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*November 2005*

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## Two Trends May Benefit Physicians

**R**ecent developments make the prospect of health reform seem rather distant. Frankly, the status quo seems more likely.

The nation's largest health insurers seem to be too busy protecting their own turf to embrace sweeping reform measures. At the same time, the federal government is seeking to reduce health care spending by cutting Medicare and Medicaid fees once again. Federal health officials believe physicians can operate their practices more efficiently by using electronic health record (EHR) systems. At the same time, employers are seeking to cut costs by introducing consumer-directed health plans (CDHPs) and asking employees to pay more for care.

While both of these trends (the growth of EHRs and the introduction of CDHPs) are unrelated, they offer hope for overworked and underpaid physicians.

By adopting EHRs now, physicians will become adept at using them and will see improvements in efficiency over time. But the most significant result of using EHRs to collect all patient-encounter data electronically is that physicians will be ready for the next generation of technology. Some day, experts predict, physicians will be able to access CPT or ICD-9 coding information online, meaning that they will be able to insert the correct codes in a claim whether they're in their office or on the road.

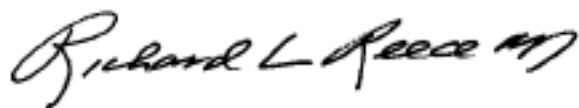
Simplified coding and greater consistency will result, meaning less lost revenue due to downcoding or incorrect coding. Physicians and other providers can enter codes at the point of care, eliminating guesswork. The chief economic benefits will be total charge capture and faster claims adjudication and payment.

Faster payment will also result from CDHPs. Many physicians are already seeing patients who use debit and credit cards to pay for services at the point of care. Health insurers introducing CDHPs also are offering high-deductible health savings accounts (HSAs) with these plans. The health insurers have made agreements with banks and credit-card companies to give their health plan members cards they can use to pay for health care.

Under a high-deductible HSA, patients must pay out of pocket for the first \$1,000 or \$2,000 of care each year, meaning physicians can get paid quickly if they collect these amounts at the time of service.

By swiping these credit and debit cards in their offices, physicians are paid promptly, just as any retailer gets paid. Physicians still need to send in claims for the balance after patients pay their deductible, but at least some of the payment can be collected upfront.

While neither of these trends is true health reform, each represents a significant improvement in two of the biggest problem areas physicians face.



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# Guidelines Complement Performance

**S**eeking to minimize variation in care practices, the American Heart Association and the American College of Cardiology have established a link between new guidelines and performance measurement.

For years, the AHA and the ACC have worked together to produce evidence-based clinical practice guidelines, says Robert O. Bonow, MD, professor of medicine at Northwestern University and chief of cardiology at Northwestern Memorial Hospital in Chicago. “But the guidelines process only goes so far in standardizing the approach to cardiovascular care,” adds Bonow who chaired the ACC/AHA Task Force on Performance Measures. “Although guidelines do help to improve quality, they do not necessarily improve quality in a uniform way. Wide variation and disparate use of evidence-based cardiovascular care still exists, even within the same community. Therefore, it was clear that if we wanted to improve quality, we had to go beyond the guidelines to provide a way that physicians could measure their performance. By publishing the guideline update and the performance measures simultaneously, physicians are able to consider the recommendations in conjunction with strategies to measure performance against them.”

The guidelines, *Practice Guidelines for the Diagnosis and Management of Chronic Heart Failure*, were first published in 1995 and were last updated

in 2001. They outline the optimal care process for heart failure patients, including assessment and therapy and special considerations for patients by age, gender, ethnicity, and comorbid conditions. When releasing the new guidelines, the AHA and the ACC released articles on two related topics: “Clinical Performance Measures for Adults with Heart Failure” and “Key Data Elements and Definitions for Measuring the Clinical Management and Outcomes of Patients With Heart Failure.” By concurrently releasing the clinical performance measures and the key data elements, ACC and AHA hope to make the guidelines more actionable, thereby encouraging improvements in quality and outcomes.

## Eye on Performance

In addition, the ACC and the AHA recognized that a growing number of payers, including CMS, are developing performance measures. “We wanted to have a process in place within the ACC/AHA quality initiative that would enable us to work with these other organizations,” Bonow explains. “In the past, our guidelines have been the standard by which others have viewed quality in cardiovascular care. We would like to maintain our leadership role in performance measurement as well.”

The guidelines can help cardiologists ensure optimal quality of care for their heart failure patients. “Adherence to the basic recommen-

dations put forth in the guidelines can clearly help prevent this increasingly common disease and extend the lives of those people who do develop heart failure despite adequate attempts at prevention,” says Sharon A. Hunt, MD, professor of cardiovascular medicine at Stanford University Medical Center and chair of the guidelines panel.

## New Therapeutic Options

Hunt says, “Major new developments in pharmacology and in devices needed to be addressed in an updated version.”

