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*September 2008*

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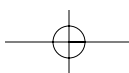
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## INNOVATIONS

### Is the Medical Home the Next Innovation?

By Richard L. Reece, MD, editor in chief

**A**t one time, primary care physicians had close professional relationships with patients and took care of all of their patients' needs. Too often today, it seems, these physicians are not treating patients but rather following the steps needed to manage a patient's condition.

Recognizing that this lack of a relationship is inefficient, Paul Grundy, MD, the director of health care transformation for IBM, says, "The next great innovation is called the medical home. It is more than a home for patients to receive comprehensive coordinated care and paying primary care doctors to deliver it. It is the restoration of primary care physicians as the centerpiece of the health system. It is credible because big business buyers and Medicare back it. It may be the ultimate key to health reform."

In the medical home model of health care delivery, the relationship between care provider and patient is essential. A medical home ensures around-the-clock access to medical consultation, respect for a patient's cultural and religious beliefs, and the comprehensive coordination of a patient's care among providers and community services.

The development of medical homes is necessary because managed care companies and other developments in health care have distanced patients from personal physicians. As a result, patients are disintermediated from doctors, Grundy comments.

Grundy leads IBM's efforts as a major health care buyer to transform health care by strengthening doctor-patient relationships and paying doctors more to do the right things. Toward that end, he and others founded the Patient-Centered Primary Care Collaborative (at [www.pcpc.net](http://www.pcpc.net)) in 2006 in collaboration with other employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, and physicians.

To develop medical homes will require health care purchasers, including employers and the federal and state governments, to support medical home arrangements that offer coordinated comprehensive care. Also, payers should reward primary care doctors who offer convenient patient-centered services, such as rapid responses to e-mails and phone calls, same day appointments, and frequent communication and follow-up care. In addition, all payers will need to support physicians in installing efficient and affordable electronic medical record systems to help them communicate with patients, hospitals, and other physicians more efficiently.

To achieve these goals will require high levels of collaboration and a change in mindset from consumers, physicians, and purchasers in our current health care system that is dominated by large managed care plans that spend much more on specialty care than on primary care. For this reason, Grundy calls his efforts "transformational" rather than "reformational."

But paying primary care physicians for prompt return of e-mail messages and phone calls, for making same day appointments, and for offering comprehensive coordinated patient care may be one way to achieve a form of health reform. In addition, Grundy believes employers wield a big stick: They pay for about half of all U.S. health care costs.

—More information on physician practice strategies is available on our Web site (see page 16).

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## RHEUMATOLOGY STRATEGY

# Studies Suggest New Approaches

**A**mong the studies presented at the Annual Congress of the European League Against Rheumatism (EULAR), held in Paris, in June, six have important implications for the quality of care that rheumatologists provide to their rheumatoid arthritis (RA) patients. The six studies are:

- Cardiovascular disease management in RA patients
- RA disease factors predict risk of myocardial infarction and stroke
- Oily fish intake reduces RA risk, while stress and smoking increase RA risk
- Foot complaints affect quality of life
- Hand bone mineral density affects mortality rate in RA patients
- Vitamin D deficiency common in RA patients.

**Cardiovascular disease management in RA patients.** Based on a review of existing evidence and expert opinion, the EULAR Task Force on Cardiovascular Risk Management in RA recommended that cardiovascular risk management should be mandatory in patients with RA and other inflammatory rheumatic diseases, including ankylosing spondylitis and psoriatic arthritis. This recommendation was based on research that shows that these diseases are closely associated with an increase in cardiovascular risk. In fact, in rheumatoid arthritis patients, the risk of cardiovascular disease is double the risk of that in the general population and may be similar to the cardiovascular risk in patients with type 2 diabetes, a known risk factor for cardiovascular

disease.

“Traditional cardiovascular risk factors occur more frequently in patients with inflammatory rheumatic disease than in the general population,” said Michael Nurmohamed, MD, a physician at Slotervaart Hospital in Amsterdam and the lead investigator of the task force.

However, traditional cardiovascular risk factors only partially explain these patients’ increased cardiovascular risk. Mounting evidence suggests that inflammation may be the missing link, Nurmohamed added. “Disease-modifying anti-rheumatic drugs (DMARDs) and biologics may lower the cardiovascular risk in inflammatory rheumatic disease patients, while statins and antihypertensives, such as ACE inhibitors and angiotensin blockers, may even yield greater benefits than they do in the general population due to their anti-inflammatory properties.”

The task force’s recommendations can help practicing rheumatologists mitigate this elevated cardiovascular risk in their inflammatory rheumatic disease patients, thereby helping them improve care quality. The recommendations include the following:

- Physicians should consider RA, ankylosing spondylitis, and psoriatic arthritis to be risk factors for cardiovascular disease.
- Rheumatologists should recommend annual cardiovascular screening to all RA patients and consider annual screening for patients with ankylosing spondylitis and psoriatic arthritis.
- Rheumatologists should recommend lifestyle changes regarding diet, exercise, smoking cessation, and stress management as needed for all patients with RA, ankylosing spondylitis, and psoriatic arthritis.

*(Continued on page 4)*

## Mineral Density Affects Mortality in RA Patients

**A**n analysis of data on 84 Swedish patients over 27 years suggests that rheumatologists can consider bone mineral density in the hand as a valid predictor of mortality in RA patients along with other well-accepted measures of disease activity.

In an analysis of data collected over almost three decades, researchers assessed different measures of disease activity for their ability to predict all-cause mortality. Measures evaluated included bone mineral density in the hand as assessed by digital x-ray radiogrammetry (DXR), the Steinbrocker functional classification, the physician’s global assessment, erythrocyte sedimentation rate, rheumatoid factor, the Larsen index, the Ritchie index, and the patient’s global assessment.

The analysis found that significant predictors of mortality included bone mineral density in the hand (relative risk of 0.55) the Steinbrocker functional classification (1.86), the physician’s global assessment (1.38), and erythrocyte sedimentation rate (1.86).

