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Five Ways to Prepare for the New Consumer

A significant shift is occurring in health care as consumers and patients get more involved in the management of their own care in what is called consumer-driven care.

For physicians, this shift means changes are coming, many of which may be welcome, and some of which may be challenging. In any case, it is best to be prepared with ideas and strategies about how to manage the care of these new consumers. Although some of these changes may place more demands on your practice, new consumers may be more self-directed and, therefore, better able to manage their health issues, especially chronic illnesses. Here are five suggestions:

First, put yourself in the shoes of health consumers. If you were spending your own money for health care services, what would you expect from your primary care physician? Consumers in these new plans will have high deductibles, meaning they will be paying out of their own pocket for the first \$1,000 to \$2,500 worth of health care each year. They will want to know what your fee schedule is and whether it is possible to negotiate a better price on some services.

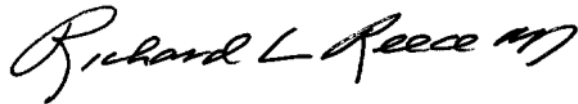
Second, consider that many of these patients may demand faster service. Therefore, it might be useful for you and your office staff to know how to use advanced-scheduling techniques. These techniques allow physicians to see many patients on the day they call for an appointment.

Third, recognize that this new breed of consumer is likely to want one-stop shopping, ample parking, computer scheduling, and quick access to laboratory, radiology, and high-tech imaging services. You may be able to meet these demands by developing creative partnerships with other groups, hospitals, and additional service providers.

Fourth, make a conscious effort to learn more about the thoughts of these consumers through satisfaction surveys, focus groups, and by listening carefully. Train your staff to be sensitive to the expressed needs of these patients who may already be well informed about their conditions as a result of information gathered from the Internet and insurers' Web sites.

Fifth, be aware that new consumers may want to know how closely you follow clinical guidelines and the rules of evidence-based medicine. They also may want to know what arrangements you have made with hospitals, and what those hospitals charge. Therefore, it will be important for you to investigate new billing arrangements with hospitals, such as bundled hospital-doctor bills for common illnesses and hospital-based procedures.

Given that these new consumers may be more prepared for their physician visit than patients have been in the past, it makes sense that physicians should be equally well prepared.



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This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

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Educational Program Aims to Improve Asthma Management in Primary Care

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

National estimates indicate that 20 million Americans have asthma, including approximately 6 million children less than 18 years of age, according to the American Lung Association, the National Center for Health Statistics, and the federal Centers for Disease Control and Prevention (CDC). Asthma is the most common chronic illness among children, and it ranks as one of the leading causes of emergency room visits, hospitalizations, and school absenteeism, particularly among those younger than 15.

In 2004, Asthma Action in America, a national asthma education program, sponsored Children and Asthma in America, one of the nation's largest and most comprehensive surveys on children and asthma. The survey revealed that in the previous year, 54% of children with asthma had a severe asthma attack, 42% had unscheduled acute care visits due to asthma, and 23% visited the emergency room. Asthma caused 62% of the children to limit their activities and 54% to miss school or daycare. In addition, 39% of parents of children with asthma missed work in the previous year because of their child's condition. These findings underlie the National Institutes of Health estimate that total annual direct and indirect costs of asthma in the United States totaled \$16 billion last year.

"We confront a paradox," says Thomas J. Helm, MD, of Allergy and

Asthma Care, PA, in Maple Grove, Minn. "The asthma disease process is well understood, and the steps to control it are clear. But asthma morbidity is increasing."

The Controlling Asthma in American Cities Project (CAACP), funded by the CDC, provides grants to community coalitions to improve childhood asthma outcomes. The American Lung Association of Minnesota (ALAMN) is the fiscal agent and organizer of CAACP in Minneapolis-St. Paul, Minn. One of their projects is conducting Physician Asthma Care Education (PACE) seminars. With additional support from the Hearst Foundation, Blue Cross and Blue Shield of Minnesota, the Minnesota Department of Health, and the Minnesota Asthma Coalition, PACE aims to enable Minnesota physicians to meet the challenges of asthma management in primary care.