The updated guidelines retain important information published in 2001, when congestive heart failure was renamed heart failure, prevention strategies were emphasized, a four-stage classification system for the condition was outlined, and assessment processes were described in detail.

The guideline recommendations also use the ACC/AHA classification system, which guides treatment decisions based on the evidence:

- Class I: Procedure/treatment should be performed/administered
- Class IIa: It is reasonable to perform the procedure/administer the treatment
- Class IIb: Procedure/treatment may be considered
- Class III: Procedure/treatment should not be performed/administered since it is not helpful and may be harmful.

The most important changes in the

(Continued on page 4)

**“A heart failure patient on a standard, ordinarily recommended treatment regimen can be taking 16 pills a day. Understandably, it is difficult to get patients to comply with therapy.”**

**—Sharon A. Hunt, MD, Stanford University Medical Center**

2005 update are related to therapeutic options. "Several new forms of therapy that have been recognized as effective since 2001," Hunt says. The 2005 guidelines recognize the use of an angiotensin receptor blocker (ARB) as a valid alternative to an ACE inhibitor in some patients, for example. "ACE inhibitors are still the first choice for therapy, but the guidelines confirm that, as a second choice, ARBs are not unreasonable," Hunt says. This option is mostly relevant for patients who are already taking ARBs when they develop heart failure, she adds. "One of the biggest questions in heart failure treatment has been whether patients who are doing well on ARBs should be switched to ACE inhibitors if they develop heart failure. Evidence since 2001 has suggested that patients who are doing well on an ARB should continue on that therapy." ARBs are also recommended for patients who cannot tolerate ACE inhibitors because of ACE inhibitor-related cough.

This confirmation of ARBs as a viable alternative to ACE inhibitors has implications for quality performance measurement. "Many checklists of quality care for patients with heart failure reflect the use of ACE inhibitors, but not ARBs," Hunt says. "Therefore, cardiologists who are choosing to prescribe ARBs rather than ACE inhibitors in heart failure patients are unfairly downgraded. By making ARBs a Class Ib recommendation, we are not only providing cardiologists with support for that process of care, but we are hoping to ensure that quality assurance measurement will not discriminate against their use."

### Combination Therapy

Another approach supported by the 2005 guideline update is the use of combination therapy with hydralazine and long-acting nitrates. "In fact, this combination was one of the earliest treatments for heart failure," Hunt says. "But it was not used extensively because it is difficult to

## Task Force Sets Performance Measures

The ACC/AHA Task Force on Performance Measures designated the following inpatient and outpatient performance measures that clinicians can use to demonstrate their adherence to ACC/AHA heart failure treatment guidelines.

Inpatient performance measures:

- Evaluation of left ventricular systolic (LVS) function
- ACE inhibitor or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD)
- Anticoagulant at discharge for heart failure patients with atrial fibrillation
- Discharge instructions
- Adult smoking cessation advice or counseling

Outpatient performance measures:

- Initial laboratory tests
- LVS function assessment
- Weight measurement
- Blood pressure measurement
- Assessment of clinical symptoms of volume overload (excess)
- Assessment of clinical signs of volume overload (excess)
- Assessment of activity level
- Patient education
- Beta-blocker therapy
- ACE inhibitor or ARB therapy for patients with heart failure who have LVSD
- Warfarin therapy for patients with atrial fibrillation.

—DJN

administer, requiring the patient to take numerous pills three to four times a day. Recent research has demonstrated that a pill which combined the two drugs was strikingly beneficial in an African American population. The guideline update notes that the hydralazine/nitrate combination therapy, whether given traditionally or via this pill, can be beneficial in patients with mild to moderate heart failure."

A third pharmacological development since 2001 has been the demonstrated benefit of aldosterone antagonists, and recommendations regarding their use have now been incorporated.

The guideline update also reflects recent research regarding the use of implantable cardioverter defibrilla-

tors (ICDs) and cardiac resynchronization therapy (CRT).

The 2001 guidelines mentioned the potential of CRT, for example, but the lack of clinical trial evidence prevented a formal recommendation for use. "Since then, several trials clearly showed that CRT resulted in an improvement in symptoms, and one landmark trial demonstrated improved survival," Hunt says.

Likewise, a number of trials indicated that ICDs led to improvements in survival, and survival curves generally diverged after one year, Hunt comments. Recommendations regarding ICD use have been appropriately expanded in the current document.

The updated version of the guidelines also recommends the use of left ventricular assist devices (LVADs) as

permanent therapy for some patients with end-stage heart failure.

Hunt does not believe that anything in the new guidelines will be considered controversial.

But one obstacle to optimal therapy is the complexity of treatment options. "All of the drugs and devices discussed in the recommendations are available, FDA-approved, and widely used," Hunt says. "Nothing about any one of them is prohibitive in the least. But clearly, heart failure treatment is increasingly complex. A heart failure patient on a standard, ordinarily recommended treatment regimen can be taking 16 pills a day. Understandably, it is difficult to get patients to comply with therapy."