“This long-term study establishes that measurement of bone mineral density in the hand may be an important physical gauge in anticipating the course of RA,” said the study’s lead researcher, Christina Book, MD, of Malmo University Hospital in Sweden. “It offers physicians an effective tool for assessing a patient’s disease and developing the most appropriate management plan.”

—DJN

## RHEUMATOLOGY STRATEGY

(Continued from page 3)

- For patients with RA, ankylosing spondylitis, and psoriatic arthritis, rheumatologists should consider recommending treatment with statins or antihypertensives and set cardiovascular management targets according to evidence-based clinical guidelines.
- Rheumatologists should consider strategies for aggressive inflammation suppression to lower cardiovascular risk in these patients.

In addition to these steps, the task force recommended that physicians adapt cardiovascular risk calculators, such as the Framingham and Systemic Coronary Risk Evaluation (SCORE), for patients with inflammatory rheumatic disease by incorporating a multiplier to reflect these patients' increased cardiovascular risk.

**Risk of myocardial infarction, stroke predicted by RA disease factors.** Certain RA disease factors have an effect on RA patients' risk of myocardial infarction or stroke that is similar to the effect of cardiovascular disease risk factors, according to research conducted by Daniel Solomon, MD, and colleagues at Brigham and Women's Hospital and Harvard Medical School, in Boston.

"It has been established that people with RA are more likely to experience cardiovascular disease or complications than the general population, but our research examines the importance of RA-specific factors compared with traditional cardiovascular risk factors," Solomon said. "We have shown that having more high-risk RA-specific risk factors increases cardiovascular disease risk to a rate similar to that of traditional cardiovascular risk factors." He hopes the results of the study will lead to more robust clinical prediction rules and appropriate management and treatment options.

The analysis included data on 10,870 patients in the Consortium of Rheumatology Researchers of North America (CORRONA) database.

## Vitamin D Deficiency Common in RA Patients

**B**ased on findings from a study conducted in Ireland, rheumatologists may want to test all patients for vitamin D deficiency and offer appropriate treatment. Vitamin D is fat-soluble and naturally present in only a few foods, although it is available as a dietary supplement. Sunlight is the main source of vitamin D for most individuals.

A study conducted at South Infirmity-Victoria University Hospital in Cork, Ireland, assessed vitamin D deficiency in all new patients presenting to the rheumatology clinic between January and June 2007. The researchers found that 70% of patients had hypovitaminosis D, defined as 21 nanograms per milliliter (ng/mL) or less, and 26% had severe hypovitaminosis D, defined as 10 ng/mL or less. Approximately one-fifth of patients had secondary hyperparathyroidism, a condition that can develop in response to severe vitamin D deficiency and that increases the risk of bone loss and fracture.

Severe vitamin D deficiency was present in a significant number of patients in a multitude of rheumatology diagnoses, including inflammatory rheumatic diseases, soft tissue rheumatism, osteoarthritis, osteoporosis, and uncomplicated musculoskeletal backache. Patients of all ages suffered vitamin D deficiency, including 78% of patients aged 30 or younger and 65% of patients aged 65 and older.

"The findings may simply reflect the background prevalence of hypovitaminosis D or may represent the correlation of low vitamin D levels with widespread musculoskeletal pains or different autoimmune diseases, one of the common presentations in rheumatology outpatients," said Muhammed Haroon, MD, lead investigator. However, he added that chronic severe vitamin D deficiency increases the risk of osteoporosis and osteomalacia, while a mild-to-moderate deficiency may contribute to non-specific rheumatic complaints.

—DJN

Cardiovascular disease risk factors included a history of coronary artery disease or myocardial infarction, diabetes, hypertension, family history of premature myocardial infarction, body mass index, dyslipidemia, non-Caucasian ethnicity, and current tobacco use. RA disease factors included duration of RA, rheumatoid factor status, Health Assessment Questionnaire Disability Index (HAQ-DI), Clinical Disease Activity Index (CDAI), subcutaneous nodules, Sjogrens syndrome (an autoimmune condition associated with arthritis), tender and swollen joints, and total joint replacements.

A regression model indicated that RA risk factors and cardiovascular

disease risk factors had a quantifiably similar association with cardiovascular disease outcomes including myocardial infarction, stroke, and transient ischemic attack. Individually, the cardiovascular disease risk factors leading to an increased relative risk of myocardial infarction or stroke were current tobacco use (relative risk of 1.92), prior myocardial infarction (1.75), non-Caucasian ethnicity (1.26), and body mass index (1.25).

The model also showed that the RA risk factors leading to an increased relative risk of myocardial infarction or stroke were the presence of subcutaneous nodules (1.44), HAQ-DI (1.20 per each one-point

increase), and CDAI (1.06 per each one-point increase).

**Oily fish intake reduces RA risk, while stress and smoking increase RA risk.** The Epidemiological Investigation of Rheumatoid Arthritis (EIRA), a large population-based case-control study in Sweden, confirms the importance of lifestyle changes in reducing RA risk. The findings of several EIRA data analyses suggest that physicians should recommend intake of oily fish to their patients while also recommending smoking cessation and stress reduction.

### Reducing Risk

One EIRA data analysis indicated that the intake of oily fish—such as salmon, mackerel, and herring—reduced RA risk by approximately 20%. Based on an analysis of 1,899 subjects with a confirmed diagnosis of RA and 2,145 matched controls, investigators found that the odds ratio for developing RA was 0.8 for subjects who consumed oily fish between one and three times per month compared with subjects who never or seldom consumed oily fish. The protective effect applied only to Rh factor-positive rheumatoid arthritis. Previous studies have shown that the omega-6 and omega-3 fatty acids found in oily fish are associated with beneficial effects in immunologic and inflammatory processes.

Smoking is an established RA risk factor, but a second analysis revealed a dose dependency between smoking level and the odds ratio of developing anti-citrulline (anti-CCP) positive RA. In a third analysis, investigators found that psychosocial stress at work (defined as a low level of control) was associated with a higher risk of RA

that had an odds ratio of 1.3 to 1.6.

