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EDITORIAL

New Challenges Present Ethical Questions 2

PEDIATRICS STRATEGY

Seeking Atypical Reflux Symptoms 3

TECHNOLOGY

Moving Beyond Office Automation 6

New Challenges Present Ethical Questions

Some physicians who have moved from being members of small groups to being part of large business enterprises have noticed a change in ethics in the workplace. Even for those physicians who have remained in smaller groups, the pressures to deliver care according to the standards of large payers, such as managed care organizations, has created ethical challenges as well.

According to the American College of Physicians (ACP), “Managed care is a major presence in today’s medical practice environment, and its focus on population-based health care can challenge the physician’s obligation to his or her patient. Resolving competing demands requires ethical principles of patient care that are embraced by physicians, patients, and managed care leaders alike.”

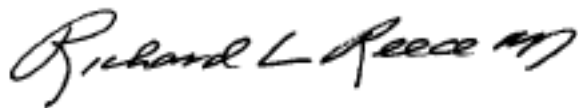
To address these issues, the ACP’s Center for Ethics & Professionalism has worked with the Harvard Pilgrim Health Care Ethics Program to assess principles of ethics and professionalism in practice. The ACP also has a Statement of Ethical Managed Care Principles.

Peter F. Drucker, the famed business consultant, observed before his recent death that business has two purposes: innovation and marketing. Since American society has entrusted the task of delivering health care to large organizations managed for profit, physicians who work for these organizations must innovate. They must seek to become productive members of these larger enterprises by creating better, more convenient, and more cost-effective services on their own, or by developing and applying new technologies.

These physician activities may require heavy investments in equipment and personnel and therefore may require marketing to recoup investments. Some observers say that certain investments (such as in a for-profit ambulatory surgery center) are unethical. Others say arrangements with preferred vendors are questionable. They may be right, but they must also recognize that costs are rising, creditors and employees must be paid, and much of the health care economy is based on free-market principles.

Last year, former Fed Chairman Alan Greenspan told business students at the Wharton School that, “Material success is possible in this world, and far more satisfying when it comes without exploiting others. In virtually all our transactions, whether with customers or with colleagues, with friends or with strangers, we rely on the word of those with whom we do business. If we could not do so, goods and services could not be exchanged efficiently.” The same is true in health care.

For more information and help on ethical questions, physicians can visit the ACP’s Center for Ethics & Professionalism (at www.acponline.org).



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Seeking Atypical Reflux Symptoms

Although the typical symptoms of gastroesophageal reflux disease (GERD) are relatively easy to identify, pediatricians also should be aware of the more atypical symptoms, which can easily be misdiagnosed as other illnesses.

Understanding both the typical and atypical symptoms of GERD is important, given the fact that many pediatric patients suffer from the condition. "Although GERD is more common in the adult population, many pediatric patients also have the condition," notes Sandeep Gupta, MD, a pediatric gastroenterologist and associate professor of clinical pediatrics at the Indiana School of Medicine in Indianapolis.

Seeking Signs

Typical symptoms of GERD in children include vomiting, upper abdominal pain, refusal to eat, irritability, and heartburn. A pediatrician who sees a patient with these symptoms should consider reflux as a possible diagnosis, Gupta says. "But physicians should not make a definitive diagnosis based on these symptoms only, since they can be caused by other conditions as well," he adds.

Still, a pediatrician may not need to refer a patient with typical GERD symptoms but should note any concerns, says Gupta. "Suppose a pediatrician sees a 6-year-old who has some vomiting, but there is no blood in the vomitus, and the child is gain-

ing weight," he offers. "If other possibilities such as brain tumor, malrotation, obstruction in the GI tract, or kidney stones are not likely, it is reasonable to consider acid-suppressive therapy for 8 to 12 weeks. If the child does not improve with use of medications, the child should be referred to a pediatric gastroenterologist. In general, when seeing a patient with typical GERD symptoms, the physician may, depending on absence or presence of accompanying symptoms, either treat the child with a trial of therapy or refer the child to a pediatric gastroenterologist."

Atypical symptoms of GERD in children can include recurrent asthma, pneumonia, or ear infections. Furthermore, children with these symptoms may not present with specific gastrointestinal symptoms or complaints, Gupta observes.