Challenges

As one of the faculty for PACE seminars in Minnesota, Helm sees three possible explanations for the asthma paradox. Patients and families do not always recognize or adequately understand the symptoms of asthma. Providers do not consistently make the correct diagnosis, and underdiagnosis of asthma is frequent. Children are often labeled as having bronchitis, bronchiolitis, or pneumonia. And even when patients and

families are aware of asthma symptoms, and providers make the diagnosis, patients may not receive care that brings their asthma under control. "Physicians are either not providing best-practice care, or patients are not adhering to recommended care plans," Helm explains.

Why do patients and families not recognize asthma symptoms? The root cause is the tendency of parents to regard asthma as an episodic illness rather than as a chronic disease. This belief helps explain why Children and Asthma in America found that four out of five respondents reported that their child's asthma was well controlled or completely controlled, despite the fact that children missed the mark on almost all of the key treatment goals defined by the National Heart, Lung and Blood Institute (NHLBI).

"Providers assume that patients will put aside their own beliefs, concerns, and goals to follow treatment plans established for them," Helm comments. "Lack of clear communication and understanding is a barrier to achieving optimal care." Physicians generally acknowledge that patient education is the most essential part of asthma management. Yet many contend that they do not have the time, resources or tools to provide it.

Among the problems that lead to the under-diagnosis of asthma, two factors seem to be most important.

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"The asthma disease process is well understood, and the steps to control it are clear. But asthma morbidity is increasing."

—Thomas J. Helm, MD, Allergy and Asthma Care, PA

(Continued from page 3)

Spirometry, the measurement of the volume and velocity of airflow from the lungs through all stages of the respiratory cycle, is recommended to establish a diagnosis of asthma. Peak flow meters are more typically used but do not offer the specific diagnostic detail of spirometry for pulmonary function testing. A peak flow meter measures how the air flows from the lungs. Spirometers more precisely measure the rate and volume of airflow to and from the lungs during the various phases of the respiratory cycle. Peak flow is not as useful as spirometry because it measures larger airflow resistance. Many pediatric patients with asthma report no symptoms between acute episodes but evidence increased small airway resistance on spirometers. Yet spirometry remains under used in primary care.

In addition, the National Asthma Education and Prevention Program (NAEPP), administered and coordinated by NHLBI, has established guidelines for the classification of asthma severity. Proper classification is critical for establishing appropriate treatment plans and goals. Physicians who are board certified in allergy and immunology or pulmonary medicine generally understand and apply these guidelines. However, many primary care physicians are not as familiar with NAEPP standards. Thus, asthma, even when diagnosed, may not be accurately classified in primary care settings, where most asthma care is provided.

The PACE Solution

“Physician Asthma Care Education (PACE) is a professional education seminar that has been demonstrated to significantly improve physician

practice in asthma treatment and to improve long-term outcomes for patients,” says Jill Heins Nesvold, senior manager, ALAMN. Pioneered by Noreen Clark, PhD, and her colleagues at the University of Michigan School of Medicine in the 1990s, and evaluated in a randomized controlled study, PACE effectively addresses the challenges of asthma management in primary care. In the program, clinicians learn to integrate best practices for asthma diagnosis and treatment with effective strategies and tactics for patient communication, counseling, and education.

In Minnesota, PACE has been enhanced with the addition of more detail on guidelines and medications as well as a section on spirometry. It is delivered as a five-hour, interactive seminar and uses peer professional asthma leaders to help practitioners learn how to optimize clinical practice based on nationally recognized asthma guidelines and to develop enhanced skills for educating and communicating with patients and their families.

ALAMN offered its first Setting the PACE for Asthma in Minnesota seminar in April 2003 and to date has conducted 22 seminars statewide. In total, 237 providers (including residents) have received PACE training. ALAMN will hold six more seminars this year.

“Follow-up evaluation of participants in the five seminars in the Twin Cities metro area in 2004 found that 84% reported improvements in at least one of four priority practice behaviors,” says Heins Nesvold. Those behaviors include use of spirometry, developing written Asthma Action Plans for patients,

patient education, and prescription of inhaled medications.