“The findings from these studies add to an increasing body of evidence to support the assertion that lifestyle modifications can have a significant effect on an individual’s risk for developing RA,” said Annmarie Wesley of the Institute for Environmental Medicine in

Stockholm and an EIRA investigator. “We hope that the data will contribute to the growing understanding of the etiology of RA and, ultimately, its treatment and prevention.”

—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 16).

## Foot Complaints Affect Quality of Life

**R**heumatologists can help their RA patients increase their quality of life by focusing on complaints about foot problems, such as pain, stiffness, swelling, and numbness.

An analysis of data collected in a 33-item questionnaire completed by 190 RA patients attending three outpatient clinics in southeast England found that 93.2% of patients said that foot complaints adversely affected their quality of life. More than half reported that foot problems badly or very badly affected quality of life, said Simon Otter, MD, of the University of Brighton. In addition, almost 80% of patients said foot problems interfered with their ability to walk, and almost 70% said foot problems interfered with their ability to wear different shoes. Large percentages of patients also reported difficulty standing and changing shoes and limited mobility and a resulting loss of independence.

On average, patients rated the effect of their foot complaints on quality of life as a 5.36 on a 10-point scale. “This result suggests that rheumatoid arthritis patients perceive that their foot complaints have a moderate to severe effect on their quality of life,” Otter explains.

Studies of RA that have included the feet have typically described the presence of deformities or a description of radiological assessment, but have not included quality of life measures, Otter says. In addition, outcome measures such as the Disease Activity Score (DAS) 28 include assessments of patients’ hands, wrists, and knees, but do not include feet.

These findings suggest that rheumatologists may want to include a thorough examination of RA patients’ ankles and metatarsal phalangeal joints to assess foot pain and other complaints such as numbness and swelling. Otter also suggests that rheumatologists should develop close relationships with podiatrists so that they can easily refer RA patients with foot problems for treatment. Such a relationship would be akin to that between podiatrists and physicians who treat diabetes, which is also frequently associated with foot problems.

—DJN

**Smoking is an established RA risk factor, but a second analysis revealed a dose dependency between smoking level and the odds ratio of developing anti-citrulline (anti-CCP) positive RA.**

## POINT-COUNTERPOINT

# Two Experts Debate the Candidates' Health Care Reform Proposals

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

**B**oth of the major-party candidates for president have proposed plans to reform the health care system. To get a full idea of how each plan would affect the health care system, we interviewed advisers to each campaign.

Simply proposing a plan is not the same as reforming the health care system and any changes that either candidate would make would have to be approved at least by Congress. And who can say now that there will be any funding to make any of these changes? Nonetheless, it is useful to review with the campaign advisers how each plan would affect the health care system.

One adviser is Grace Marie Turner, founder and president of the Galen Institute, a nonprofit research organization in Alexandria, Va., that is devoted to promoting individual freedom in health care, consumer choice, and competition in the health sector.

The other adviser is David Cutler, PhD, the Otto Eckstein Professor of Applied Economics, at Harvard University, and an adviser to Sen. Barack Obama (D-Ill.) on health plan strategy. He is the author of *Your Money or Your Life: Strong Medicine for America's Health System*, (Oxford University Press, 2004).

**Q:** *What are the differences between the approaches of Obama versus the approaches of Sen. John McCain (R-Ariz.)?*

**Turner:** There are stark differences. In the general election I thought we would have a debate about universal coverage versus costs. Instead that debate occurred in the Democratic primary. Sen. Hillary R. Clinton (D-N.Y.)

**“McCain believes that part of what’s wrong with our health system could be cured if we brought many of the forces that work in the rest of the economy to bear on prices in health care and expanded access to coverage by giving more choice to patients and make policies more portable.”**

**—Grace Marie Turner, the Galen Institute**

argued for universal coverage with individual mandates, but Obama said costs were the major issue.

That focus on getting costs down is not only Obama's starting point but also McCain's. We're having a different general election debate over health care than I expected we would have. But in the debate about how to get costs under control, you see strikingly different philosophies.

McCain believes that part of what's wrong with our health system could be cured if we brought many of the forces that work in the rest of the economy to bear on prices in health care and expanded access to coverage by giving more choice to patients and making policies more portable.

Obama wants a bigger role for government. He wants to create new government programs and place mandates on employers. He wants all children to have health coverage.

McCain would move toward a private, independent system for patients and they would own their health policies that they could take with them wherever they are with new subsidies to help them buy coverage. He would give new incentives to

patients to help expand access to coverage especially for those who have difficulty buying insurance now. Obama would try to achieve those same goals through government mandates.

**Q:** *How does Obama plan to reduce costs?*

**T:** He advocates more chronic care management, which McCain agrees with. Obama and McCain want to use information technology more widely. Obama says we could save several thousand dollars a year for the average person in the United States. These costs are going to be very difficult to capture, especially on an individual basis.

But competition, giving people choice, and providing health insurance that fits their needs, can, in fact, cut costs and give people more affordable coverage.

**Q:** *Obama says Americans ought to be able to participate in the Federal Employees Health Benefits Program (FEHBP) which serves more than 10 million federal employees.*

**T:** We have supported that proposal for a long time. Basically it means insurance companies are competing for

the business of individuals, whether they want an HMO, PPO, or high deductible account.

**Q:** Are you optimistic about the road ahead for health reform?

**T:** So much is riding on this presidential election. We have two very different visions. Health care is only one of the issues. McCain believes patients and doctors ought to be in charge, and we've got to give them incentives to allow them to get away from a top-down, bureaucratically run health system.

After discussing the issues with Turner, we interviewed Cutler.

**Q:** What is Obama's basic health care position?

**Cutler:** The senator believes there are three very important goals in health care.

1. We have to get everybody coverage to guaranteed affordable care.
2. We have to work to improve the value of the services we get. We can't afford to spend \$2.5 trillion on health care and not know what we're getting. We need to improve the value of what we provide.
3. We need to have a public health system that works, including one that is capable of addressing bioterrorism threats to food and water safety, tobacco and obesity control, and other segments of the health system.

**Q:** I have heard Obama wants to lower costs before we offer universal coverage. Can you explain that part of the plan?