"Extraesophageal or supraesophageal reflux disease includes a variety of upper airway symptoms including cough (either paroxysmal or chronic), wheezing, asthma, and otitis media," says George J. Fuchs, MD, professor of pediatrics at the University of Arkansas Medical School College of Medicine and director of gastroenterology, hepatology, and nutrition at Arkansas Children's Hospital in Little Rock. "The real dilemma is that it is hard to prove with certainty in many of these cases which of these symptoms are caused by reflux disease as opposed to

the more usual causes."

Most of those upper airway conditions are not caused by reflux, although reflux is one cause, Fuchs emphasizes. "When one of these conditions does not resolve with the typical treatments, pediatricians might then consider reflux to be a possible cause," he says.

Considering Causes

These atypical symptoms do not necessarily indicate a more serious or advanced case of reflux. Rather, the main concern is that diagnosis is likely to be delayed because these symptoms may not immediately be associated with GERD. A delayed diagnosis can have negative consequences for the patient's health.

"If not properly diagnosed, GERD can worsen over time," Gupta says. "The longer gastric contents and acid reflux flow into the food pipe, the greater likelihood of inflammation, erosions, and ulcers. Other serious conditions also can develop, such as hiatal hernia, strictures in the esophagus, or Barrett's esophagus, which is abnormal growth of intestinal-type cells into the esophagus and a significant risk factor for esophageal cancer."

Fuchs adds, "The reason these atypical symptoms are more consequential is that they have the potential to go unrecognized, and therefore may not be treated adequately. For example, a certain proportion of

(Continued on page 4)

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—Sandeep Gupta, MD, Indiana School of Medicine

(Continued from page 3)

children have asthma that is caused or aggravated by reflux. If the reflux is not recognized and treated, the asthma will persist and the quality of life of these children can be quite significantly impaired. They will have more frequent asthma attacks, miss school, and may require hospitalization. These children also may be taking standard or intensive asthma medications unnecessarily.”

Gupta acknowledges that community pediatricians may not identify recurrent asthma, pneumonia, or ear infections as symptoms of GERD. “They may consider these symptoms to be the actual diagnosis,” he says. “However, when pediatricians see patients with asthma, pneumonia, or ear infections that recur or do not resolve with usual treatment, they should consider the possibility that GERD is the underlying cause.”

The presence of atypical symptoms does not necessarily affect the type of treatment selected, Gupta adds. “Rather, the bottom line is to control the GERD, regardless of particular symptoms,” he says. Fuchs counters, however, that referral to a pediatric gastroenterologist is warranted when the pediatrician suspects that reflux may be the cause of one of these conditions, in particular asthma that is refractory to maximal medical therapy.

Physicians also should consider that patients whose symptoms appear to be GERD-related may actually suffer from a different condition, called allergic eosinophilic esophagitis.

Diagnosis and Treatment

“Pediatricians may try to put the patient on reflux medical therapy,” Fuchs explains. “Perhaps the best diagnostic test we have to confirm that reflux is the cause of one of these conditions is the response to maximal anti-reflux therapy. But referring physicians sometimes are not comfortable managing this diagnostic therapeutic trial, so they send the patients to a pediatric gastroenterologist.”

Similar Symptoms, Different Condition

Pediatricians should also be aware of the possibility that patients with symptoms of gastroesophageal reflux disease (GERD) may instead suffer from a recently identified condition, allergic eosinophilic esophagitis. In fact, an article, “Eosinophilic Esophagitis,” published in *The New England Journal of Medicine* (New Engl J Med 351(9):940-941, Aug. 26, 2004) demonstrated that rates of eosinophilic esophagitis have risen so dramatically in recent years that they may be at higher levels than those of other inflammatory gastrointestinal disorders, such as Crohn’s disease or ulcerative colitis.

Allergic eosinophilic esophagitis occurs when eosinophils—a type of white blood cell—grow uncontrolled in the esophagus, causing inflammation. Eosinophils are not normally found in the esophagus; high levels often indicate an allergic response. Allergic eosinophilic esophagitis can occur at any age; many of the children with this condition have other allergic conditions, such as asthma, eczema and sinus disease.