Seminar Components

PACE seminars include five major sections: Asthma Guidelines and Management, Spirometry, Asthma Medications, Asthma Education, Coding and Reimbursement. The seminar begins with a review of the key points of diagnosis including medical history, physical exam, and objective measures. This first section also includes discussion of the NHLBI guidelines and the stepwise approach to managing asthma. Thus, special attention is paid to the definition of symptoms and findings that classify asthma severity into four levels (mild intermittent, mild persistent, moderate persistent, and severe persistent) and the therapies appropriate for each level. The first section concludes with a detailed discussion of the importance of written Asthma Action Plans, which help families adjust medications at home and provide clear explanations of control measures for managing mild, moderate, and severe episodes.

The faculty then leads attendees through the main components of spirometry in the diagnosis of asthma. Participants learn how to achieve acceptable readings and how to interpret the results, based on American Thoracic Society (ATS) guidelines for conducting spirometry. This section features an interactive demonstration of spirometry by a volunteer in the audience.

The asthma medications review explains the latest information on each of the asthma treatment options. The faculty compares the effectiveness, dosages, and potential side effects of major medications.

Physician Asthma Care Education has improved physician practice in asthma treatment and long-term outcomes for patients.

—Jill Heins Nesvold, American Lung Association of Minnesota

Recognizing the importance of education and communication, the fourth component focuses on theoretical and practical considerations for patient education. Participants learn how the health beliefs and health literacy of patients and families influence their willingness and ability to follow preventive and medical recommendations. Communication strategies and key educational messages are presented. This section also provides the opportunity for hands-on mastery of placebo medication delivery devices and peak flow meters to help physicians and other providers prepare to teach patients and families proper usage.

Finally, to ensure that clinicians receive reimbursement for the services they provide, the last section of the seminar offers recommendations for maximizing appropriate and legal reimbursement. Faculty members with expertise in coding demonstrate how quality asthma education and counseling should be documented and coded. Specific diagnosis and procedure codes are reviewed in detail.

Physician Perspectives

Fairview Lakes Regional Health Care, part of Fairview Health Services, of Minneapolis, serves a large geographic area northeast of the Twin Cities. Fairview Lakes includes a central medical center in Wyoming, Minn., and five community clinics with more than 65 physicians. Fairview Lakes' asthma team focuses on the challenges of enhancing the quality of care for patients with asthma. Local utilization rates for asthma-related emergency room and urgent care visits provided the team with an opportunity to improve primary care asthma management in the clinics.

"Our ER and urgent care visit rates were a strong indicator that we could do a better job of providing more appropriate and less costly care for asthma patients in our outpatient settings," says Sarah Manney, DO,

FAAP, a Fairview Lakes pediatrician, who has had a keen interest in asthma since her residency. "I attended a PACE seminar in St. Paul in April 2004 primarily to determine whether it might be a useful resource for our physicians, and I concluded that it could really support our efforts."

ALAMN offered to conduct a

dren with wheezing episodically," says Benson. "PACE updated our physicians on current asthma care standards, and gradually we are now defining and diagnosing asthma more consistently and classifying severity more accurately." Also, more physicians are completing written Asthma Action Plans. The PACE section on

The asthma management guidelines helped physicians work toward providing best-practice care consistently.

PACE seminar specifically for 30 physicians at the Fairview Lakes medical center. "Coming to our location was unique and enabled us to get a large number of physicians involved," says Manney. "The PACE section on best-practice asthma management guidelines and rating symptom severity was especially useful, helping all of our physicians get on the same page and working toward providing best-practice care consistently."

Fairview Lakes is now beginning the implementation of an electronic medical record (EMR) system. According to Manney, EMR features and functions, such as automating guidelines and best-practice alerts, will support ongoing efforts to implement the standards of care the physicians learned in PACE.

Kristin Benson, MD, a pediatrician at Southdale Pediatrics, also attended PACE in April 2004. Southdale Pediatrics is in Edina, Minn., a suburb immediately southwest of Minneapolis, and has 34 physicians practicing in three offices. ALAMN conducted a PACE seminar for 15 physicians at Southdale Pediatrics last year. According to Benson, the small group seminar was ideal, offering ample opportunity for questions and discussion specific to the group's practice.