**C:** That's incorrect. Obama says we must do both things together, meaning lower costs and provide universal coverage. We're not going to improve the value of care until everybody is in the system. It's crazy to think you'll save a lot of money with 48 million uninsured people and 15 million who are in and out of coverage.

**Q:** Early in the primary campaign Obama said he was opposed to individual mandates.

**C:** What he said was that the key issue in getting people covered was making insurance affordable and accessible. If insurance is affordable and accessible, most people will buy it. If it's not, people won't buy it. That is independent of whether you require them to do that. He is saying we must do the hard work of making insurance affordable and accessible. Once we've done that, we believe most people will buy it.

**Q:** How do we make health insurance affordable?

**C:** There are two primary methods that we can use to make health insurance affordable. First, we have to

save money by eliminating services we don't need, and second, we should give tax credits to people so they can afford to buy health insurance. You have to make the package cost less, but low and middle income people are still going to need help.

**Q:** The problem of accessibility worries me. There is a looming primary care physician shortage. Does Obama have any proposals to solve this situation?

**C:** Yes, but we had a primary care crisis even before we covered more people. In many areas of the country, people can't get access to  
(Continued on page 8)

## Urban Institute Evaluates McCain's Health Care Plan

**T**he Urban Institute, a nonpartisan, nonprofit organization in Washington, D.C., has evaluated the health care reform proposals from the two major-party presidential candidates. Here's what the institute said about the McCain proposal.

"The McCain health care plan represents a philosophical advance over many proposals, principally in its commitment to redistributing the current tax exemption for employer-based health insurance," the institute said. "However, the plan raises more concerns than it addresses. McCain's proposal would dramatically change how many obtain insurance, make coverage less accessible for those with health problems, have a high budget cost, but have little effect on the number of uninsured. These problems could be addressed by providing a guaranteed source of adequate, affordable coverage; phasing-out the tax exemption slowly; larger subsidies to the low-income; spreading health risk broadly; and a significant commitment to cost-containment.

The plan would:

- Provide a refundable tax credit that is more valuable to low-income workers than the current tax exemption for employer-based insurance, though the credit is not adequate to make coverage affordable for many;
- Make insurance coverage less accessible and affordable for those with high health care needs;
- Increase coverage among the currently uninsured through the non-group market but reduce the number already covered by employers, leaving about the same number of people uninsured;
- Have a high budget cost, at least in its early years.

In brief, McCain's proposal would dramatically change how many Americans obtain health insurance coverage, make coverage less accessible for those with health problems, have a high budget cost, but have little effect on the number uninsured.

## POINT-COUNTERPOINT

(Continued from page 7)

primary care physicians. One of the basic reasons for that is we have a medical system that rewards specialties. Everybody believes primary care doctors ought to be the ring leaders for patients. But they can't because they don't have any information base, and they need electronic records to do the job. And they don't get any financial support. What we've done is starve the primary care sector and not given it the resources. Then we're surprised when people say they have difficulty finding a primary care doctor.

**Q:** *A recent study showed that only 4% of 2,000 doctors had fully functioning electronic medical record systems (EMRs) and only 13% had basic EMRs. There are many reasons doctors don't buy these systems. What does Obama say about this slow rate of adoption?*

**C:** Obama has a very ambitious plan for a wireless and a wired system. He would provide \$50 billion to make sure every provider could get and could afford an EMR. It's one of the differences between the Obama plan and the McCain plan. McCain talks about why it might be a good thing, but he doesn't offer any money. If you don't give any money, you don't get anywhere, which is why the so-called interoperable computer system hasn't gone anywhere for seven years.

Every doctor I know thinks EMRs are important. What they say is that if they don't get paid for it, they can't afford to do it.

**Q:** *What about the medical home concept, where the primary care doctor coordinates care and gets paid more to do so and uses information*

**“McCain would move toward a private, independent system for patients and they would own their health policies that they could take with them wherever they are, and get new subsidies to help them buy coverage,” says Grace Marie Turner.**

*systems to support him?*

**C:** Obama wants to see more development of the medical home model. His plan provides the technical, financial, and clinical backbone to make that happen. He'll give physicians all the help they need and do it the way the medical literature says you should do it.

**Q:** *You're known as a champion of pay-for-performance programs and getting doctors bonuses for quality care and better outcomes.*

**C:** Yes, I think those are important elements for improving care.

**Q:** *How long do you think it will take for P4P and doctor bonuses to catch on?*

**C:** One of the problems with P4P is that sometimes insurers have been thinking only about saving money. I think about it as enabling doctors to do the right thing. Take diabetes, for example. There a number of well accepted guidelines for managing diabetes. Every doctor accepts these guidelines, but when you ask if they follow all the guidelines, they say, “Not very often.” When you ask why, they say, they're not paid to do it. I think of pay-for-performance as a way of paying them to do the right thing. When you

do the right thing, we'll make sure you get paid.

**Q:** *To measure quality effectively, you need the infrastructure of larger groups. Yet some 60% of doctors practice in groups of four or fewer. How do you make that transition?*

**C:** That depends on what you're trying to accomplish. With outcome measures you might need a large group, but for process measures, you could do it with small groups. I don't think there's a single answer. You have to consider each measure to see how one does it. Also, even when they practice individually, many doctors are affiliated with other doctors. Insurers are going to doctors in small or solo practice and saying, “If you work together, and save money, we'll make sure you're rewarded.”

**Q:** *How do you do that? By having doctors work together in their communities?*

**C:** These arrangements are not for everybody, and you don't force it upon them. It's counterproductive to impose many of these things on doctors. And imposing guidelines on doctors is not what the Obama plan is about. Obama is saying, “Look we know you're struggling, but the system is making it

**“Obama wants to see more development of the medical home model. His plan provides the technical, financial, and clinical backbone to make that happen. We'll give physicians all the help they need and do it the way the medical literature says you should do it.”**

**—David Cutler, PhD, Harvard University**

impossible for you to do the right thing.”

**Q:** *And what do you regard as the principle barriers to doing the right thing?*

**C:** There are two primary barriers. One is knowledge and the other is incentives. Doctors don't know what to do because they don't have the information at their fingertips. You need to tell me if this new drug is better than this old drug. You need to tell me which one of the specialists gets the best results. I need help doing all of that. I need research as to what works and doesn't work.