Like GERD, symptoms of allergic eosinophilic esophagitis include vomiting, abdominal or chest pain, refusal to feed or failure to thrive (in young children), and difficulty swallowing. Some patients present with a history of food impaction. Anti-reflux medications may help alleviate symptoms in certain patients, but generally do not improve the eosinophilic inflammation. Unfortunately, due to lack of awareness among community physicians, patients may suffer for long periods of time before a diagnosis is made.

Sandeep Gupta, MD, a pediatric gastroenterologist and associate professor of clinical pediatrics at the Indiana School of Medicine in Indianapolis, confirms that pediatric gastroenterologists are seeing a growing number of cases of this condition. “Allergic eosinophilic esophagitis presents with symptoms that mimic or resemble GERD,” he says. “Sometimes patients will experience symptomatic relief with a proton pump inhibitor, but the inflammation will not go away. Furthermore, a definitive diagnosis of the condition requires endoscopy with biopsies, and a pH probe. This is all the more reason that if physicians try a course of medical therapy in a child in whom reflux is suspected, and the child does not improve or symptoms return on discontinuation of medications, a referral to a gastroenterologist is warranted.” —DJN

Physicians have a number of diagnostic tests at their disposal when seeking to confirm a diagnosis of GERD in a pediatric patient. “These tests provide distinct information, and they compliment each other,” Gupta notes. “The results of several tests, taken together, can guide the physician in making appropriate treatment decisions.”

An upper GI barium study can be used to evaluate the patient’s anatomy. Also, the patient can have a stomach

emptying study, or gastric scintiscan. This study is a nuclear medicine test that examines how the stomach is emptying. Endoscopy enables the gastroenterologist to examine the esophageal tissue and lining. Endoscopy is safe for pediatric patients unless an underlying condition or overall poor health does not permit them to go under anesthesia or sedation, Gupta notes. Finally, a physician can use an esophageal pH study to diagnose reflux in children. This test

An Important Referral Role

Pediatric gastroenterologists have an important role to play in educating primary care physicians to ensure appropriate referrals of patients with GERD, says Sandeep Gupta, MD, a pediatric gastroenterologist and associate professor of clinical pediatrics at the Indiana School of Medicine in Indianapolis.

This role could be formal as explained in lectures for pediatricians and community physicians about reflux. The lectures were sponsored by the North American Society of Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN). It could also be more informal through one-on-one discussion among colleagues. "The important thing is to get the message out," Gupta says, adding that presenting different clinical scenarios helps to illustrate situations in which physicians might choose to refer to specialists.

For physicians considering when to refer a patient with GERD to a pediatric gastroenterologist, the key questions to address involve the symptoms and age of the patient, Gupta comments. There are three separate groups of pediatric GERD patients, Gupta says.

The first is uncomplicated reflux in an infant. "The main symptom is frequent spitting up, but the baby is gaining weight, has no respiratory issues, and is not irritable," he adds. "Most of these cases can be handled by community pediatricians. Parents are advised to adopt behavioral modifications that basically constitute anti-reflux precautions, such as limiting the volume of feeds and keeping the baby upright following feeding. An upper GI barium study may be considered to evaluate for anatomical issues. Often, patients simply get better over time."

The second group includes babies with complicated reflux. "In addition to frequent spitting up, the baby is not gaining weight, shows signs of distress, and may have respiratory issues causing cyanosis," Gupta explains. "In this case, the pediatrician should refer the patient to a specialist, who can perform various diag-

nostic tests to determine the cause of the problem. For example, a pediatric gastroenterologist may perform an upper GI barium study to examine the anatomy for malrotation or tracheoesophageal fistula."

The third group includes children who are older than 12 to 18 months with reflux symptoms such as vomiting and abdominal pain. "If there are no major concerns, such as blood in the vomitus or insufficient weight gain, the pediatrician can either refer the patient or first consider a trial of therapy," Gupta states. "But if the patient does not get better or if symptoms return after 8 to 12 weeks of therapy, a referral should be made."

