;344:e1257. [March 8, 2012]
The risks of atrial fibrillation (AF) and stroke are higher in patients with rheumatoid arthritis (RA) compared with the general population. The entire Danish population aged more than 15 years as of January 1, 1997, who were free of RA, stroke, or AF served as the study cohort. They were followed for a median of 4.8 years, during which time 18,247 developed RA. Those who developed RA had a 40% greater risk of AF and a 30% greater risk for stroke than the general population. Rates of AF were 8.2 per 1,000 person-years in patients with RA versus 6.0 in the general population. Stroke rates were 7.6 per 1,000 person-years in patients with RA versus 5.7 in the general population. Relative risks for each were higher in younger patients.

Statins may offer slight protection against Parkinson’s disease in younger patients
Self-reported statin use was associated with a modest reduction in the risk of developing Parkinson’s disease (PD), according to results from a prospective study that included 38,192 men and 90,874 women from the Health Professional Follow-up Study and the Nurses’ Health Study. During 12 years of follow-up, 644 incident PD cases occurred. The incidence of PD was 26% lower in current statin users relative to nonusers. The protective effects of statins appeared only among adults younger than 60 years, with a 69% reduction in risk among statin users in this age group. The authors advise interpreting these results with caution, because only approximately 70% of users of cholesterol-lowering drugs at baseline were actual statin users, and the results were only marginally significant.

Vitamin D, but not calcium, associated with fewer stress fractures in girls

Vitamin D is associated with a lower risk of developing stress fractures, especially among very active girls who engage in at least 1 hour of high-impact activity per day. In a study of 6,712 girls (aged 9 to 15 years at baseline), dairy and calcium intakes were unrelated to the risk of developing a stress fracture. The girls ate a mean of two servings of dairy foods daily. Over 7 years’ follow-up, 33% of the girls developed a stress fracture, but those in the highest quintile of vitamin D intake had a 50% lower risk compared with girls in the lowest quintile. These findings support the Institute of Medicine’s increased recommended dietary allowance for vitamin D for adolescents from 400 IU/day to 600 IU/day.

Longstanding diabetes greatly increases stroke risk
Stroke. Online before print. [March 1, 2012]

Patients who have had diabetes for 10 or more years have three times the risk of stroke compared with those without diabetes. As part of the Northern Manhattan Study, researchers followed 3,298 participants (22% with type 2 diabetes) without a history of stroke at baseline. Over a median of 9 years, another 10% developed diabetes. Some 244 ischemic strokes occurred during follow-up. The presence of diabetes increased the risk of stroke by 3% per year. The risk of stroke was increased by 70% for patients who had diabetes for less than 5 years, by 80% in those who had diabetes for 5 to 10 years, and by 3.2 times in those who had diabetes for 10 years or more (versus those without diabetes).

Retinopathy associated with cognitive problems
Neurology. Online before print. [March 14, 2012]

Persons who have mild vascular disease that causes retinopathy are more likely to have cognitive problems, indicating vascular disease in the brain, as well. In a study of 311 women (average age: 69 years), thinking and memory skills tests were conducted annually for up to 10 years. Some 76% of the women had retinopathy. On average, women with retinopathy had lower scores on cognitive tests than those who did not have retinopathy. Compared with women without retinopathy, those with retinopathy also had 47% larger volumes of areas of small vascular damage within the brain and 68% larger volumes of areas of damage within the parietal lobe.
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I can’t afford many more emergencies
RIGHT OF FIRST REFUSAL IS THE LEAST WE CAN ASK FOR

A s a primary care physician, you may find yourself providing care in the emergency department (ED) from time to time. Perhaps more so in plastic surgery than in other medical specialties, however, actually caring to repair that which is broken is a definite disadvantage when it comes to making a living. Despite the fact that doctors in other disciplines often deride us for having it easy, our overhead is substantial.

Having an interest in the “medically necessary” part of plastic surgery translates to considering ED call. Although the concept of running around at all hours of the evening to repair people injured in accidents may seem romantic to the layperson, as you know, trying to obtain fair reimbursement for this work is more of a comedy or a tragedy.

REALITY HITS HOME
On a recent holiday, this truth became even clearer to me when a local hospital ED called for a dog bite emergency. It was close to midnight. A woman had been bitten by her partner’s dog, and it had created wounds in her lips and nose.

I repaired her wounds in the ED while she was under local anesthesia, saving her a pile of money by not using the hospital operating room. She had an independent practice association insurance plan for which I was not a provider, but in California, where I practice, it doesn’t make much of a difference anymore whether you are a provider for a plan. In 2006, Gov. Arnold Schwarzenegger outlawed balance billing by executive order. The California Supreme Court backed this position in 2009.

These days, emergency care essentially pays whatever the insurer wants it to pay—assuming the patient has insurance. If there isn’t an insurer, then you usually get paid nothing. It is not as if you can go after the patient anymore. They just don’t pay the bills.

About a week after the surgery, the patient reported to me at follow-up that she was suing her partner’s homeowner’s insurance for the incident and that her attorney wanted to speak with me. Later, the lawyer settled for a brief letter written about the event in lieu of more involved testimony. I dodged a bullet there.

The patient’s face healed fairly well, considering she was a smoker. The wound matured, and her motor function recovered quite well. A few months after the surgery, her insurer paid less than one-third of the bill for her surgery. Later, the company denied coverage for her follow-up visits, citing the fact that I was not a provider with the plan. The patient ultimately paid these bills as a condition of obtaining the letter to help her legal case. On a percentage basis, I made less than half of what I billed for her care.

MORE TROUBLE THAN IT’S WORTH
The summation of this experience for me is that, when it comes to providing emergency care, in most cases it is far more trouble than it is worth for physicians. The economic and political climates are such that a doctor cannot be assured of being paid anything for providing such care. Not only are we not paid additionally for working at ridiculous hours or on holidays, but in California, we can’t even bill the patient when the insurer underpays or refuses to pay the claim. I followed this experience by resigning at any hospital that made ED call a condition of having operating room privileges.

Having the right of first refusal is the least we can ask for in an emergency. We are not permitted to inquire about insurance coverage when the hospital calls, and if a printed call schedule exists, we are obligated to serve the patient whether or not we ultimately will be paid for the care.

I will not permit my name to be added to such a call schedule, and when a hospital calls, I am selective about when I will participate and what kinds of cases I will see. The late-night emergency adventures of my past are going to stay in my past.

In the grand scheme, I liked doing trauma work. One of the last ED patients I repaired at a local hospital I subsequently dropped returned recently. Her surgical result is outstanding, and she is grateful. She also is among the very rare patients who paid her bill when her insurer refused to do so. If more people like her existed, the ED gambit wouldn’t be such a bad bet for me and others like me.

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