"Our main problem was that we were treating and documenting chil-

dr asthma medications was useful as well. "Reviewing when controllers should be used and learning practical approaches on coaching children on proper use of inhalers have proven to be valuable in everyday clinical practice," comments Benson.

Conclusion

Asthma management requires that providers not only understand and implement current treatment strategies according to evidence-based best practices but also establish strong, ongoing partnerships with patients. Such partnerships must be based on good communication, mutual trust and respect, patient education, and a commitment to empower patients as real partners in setting treatment goals and self-regulating the management of their illness.

PACE supports this approach to asthma management by improving physicians' diagnostic and prescribing practices as well as their use of effective communication strategies with patients (including teaching patients using specific asthma messages). It is proven to have a positive effect on physician performance and parents' opinions of their performance and improves children's medical care utilization rates and asthma outcomes.

—More information on physician practice strategies is available on our Web site (see page 8).

Report Offers Advice on CAM

Since more Americans are pursuing complementary and alternative medicine (CAM), physicians are wondering how to assess the safety and efficacy of these measures and how to advise patients who want to incorporate CAM with traditional health care. Recognizing the need for answers, the Institute of Medicine asked the Committee on the Use of Complementary and Alternative Medicine by the American Public to offer suggestions for an informed approach to CAM. In a report released in January, *Complementary and Alternative Medicine in the United States*, the committee said all treatments, whether conventional or alternative, should be subjected to the same principles and standards for demonstrating clinical effectiveness and safety. For therapies whose nature makes it difficult or impossible to conduct randomized controlled trials, innovative methods of evaluation should be developed. The report is available online (at www.iom.edu).

The report cites surveys showing physicians are using or providing referrals for certain therapies they consider legitimate, including acupuncture, massage therapy, and biofeedback.

The committee also recommends that CAM practitioners be involved in clinical studies to ensure that the research methods accurately reflect the way CAM therapies are administered in practice. In addition, the committee recommends that CAM practitioners develop practice guidelines for CAM therapies.

“Ideally, health care should be comprehensive, grounded in the best avail-

able scientific evidence, and centered on patients’ needs and preferences,” said Stuart Bondurant, MD, chief of the committee and executive dean of the Georgetown University Medical Center in Washington, D.C. “Health professionals and patients should have sufficient information about safety and efficacy to take advantage of all useful therapies, both conventional and complementary and alternative.”

Widespread Use

Judging the effectiveness of CAM therapies is particularly important because the public’s use of CAM is widespread. The report says:

- More than one-third of American adults report using some form of CAM
- Patients do not view CAM and conventional medicine as mutually exclusive and are interested in pursuing both modalities of care
- Annual total visits to CAM providers exceed those to primary care physicians
- An estimated 15 million adults take

herbal remedies or high-dose vitamins along with prescription drugs

- Insurance coverage for CAM therapies is increasing
- Out-of-pocket costs for CAM are estimated to exceed \$27 billion annually.

Driven by patient demand, many hospitals, managed care plans, and conventional practitioners are incorporating CAM therapies into their

practices, and schools of medicine, nursing, and pharmacy are teaching CAM techniques, the report says.

Most commonly, CAM therapies have been incorporated into cancer treatment. For example, Memorial Sloan-Kettering Cancer Center in New York has added an Integrative Medicine Service, which offers both inpatient and outpatient therapies including therapeutic massage, music therapy, meditation, acupuncture, and mind-body therapies that can provide much-needed relief of symptoms. Similarly, the Dana Farber Cancer Institute’s Zakim Center for Integrated Therapies offers massage therapy, yoga, acupuncture, and nutritional guidance. To meet the needs of oncologists interested in integrating CAM with conventional medicine, the Society for Integrative Oncology (www.integrativeonc.org) in Mount Royal, N.J., was established in 2003 to provide a forum for discussion and peer review of treatment modalities and evidence-based research.