A referral should be made immediately if food is getting stuck in the child's throat. "This indicates the possibility of stricture, and further evaluation is warranted," Gupta says. "Referral to a specialist is also warranted if there is blood in the vomitus. This could be a sign of reflux, or it could be an ulcer. In these cases, immediate referral would ensure the most timely diagnosis and resolution of the problem."

Referrals to pediatric gastroenterologists are also warranted when reflux is suspected as the cause of other significant but more typical symptoms such as hematemesis (vomiting blood), chest pain, or anemia.

George J. Fuchs, MD, professor of pediatrics at the University of Arkansas Medical School College of Medicine and director of gastroenterology, hepatology, and nutrition at Arkansas Children's Hospital in Little Rock, says reflux is a possible cause of infantile apnea, though it is an infrequent cause. "Reflux may cause apnea by fostering pooling in and obstruction of the upper airway, or via reflex bronchoconstriction in response to gastric acid in the esophagus," he says. "But apnea is a severe, life-threatening event that generally requires the involvement of multiple specialists, including cardiologists, neurologists, and gastroenterologists, who focus on those children to provide an intensive, comprehensive evaluation." —DJN

also will indicate the severity of the condition. Decisions about which tests to use are guided by the presenting symptoms of the individual patient.

Physicians can suggest a variety of interventions for GERD patients. One is lifestyle modification. "Patients are counseled to avoid greasy foods, large meals around bedtime, and exposure to tobacco smoke," Gupta says.

Medications such as metoclopramide can be used to improve motility. Also, H₂ blockers and proton pump inhibitors can decrease the production of acid, thereby relieving symptoms.

"In some instances, surgical management of GERD is considered," Gupta says. "For example, if the child has a hiatal hernia, or if it is difficult to control symptoms with medical

therapy, surgery may be an option," Gupta says. "The most common surgical procedure for GERD in children is called fundoplication and can now be done laparoscopically. Some newer techniques are being evaluated in adults too."

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

Moving Beyond Office Automation

By Gary Kennedy

While most physicians and practice managers continue to evaluate electronic medical record (EMR) and electronic health record (EHR) systems, an innovative few understand the goal of moving beyond automation. They ask: Why strive to replace paper when we can reinvent the way information is managed at the point of care?

These innovative few physicians are using EHR systems that include real-time decision support that uses aggregated patient information. They are working with specialty-specific systems that are fully integrated into their workflow and into their other systems. These systems capture all relevant information necessary to enable personalized medicine at the point of care.

Most physicians are not using systems that include real-time decision support and aggregated patient information. Instead, it has become accepted that EHR systems improve efficiencies, increase accuracy, capture lost charges, and eliminate transcription costs. The federal government is pushing us all to implement systems. Patients expect their health care providers to use the best tools available, and 80% believe that using EMRs would improve quality, according to a report by the Markle Foundation. There is an increased focus on electronic prescribing to reduce medication errors.

Several initiatives are underway to connect various health organizations,

such as regional health information organizations (RHIOs). The goal is to exchange patient health information among disparate clinicians and other authorized entities in real-time and under stringent security, privacy, and other protections, the federal government says. This plan is known as the National Health Information

practice personalized medicine by comparing these patterns with the unique attributes of the individual patient and will be able to assess patient risk and develop the most effective treatment plan.

Usually the term “personalized medicine” applies to assessing a patient based on his or her genetic

Innovative physicians are using EHR systems that include real-time decision support.

Network (NHIN). To achieve this goal, practices must be using electronic clinical systems.

It is important to note that all of these initiatives are focused primarily on automating the paper process and sharing information among different practices or organizations. Once automation is complete, there is a tremendous opportunity to measure and improve health and financial outcomes still further. Improving health care outcomes requires making better decisions and increasing communication among all parties involved. This increased communication delivers higher quality information, so that decisions are more informed and relevant to each patient.

The Next Step

One way to move beyond simple office automation is to put the clinical information now captured in physicians' office computer systems to full use. This information can help physicians identify trends, highlight problems, and do predictive analytics. Predictive analytics assists in identifying the patterns hidden in the massive amounts of accumulated clinical information. Physicians will

makeup. But for this discussion, the term is used more generally to include an assessment based on a person's uniqueness, including individual genetics.