And you need to pay more for providing good care and for making it affordable to find the right information to provide that superior care, for illness prevention, and for chronic care management. Broadly speaking, you need to know the right thing to do and you need to pay for it.

**Q:** *Do you think it is possible to reduce variation in care?*

**C:** Yes, it is. But the key is information. It's not simple in high spending areas, where you have a lot of specialists. It's hard to control the galaxy of tests surrounding a given diagnosis. You've got to go to them with an information base and show them how the use of services and outcomes compares. Then we'll pay physicians to do the right thing.

**Q:** *Obama favors individuals participating in larger groups and pools, such as the FEHBP.*

**C:** Obama wants to bring individuals in small firms into bigger pools where administrative costs are lower and you get more choice. He wants to reduce the administrative load from 30% to 5%. This is another

big difference between Obama and McCain. McCain advises people to buy individually. He would cause people to lose employer benefits and cause people to go into individual markets.

**Q:** *McCain favors a market-driven, consumer-based approach, based on wider use of health savings accounts (HSAs) and high deductible plans. You've been dismissive of these plans and called them a fad.*

**C:** That still holds true. HSAs and high-deductible plans have been around for nearly five years now, and haven't exactly taken the market by storm. People in high deductible plans spend less money, but they tend to ignore preventive tests, and they lose money if they have a chronic disease.

—More information on physician practice strategies is available on our Web site (see page 16).

## Urban Institute Comments on Obama's Plan

**H**ere's what the Urban Institute said about the proposal from Sen. Barack Obama (D-Ill.) to reform the health care system. The Obama health care plan would greatly increase health insurance coverage, substantially increase access to affordable and adequate coverage for those with the highest health care needs, significantly increase the affordability of care for the low-income, and reduce the growth in health spending through a broad array of strategies.

Despite the overall positive assessment, a few concerns remain. The plan would leave about 6% uninsured, necessitating the maintenance of the current inefficient safety net system; the employer mandate may engender significant political opposition; and the cost estimate may be somewhat low depending upon how some plan details are resolved.

In its general assessment of the Obama plan, the institute said it would:

- Greatly increase health insurance coverage but would still leave about 6% of the non-elderly population uninsured, compared with 17% today.
- Substantially increase access to affordable and adequate coverage for those with the most health care needs, including those with chronic illnesses, by spreading health care risk broadly;
- Significantly increase the affordability of care for low-income individuals; and
- Reduce the growth in health spending through a broad array of certain strategies.

In short, Obama's proposal contains the basic components necessary for effectively addressing the most important shortcomings of the current health care system, that is, limited coverage, inadequate risk pooling, and high-cost growth.

**“Obama wants to bring individuals in small firms into bigger pools where administrative costs are lower and you get more choice. He wants to reduce the administrative load from 30% to 5%,” says David Cutler, PhD, a professor of economics at Harvard University.**

## COMMENTARY

# What Are the Prospects for Reform?

By Richard L. Reece, editor-in-chief

**T**he Nobel Prize winning economist Friedrich Hayek wrote, "I am certain that nothing has done so much to destroy the safeguards of individual freedom as striving after the mirage of social justice."

It could be argued that the views on health care of the two major-party candidates for president have deep implications for physicians in independent practice and for their individual freedom to practice as they please and use their clinical judgment.

But since the government may spend over \$1 trillion to bail out the financial system, it could be that there will be no funds left over for either candidate to reform the health care system. And, while reformers argue that the health care system needs to be reshaped because costs are too high and too many Americans are left without health insurance, it is doubtful that government can reform the system and save costs simply because it has no track record of doing so. In addition, the parties involved are likely to protect their own interests to such a degree that reform would be almost impossible.

## Rising Cost

In 1965, government officials estimated that Medicare costs would never exceed \$9 billion, yet today they total more than \$450 billion. Also, it is doubtful that government can identify the proper methods to use to improve the system regardless of the size of its information base, the sophistication of its algorithms, or the value of its guidelines. The health system is simply too complex.

In addition, even though Americans tend to be individualistic and leery of sweeping changes dictated by government, they are also unlikely to tolerate a free-wheeling

market-based system that doesn't protect the poor, the sick, the frail, the disabled, or victims of violence.

But if we are going to have universal coverage, we would do well to note that expanding coverage significantly expands costs as officials in Massachusetts and California have found. Often, government lacks the resources, personnel, and systems needed to contain the cost of the more than 2 billion health care transactions annually. The U.S. government also has been incapable of measuring quality or value, or improving outcomes effectively. Too date, it also has been incapable of changing patient behavior, which is the critical factor that determines most outcomes.

Nor can government second-guess every patient-doctor transaction effectively. Many such transactions lack a basis in scientific evidence and may be non-urgent and consultative in nature so that they do not lend themselves to data gathering or justification. Some physician-patient encounters may be required based on a physician's clinical experience or needed to improve a patient's satisfaction. Or, physicians may do some procedures simply for revenue or for reasons related to defensive medi-

cine, or because individual patients want or demand these procedures. It may be appropriate to seek to eliminate these procedures from our overburdened health system, but doing so likely will anger patients and thus prove to be challenging.

## Second Guessing

One reason the United States health care system is difficult to reform is that most physicians and other health care providers work at for-profit companies that are designed to meet Americans' seemingly unquenchable desire for choice, access, and the hope of a cure. To sustain profit growth, satisfy stockholders, and finance innovation, these health care enterprises must report good results every quarter. As soon as any proposal is made that threatens their market share, they hire lobbyists to argue on their behalf in Washington and state houses nationwide. All of the nation's largest health care providers and provider organizations engage in lobbying and have become quite adept at it.

Given these hurdles, it's easy to see that intervening into existing health markets has limits. We know that meaningful reform of the health care

## Questions To Answer

**A**mong the questions to answer about any health reform proposal offered by any candidate regardless of party affiliation are these:

1. Should we have a central command and control system or a decentralized market-driven system?
2. If neither, what should be the mix?
3. Is it possible to achieve universal coverage with the present system without cutting costs, or inviting state and federal bankruptcies?
4. How would a system of management based on evidence-based medicine work?
5. In a consumer-driven environment, will physicians be willing to publish their performance data so that consumers will know which providers to choose?