Cardiac Wellness

CAM therapies are being used to complement traditional care in other specialties as well. For example, at the Heart Hospital of New Jersey, part of the Saint Barnabas Healthcare System in West Orange, the Integrative Cardiac Wellness Program offers therapies such as breathing meditation, guided imagery, massage, and reflexology to patients who are undergoing cardiac surgery. Upon discharge, patients may be referred to the Siegler Center for Integrative Medicine at the Saint Barnabas Ambulatory Care Center in Livingston, N.J., for outpatient integrative therapies and wellness services including acupuncture, biofeedback, guided imagery, herbal consultation, massage, tai chi, or yoga.

Report Offers Advice for Clinicians

In its report, *Complementary and Alternative Medicine in the United States*, the Institute of Medicine says that when physicians are working with patients who are considering complementary and alternative medicine, they should work collaboratively to reach an appropriate decision on treatment. The report says, "Any framework for decision-making should encourage patients and practitioners to engage in shared decision-making about treatment."

An article in the *Annals of Internal Medicine* offered conventional physicians and other practitioners a nine-step strategy for advising patients interested in CAM therapies:

1. Ask the patient to identify the principal symptom
2. Suggest that the patient keep a symptom diary
3. Discuss the patient's preferences and expectations
4. Review issues of safety and efficacy
5. Identify a suitable licensed practitioner
6. Provide the patient with key questions to ask the practitioner during the initial consultation
7. Schedule a follow-up visit or telephone call to review the treatment plan
8. Follow up to review the response

Spurred by the growing numbers of physicians who are incorporating CAM therapies into their practices, the Federation of State Medical Boards of the United States has developed "Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice," available at www.fsmb.org.

Integrated Care

Tools to assist practitioners in assessment and decision-making regarding CAM will be extremely useful, espe-

to treatment

9. Provide documentation.

A follow-up article addressed another step in the process that involves reviewing the safety and efficacy of the CAM treatment. The article proposed the use of a matrix to guide practitioners' recommendations for treatment.

- Option A: Supports both safety and efficacy
- Option B: Supports safety, but evidence regarding efficacy is inconclusive
- Option C: Supports efficacy, but evidence regarding safety is inconclusive
- Option D: Indicates either serious risk or inefficacy.

If the medical evidence supports Option A, the practitioner may recommend the therapy to the patient and continue to monitor the patient's health status and progress. If the medical evidence supports Option B, the practitioner should tolerate the therapy but caution the patient and closely monitor the effectiveness of the therapy. For Option C, the practitioner should consider tolerating the therapy, but should again caution the patient and closely monitor the therapy's safety. Finally, if Option D is indicated, the clinician should actively discourage use of the therapy.

cially since, as Bondurant noted, "Complementary and alternative therapies are frequently used in conjunction with conventional medical therapies."

Many conventional medicine physicians are interested in CAM services. Numerous surveys cited by the report indicate that physicians are already using or providing referrals for certain therapies they consider to be legitimate, including acupuncture, massage therapy, and biofeedback.

While surveys of hospitals and

"If patients choose to make their own decisions against their conventional practitioner's advice, the practitioner should document this in the patient's medical record," the report says. "From a liability perspective, the more acute and severe the condition is or the more curable the condition is by conventional medical therapies, the more important it is to monitor and, as necessary, treat the patient by conventional medical practices."

The committee offers additional advice to conventional physicians regarding ongoing communication with patients about new evidence. "Because research regarding both conventional and CAM therapies is ongoing and the medical evidence can change rapidly, the clinician should communicate regularly with the patient regarding any new developments," the report says.

Finally, the report notes that if the decision is made to pursue a CAM therapy, the physician should identify a practitioner with acceptable expertise. "When a patient is referred to a CAM provider, it is important for the conventional medical practitioners to inquire about the provider's training, practice experience, scope of practice, and history of malpractice litigation or professional discipline," the committee writes. —DJN

health plans have identified why these entities are incorporating CAM into conventional medicine, the committee found that few studies have focused specifically on factors that have driven physicians' growing interest in offering CAM therapies. Existing evidence shows, however, that physicians believe they need to keep up with their patients' interest in CAM.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

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