Having access to relevant information at the point of care is the primary difference between generating fair outcomes and best-in-class outcomes. Innovative EHR systems can ensure that all caregivers are making decisions with the most accurate and current information available. Enabling the free-flow of information among patients, physicians, and other caregivers is paramount to improving outcomes.

Involving the Patient

The best EHR systems include integrated tools so that physician practices can assist patients with tracking and managing their conditions. These systems also allow physicians to work with patients to develop customized plans and set personalized goals.

These patient-oriented tools are often referred to as patient portals. The portal concept denotes openness and accessibility. Patient portals must be secure and available anytime, from anywhere via the internet. A

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few EHR systems allow physicians to use patient portals to register new patients and capture in-depth medical history information before the first visit. Portals also should deliver educational materials and provide secure communication. They should provide patients with a mechanism to review test results and visit notes, order medication refills, and request an appointment.

Current Decision Support

Clinical decision support must occur at the point of care. It must provide access to information relevant to the specific patient in relation to the whole patient and to his or her predispositions. When pertinent clinical knowledge is combined with aggregated information from millions of patients, decision support will reach its full potential.

Many of the less effective decision support approaches available today merely present evidence-based materials. Some systems claim to include clinical decision support because they provide online access to medical textbooks. Disease-specific clinical pathways provide some value, but such pathways do not necessarily apply to each patient.

All of these approaches are not specific to individual patients because they view multiple patients

then decision support must be more automated, more relevant, and based on current patterns specific to each patient. We can harness the power of information to identify patterns relevant to specific patients so that trends can be identified immediately. These patterns become knowledge. Applying this knowledge in context, at the point-of-care, is an effective way to improve care.

This innovative solution uses the power of the computer to compile relevant information and recognize patterns. Relevant information can be aggregated across clinicians, patients, payers, and researchers. Information specific to one physician or hospital system is too narrow in focus. Information provided by patients about behavior patterns and compliance is invaluable, and should be included for analysis.

Researchers collect disease-specific information that can be aggregated into a collective reference data source. Additionally, evidence-based medicine, genomic data, patient monitor information, devices, and lab information must be included. Aggregating such information provides a full view of the patient and enables comparison against a greater volume of findings.

Once the information is collected, refined, and distilled, an intelligent

engine can identify patterns and test for statistical relevance. The intelligent engine will compare the specific attributes of the patient (such as gender, age, family history, problems, vital signs, and lab values) to find success factors common among the pool of similar patients. The power of pattern recognition when applied to specific patients can yield improvements in personalized medicine. Personalized information is more likely to result in positive outcomes and to stimulate a positive change in the patient's behavior.

What to Pursue

The ideal EHR system will be intuitive and have many tools to aid in quickly and accurately documenting each visit. The system will be integrated with other devices in the practice and allow communication and information-sharing with systems in other organizations.

The ideal EHR system also will be designed for your medical specialty and customizable so that it follows your unique workflow. The customization tools will be designed so that users can make their own changes without having to pay the EHR vendor for these changes. These customizations enable far more control than mere templates.

You must be empowered to customize the display to eliminate multiple clicks when searching for specific answers. You should be able to define different views for different disease states and visits.

The decision to purchase a clinical system is a significant one and should not be made solely on cost. Too often, practices select a clinical system primarily based on short-term costs. Be sure to include the long-term costs of system support, hardware maintenance, software upgrades, internal support, and interface fees. Considering that most practices are small (having fewer than eight physicians), the lowest upfront and long-term costs will likely be incurred by selecting a Web-based system.

Personalized medicine delivers enlightened decisions, which lead to improved outcomes. In this way, these systems improve care while also lowering the total cost of care.

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

The ideal EHR system will be intuitive and have tools to aid in quickly and accurately documenting each visit.

with the same condition and similar symptoms in the same way. The whole patient is not understood due to the significant number of variables that must be considered. There is a better solution.

Real-Time Decision Support

If the ultimate goal is to improve patient outcomes and reduce costs,

engine can identify patterns and test for statistical relevance. The intelligent engine will compare the specific attributes of the patient (such as gender, age, family history, problems, vital signs, and lab values) to find success factors common among the pool of similar patients. The power of pattern recognition when applied to specific patients can yield improve-

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