—RLR

system is challenging because many organizations are likely to be aggrieved. While proponents of reform say we should do away with for-profit enterprises, have government negotiate all pricing, and stop two-tier medicine, none of these proposals is likely to be approved without a long fight in the halls of Congress. Still, the reform proposals from Sen. Barack Obama (D-Ill.) or Sen. John McCain (R-Ariz.) are worth considering.

### Controlling Costs

In a report earlier this year, Dallas L. Salisbury, president and CEO of the Employee Benefit Research Institute, in Washington, D.C., and a member of The Commonwealth Fund's Commission on a High Performance Health System, wrote that one of the most important goals of any health reform plan is to control costs. Yet, the candidates have been short on specifics in their call for health care cost control, he wrote.

In his report, "Tough Choices Ahead: Candidates Ignore Pain of Needed Cuts to Health Costs," Salisbury said, "Republicans mainly suggest that moving to an individually based system where individuals have to pay more will bring a market solution: lower spending. Yet, if most spending is tied to chronic disease—as the data firmly show—deductibles at the levels required for health saving account tax preferences will achieve little total system savings. Democrats mainly suggest universal coverage, better information, and new payment approaches. Again, given the high proportion of total spending attributable to chronic conditions, these changes may improve efficiency and outcomes, but they will not come close to solving the health care cost spiral.

"Candidates of both parties seem to be spending most of their time trying to appeal to public wants, with almost no discussion of the dire choices lying ahead if fairly radical

## Will Self-Interest Derail Reform?

In addition to the roadblocks that health reformers face, there is a great deal of inertia. The health care provider organizations are likely to oppose any change in the system simply because reform may not be in their best interests.

When President Clinton presented a plan to reform the health care system in 1992, the nation's entrenched provider systems launched a successful lobbying and advertising effort that derailed the plan in a matter of months.

In their book, *The Tyranny of the Status Quo*, Nobel prize winning economist Milton Friedman and his wife, Rose Friedman, explained that upsetting existing conditions is inherently difficult. Brian Klepper, PhD, a health care consultant and founding director of the Center for Practical Health Reform, in Jacksonville, Fla., explained this tyranny in a recent entry on the Health Care Blog, "Is Meaningful Health Care (Or, any Other Kind) of Reform Possible?" (at [www.thehealthcareblog.com](http://www.thehealthcareblog.com)).

"There is broad expert consensus that one-third to one-half of all health care expenditure is waste," Klepper wrote. "Talk privately with most health care professionals—physicians, hospital executives, health plan administrators, benefits managers, supply chain executives—and there is reasonable agreement on critical principles that are necessary to re-establish the system's stability and sustainability: some form of universal coverage for at least basic health services; a comprehensive and compatible IT infrastructure; a transition from fee-for-service to some form of performance-based reimbursement; pricing and performance transparency; and much more."

But, he added, "Such changes could drive tremendous savings for individual, corporate and governmental purchasers, but at significant cost to health care firms and professionals. Revenues and profitability would plummet. As the struggles over health care resources intensify, the efforts to protect and enhance each interest's position through policy will intensify as well."

In fact, what Klepper describes is similar to what happened to the Clinton health reform plan 14 years ago. Each party looks out for its own self interest and the political consequences of the plan overwhelm its chances for success.

—RLR

and politically unpopular changes are not made soon," he added. "The Congressional Budget Office's and the Government Accountability Office's reports of recent months clearly set forth this health care fiscal reality, which, to date, is being totally ignored by candidates in both parties as well as the media covering the campaigns and moderating the debates. During the New Hampshire debate, Candidate Mitt Romney actually started to touch on some of

the core issues and was immediately cut off by the moderator as 'getting into the weeds.' Ironically, the health care weeds are exactly where the nation and its leaders need to focus. Real solutions are likely to carry with them far less individual choice, as opposed to more. That is going to be an unpopular prescription and a tough pill to swallow."

—More information on physician practice strategies is available on our Web site (see page 16).

## REIMBURSEMENT

# Are Coders Police or Firefighters?

By Sheri Poe Bernard, CPC, CPC-H, CPC-P

**W**hen your coder asks a question or offers suggestions, do you view his or her role as that of a firefighter or police officer? This may seem like a silly question, but the answer may give you a glimpse into the level of risk your practice could face should it become the target of a federal or state audit or investigation.

It's a question of perception. Intellectually, we understand that both the police and fire departments keep our neighborhoods and families safe because these trained professional first responders would risk their own safety to protect us from harm.

### Contrasting Views

Emotionally, however, each creates a very different response in us. When we think about an encounter with a firefighter, we think of someone saving a cat in a tree or rescuing a sleeping family from a burning house. We view a firefighter as one who puts himself or herself between us and certain danger. His or her goal is public safety, and we look upon him or her as our lifesaver.

When we think of an encounter with a police officer, however, the images are a bit different. We think of someone who may demand that we slow down, or someone waiting to give us a ticket. The police officer is seen as an obstacle between us and our goals. He or she may have public safety as an objective, but to us, he or she is at best a disapproving chaperone, and at worst, an unwelcome enforcer.

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**One midsize Florida practice was audited during the RAC pilot program completed earlier this year and required to repay \$2.5 million in "overpayments," many of which were attributed to underdocumentation or lack of medical necessity.**

Recognizing the difference between our perceptions associated with these roles, consider again: When your coder asks a question or offers suggestions, is he or she placing unwelcome obstacles between you and your goals, or is he or she keeping you and your practice out of harm's way? The answer correlates directly to your own philosophy about documentation and coding compliance, and your coder's job satisfaction and willingness to ensure your practice is meeting its regulatory requirements.

