LETTERS

Managing referrals and referral specialists

The Practice Pearls section is frequently where I turn first to get the best tips for our practice, and I was tickled to see "Stop providing secretarial services for referrals" [July/August 2012, http://www.aafp.org/fpm/2012/0700/p33.html]. We have been working toward the goal of handing over more work to referral specialists for years and are beginning to see great progress. Many of our referrals are done by faxing a form, along with demographics and records, to the specialist, who then contacts the patient directly or faxes or calls us with an appointment time. Now if we could just get more physicians to send us their notes after they see our patients!

Dena Deweese
Knoxville, Tenn.

Our small group practice remains full, and our balance sheet positive, precisely *because* we perform patient advocacy and stewardship tasks such as ensuring that referrals are completed. We balance the work with the other specialists, and sometimes we have to sigh when we find a specialist who appears to "dump" work on us. However, overall, this type of service is less expensive than marketing and more effective at attracting long-term, loyal families to our practice.

Ken Franklin, MD
Vicksburg, Mich.

Medicare annual wellness visit health risk assessment

As part of the annual wellness visit (AWV), Medicare requires that we establish "a list of risk factors and conditions for which relevant primary, secondary, and tertiary interventions are underway … and a list of treatment options and their associated risk and benefits." What should I write in my note to meet this requirement? Is it OK to use check boxes? I assume the risk factors should focus on well-being – not on chronic comorbidities like hypertension and diabetes, which are addressed separately during my simultaneously billed evaluation and management visit.

Ashish Sitapara, MD
Newtown, Pa.

Response: Your documentation should focus on the 17 risk factors that the Centers for Medicare & Medicaid Services has identified for use in health risk assessments and should include your related recommendations or plans for follow-up care. The risk factors are physical inactivity/lack of exercise, poor nutrition, smoking/tobacco use, excessive alcohol consumption, high blood pressure, high blood glucose, high total cholesterol, being overweight/obese, inappropriate use of clinical preventive services, depression, high stress, lack of general well-being, burden of providing care giving, social isolation, lack of motor vehicle/home safety, falls (preventable accidents), and polypharmacy/medication issues. Yes, you may use check boxes. *FPM* has published a health risk assessment form (http://www.aafp.org/fpm/2012/0300/p11.html) and an AWV encounter form (http://www.aafp.org/fpm/2011/0100/p22.html) that you may find helpful.

Debra Seyfried, MBA, CMPE, CPC
Leawood, Kan.

"Heartsink" patients

Thanks for the article about difficult patient encounters ["Rethinking the Difficult Patient Encounter," May/June 2012, http://www.aafp.org/fpm/2012/0700/p17.html]. I like the term "heartsink." I agree that it's often our own perspective or reaction that makes certain patient encounters difficult. Once I get out of the "fix-it" mode (which can't always be done in these instances) and just listen empathetically, visits go much smoother and can even be enjoyable.

Nelsa Ciapponi, MD
Charlotte, N.C.

Clarification

The Practice Pearl titled "Dictate faster and for less with your smartphone" [May/June 2012; http://www.aafp.org/fpm/2012/0500/p34.html] described an innovative solution for easing dictation that uses a note-taking app and Dropbox. Unfortunately, Dropbox is not compliant with the HIPAA (Health Insurance Portability and Accountability Act) security rule. For more information, see https://www.dropbox.com/help/238/en. FPM

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