If you see your coder as a firefighter, bravo! You're part of a team with common goals and mutual respect. Because you invite discussion regarding coding compliance and listen to advice on how to provide better and safer documentation and business practices designed to prevent problems, your coding team is empowered and takes the time to research the ever-changing rules of reimbursement. The staff knows what is necessary to meet today's regulatory requirements. As a result of their vigilance, you and your practice are less likely to come under the scrutiny of the federal Office of Inspector General (OIG) or the Recovery Audit Contractors (RACs). Count yourself lucky.

If you see your coder as a police officer whose efforts slow you down or cost you money, beware. Employees are quick to understand

actions that may be considered career limiting, and if you consistently respond negatively when coders communicate compliance problems, they may create ways to work around you by downcoding, for example. Doing so would improve their working situation but may mean the practice does not bill for all the services it should.

### Increased Vigilance

Others may take you at your word: If you don't think compliance is important, they won't either.

Medical coding is complex, and certified coders are trained to stay up-to-date on the regulations. They know where to find answers to compliance questions. If your attitude communicates that compliance discussions are unwelcome, you have only yourself to blame if the OIG or RAC comes knocking.

As one certified professional coder wrote in response to a recent American Academy of Professional Coders (AAPC) survey in her office, "Physicians do not believe the coders when they tell them what the limits or requirements are. Coders play the role of 'code police' and try to correct claims before they can leave the office, but do it discreetly. We constantly worry about audits."

Many practices have been flying under the OIG's radar since it started being more vigilant in its fraud and

abuse enforcement activities 10 years ago. In these years, the OIG has focused its efforts on fraud among providers in large practices or high-dollar healthcare settings. Under the new RAC program, auditors will be running Medicare claims through an automated editor that will identify practices that have minor errors in coding and billing. Individually, these small errors may seem inconsequential but they can add up to significant dollar amounts. Practices will be required to repay past Medicare overpayments on claims that are as much as three years old. Because the system is automated, virtually every practice with Medicare patients could be audited.

### Repayment Ordered

One midsize Florida practice was audited during the RAC pilot program completed earlier this year and required to repay \$2.5 million in "overpayments," many of which were attributed to underdocumentation or lack of medical necessity. In nearly all the cases, the practice administrator said the work was performed and the medical necessity was there. But the records were sloppy or nonexistent, despite regular requests for improvement from the coding staff. The repayment cost this particular practice \$100,000 for each of its 25 physicians.

The AAPC completed its Work of a Coder survey this summer, and the results echo the importance of physicians working with their coders to ensure that the practice addresses compliance issues. Nearly half of coders surveyed felt their physicians did not have enough knowledge about coding and reimbursement issues to document effectively, and one in four said their physicians did not welcome discussions of documentation problems. Among physi-

cians performing coding duties, such as selecting E/M levels or circling codes on a superbill or EMR menu, 58% did not have any formal coding training, the survey showed.

"My providers sincerely think they understand coding and reimbursement," one coder commented. "They want me to submit accurate and appropriate claims. They feel that they do not have enough time to document in the manner in which I suggest. I feel that I leave a significant amount of money on the table due to the lack of documentation and that frustrates me." While aggravated, this coder is still protecting the

**To protect practices from fraud charges, coders tend to under-code.**

## How to Make Changes in Coding Compliance

**W**hat can physicians who want to see their coders as firefighters instead of police officers do to foster a change? To change the perception of coders in your office, consider:

**Adjusting your attitude.** As a physician, your primary focus should be clinical. You need to get to a point where you trust your business staff to know the regulatory requirements, and then you must be willing to conform to their requests. Early on, you may want your coders to cite government sources or show you the guidelines. But you must eventually trust their judgment. They are professionals. If you aren't comfortable relinquishing control, you may need to consider new staff. You simply don't have time to do it all yourself.

**Be willing to change.** Documentation requirements change every year, as new codes develop. Everyone needs to learn new habits and change old ones. Be willing to make adjustments to ensure compliance in your practice.

**Prepare for the worst.** Even if you are doing everything right today, auditors can review old claims and ask for refunds. Work with your coding staff to assess how noncompliant past practices were, and determine what's at risk from the past.

**Be a team player.** No one in your office underestimates the importance of the physician to the practice. Can you say the same for the importance you place on your coding staff? The business side of medicine keeps the office going. Make sure your office staff perceives you as a team player, and one who values their contributions. A little time invested in developing relationships and goodwill can pay big dividends.

—SPB

practice from charges of fraud or abuse by not billing when the documentation is insufficient.

Another coder said, "I love my physicians, but sometimes I think that they think the coders are the bad guys because we give them back charts needing more information. We don't have the same relationship as the other administrators in our office. Everybody is laughing and having great relationships with everybody else, except for us."

Which hat will your coder wear? The choice you make may affect the practice far beyond the interpersonal relationships you build in your office, leading to compliance and reimbursement patterns that can set your practice apart from the rest.

—More information on practice strategies is available on our Web site (see page 16).

## TECHNOLOGY

# Decision Support Improves Diagnosis

By Art Papier, MD

**R**esearch shows that 15% of diagnoses are incorrect, costing millions of dollars and thousands of lives every year. Such levels can be attributed to the fact that for any primary care physician, there is simply too much to know and certainly too much to memorize. The nature of medical school training, financially driven time pressures on doctors, a fragmented health care system, and the ever-increasing volume of medical information are part of the problem. In addition, there is so much data available to physicians every day that it's difficult for them to stay up to date on all new developments in medicine.

The resulting medical errors and startlingly high levels of misdiagnosis have taken a toll on the public's view of the health care system. But for all the hand wringing and conversations about improving quality, why is diagnostic decision support so rarely used? Professionals in all areas of health care have considered diagnostic decision support systems but have infrequently implemented the technology. Concerned about the complexity, cost, and workflow difficulties, physicians tend to be skeptical that clinical decision support systems will work as advertised.

## Facing the Challenges

The missing element in clinical decision support that counters all of these claims is images. It may seem simplis-

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**Visual diagnostic decision support can help physicians identify problems because half of all diseases have a skin or pattern clue, and 10% to 20% of diagnoses that primary care practitioners make are visually based.**

tic, but visual diagnostic decision support addresses the non-analytical, perceptual issues that arise when a doctor examines a patient and identifies a problem.

## Improving Accuracy

Traditional medical reference sources such as textbooks and atlases offer limited information and require clinicians to search by diagnosis name. Searching in this way means users must consult and index multiple pages, which takes time and focus away from patient care.

A better way involves using what's called visual diagnostic decision support tools that can help physicians identify problems. These tools are particularly useful because half of all diseases have a skin or pattern clue, and 10% to 20% of diagnoses that primary care practitioners make are visually based. Yet primary care practitioners receive minimal training in how to recognize these clues.

Using the best visual diagnostic decision support tools, clinicians can enter the patient's clinical features, such as lesion morphology, body location, symptoms, and medical history. The system uses this information to build a customized pictorial differential diagnosis in seconds. These systems will organize this information logically by age group, body location, and problem area to make it easier to initiate a differential diagnosis. These programs will then color-code the

results and list the most relevant findings at the top.

## Training and Practice

These systems are designed to reduce complexities in health care. Physicians in busy clinics, emergency rooms, and hospitals often have to make quick decisions with incomplete data. Physicians in these settings can use visual diagnostic decision support tools at the point of care to diagnose diseases accurately using distinct visual clues and symptoms.

While medical errors involving physician orders and drug reactions make headlines, the more serious and underlying concern is misdiagnosis. Diagnostic error leads to incorrect treatment, failure to use an indicated diagnostic test, misinterpretation of test results, and failure to act on abnormal results. Cognitive errors may result in poor quality of care, patient safety risks, increased costs, and in some cases, malpractice litigation.

In their medical education, physicians learn a highly structured method to think, and they habituate this methodology throughout training and subsequent practice. Medical education stresses memorization of basic science and clinical facts. This approach means that students must focus on prototypical classic cases rather than learning all the variants. As the medical student moves from the classroom to residency appren-

ticeship years, training shifts to practice-based learning from unique clinic or hospital patient cases.

Soon, residents realize that most patients do not neatly present as textbooks suggest. Thus, the life-long learning of the physician begins. Expertise is gained from experience and evolves from interactions with thousands of patients, synthesized during the twists and turns of each individual case and a vast array of symptoms and examination patterns over a career. Our patients hope we have this expertise and assume that younger doctors have at least developed a methodology to consider, recognize, and diagnose problems even if they lack years of experience.

### Recognizing Patterns

Regardless of how many years a physician has practiced, he or she undoubtedly will see a great number of patients who have patterns not seen previously in practice or encountered in texts. For physicians in family practice, internal medicine, pediatrics, or emergency medicine, this problem can be particularly difficult because they are expected to recognize patterns and make diagnoses that span all medical specialties. Given the immense disparity in disease presentation, it is clear that the frequent variants of the common and the rare diagnoses might be difficult for these physicians to recognize, even after 20 years of practice, never mind the first 5 or 10.

Diseases have hundreds of skin, eye, and oral clues. When physicians are making a diagnosis from skin or pattern-recognition-based clues, they readily admit that they are insufficiently trained to recognize visual clues. This challenge is compounded every day in fast-paced clinics, emer-

gency rooms, and hospitals, where generalists are forced to make quick decisions, often with incomplete data and a dearth of experience in evaluating the subtleties of disease characteristics.

Many practitioners falsely believe that search engines are an answer. But searching by diagnosis is impossible without one. In addition, an article in the *British Medical Journal*, "Googling for a diagnosis—use of Google as a diagnostic aid: Internet based study," researchers in the Department of Respiratory and Sleep Medicine, at Princess Alexandra Hospital, Brisbane, Australia, showed that Google-aided diagnoses were accurate only 58% of the time (BMJ. 2006 Dec 2;333(7579):1143-5. Epub 2006 Nov 10). This rate is poor and would never be acceptable for pilot cockpit data, nor should it be acceptable in medicine.

### Assessing Possibilities

Diagnostic decision support systems, though rarely used, allow physicians to enter their patient symptoms and other medical factors, such as laboratory results, to produce a list of diagnostic possibilities. To date, all diagnostic systems limit the dynamic nature of medical diagnosis and do not allow for the incorporation of perceptual and visual data into clinical thinking. Many physicians do not know how to describe with words the visual clues and patterns they observe, and extensive words on a page or screen make it difficult to recognize patterns of disease. Furthermore, the findings in the physical examination are essential elements for diagnostic acuity.

Accurate diagnostics involves having the physicians synthesize complex, often ambiguous data and

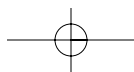
clinical judgment. Experienced physicians have an extensive knowledge base that matches up the features of the case at hand with one or more patterns. For rare diseases and variants, these decisions are highly accurate when experts make them, but generalists lack the requisite knowledge base, especially with regard to the intricacies of visual clues.

Therefore, one of the greatest areas of need for information in medicine is a visual approach for pattern recognition, or a visual diagnostic decision support system (VDDSS), organized to match the way a physician thinks about signs, symptoms, and diagnoses. Such a system would allow rapid visual and iconic search entry of visual patient clues and presents multiple images and graphics of each disease alternative, demonstrating how each might look at different stages and in people of different ages and ethnicities.

Edward A. Bartkus, MD, EMS medical director of Clarian Health in Indiana, uses a visual diagnostic decision support tool called VisualDx from Logical Images Inc. "VisualDx enhances health care quality and offers fast, convenient access to a wealth of medical images and information that I use to supplement my clinical judgment to accurately diagnose diseases I don't see every day," he said. "The ability to enter and select a patient's findings as a combination of text and images, and to compare multiple diagnoses and images simultaneously, is a particularly effective way to build a customized differential diagnosis."

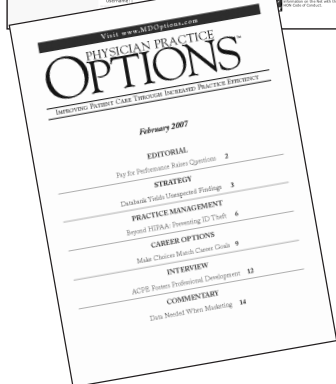
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**By entering and selecting a patient's findings as a combination of text and images, clinicians can build a customized differential diagnosis.**



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