Cost also may be an obstacle to implementation. "If followed to the letter, the recommendations regarding both prevention and treatment would be very expensive," Hunt observes. "When we write guidelines, we consider only the scientific evidence, not the cost of implementation. Due to the costs involved, practicing cardiologists will likely be forced to make some hard decisions about whether the evidence should be applied in care decisions for each individual patient."

A final obstacle is the lack of aggressiveness with which prevention measures are pursued. "The 2005 guideline update offers nothing new with regard to prevention messages," says Hunt. "For years, we have built a tremendous body of evidence regarding the efficacy of a variety of strategies to prevent heart failure. For example, the most straightforward strategy is to find people with high blood pressure and control it. Unfortunately, prevention is not pursued to an optimal degree. Early

detection is also key, because we do have adequate disease modifying regimens that can be implemented once heart failure is recognized."

### **Quality Measurement**

The guidelines offer a summary of what cardiologists should do to optimize care. But quality measurement initiatives can help prompt cardiologists to ensure that these optimal care processes are taking place.

"Cardiologists who measure their performance against standard objectives can enhance their care quality and solidify their relationships with payers and other groups measuring performance," says Hunt.

"The guidelines include numerous recommendations, but we carefully chose those recommendations that we thought were the most important, so that physicians could become familiar with the process," Bonow points out. "There are many potential measures, but not every guideline recommendation lends itself to becoming a reasonable performance measure. We all agree on certain very obvious steps in care, but the actual ability to retrieve the information and document it is sometimes quite difficult. We chose measures that not only reflected care quality but that could actually be measured and gathered reasonably easily."

### **Worksheets Available**

Five inpatient performance measures and eleven outpatient performance measures have been designated. Each performance measure falls into at least one "dimension of care" (diagnostics, patient education, treatment, self-management, and monitoring of disease status). In the published document, the ACC and AHA also pro-

vide a detailed description of each performance measure along with checklists and worksheets to facilitate either prospective or retrospective data collection. Instructions for calculating performance measures are also provided where applicable.

"Our goal in creating these performance measures was to drive quality improvement," Bonow says. "But obviously, the measures can be used, and may eventually be used, for other purposes such as pay for performance. Therefore, it is important for cardiologists and other physicians to be aware of these measures."

Awareness is important in part because the performance measures align well with the JCAHO/CMS Heart Failure Performance Measures and the measures and guidelines developed by other organizations, including the Heart Failure Society of America and the RAND Corp., Bonow says. The ACC/AHA added one measure (on anticoagulation for patients in atrial fibrillation) that is not part of the JCAHO/CMS standards.

While CMS as well as private payers are increasingly implementing clinical performance measurement, it is important for cardiologists to measure their performance in advance of demands from health plans, Bonow adds. "Performance measurement is a process by which physicians can demonstrate adherence to guidelines, quality of care, and improvements in quality," he says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. The guidelines and performance measures were published Sept. 20 in *Journal of the American College of Cardiology* and are available online (at [www.americanheart.org](http://www.americanheart.org) and [www.acc.org](http://www.acc.org)). More information on physician practice strategies is available on our Web site (see page 8).

**"We chose measures that not only reflected care quality but that could actually be measured and gathered reasonably easily."**

**—Robert O. Bonow, MD, Northwestern Memorial Hospital**

# A Family Doctor's Katrina Diary

By Ron Kellum, MD

**A**fter three days of unsuccessful attempts to reach state and federal authorities to offer my services as a physician and as someone familiar with one of the areas hit hardest by the storm, I decided to go back to Mississippi alone. On Thursday, Sept. 1, I bought two electric generators, gasoline, some food and water, and drove east on Interstate 10. My wife and daughter stayed behind in Austin. I was unauthorized and not part of any coordinated relief effort.

## Chilling Scenes

What I saw on the road that day was chilling. As I drove, it was clear that nothing in the area had withstood the storm without impact or trauma. Stalled cars dotted both sides of the highway. Some cars looked as if they had been thrown into the woods. Others were tumbled over onto their hoods. Were people driving these cars when the worst of the storm hit? Were the drivers still in their cars? I drove on.

In Diamondhead, my home and office were only slightly damaged, and I met with officials from the flooded-out community hospital (Hancock Medical Center in nearby

Bay St. Louis) and members of the Diamondhead Community Fire Department. Also, I met Jeff Kennedy, MD, an orthopedist from Jackson, Miss., and Rodney Biggs, his surgical assistant. They were volunteers with the Mississippi Emergency Management Agency (MEMA). We decided to open my office the following morning.

Friday, Sept. 2. That morning we met at my five-room office (Hancock Family Medicine), made a sign from

need, stocked up on supplies, and drove to the coast hoping to provide medical care to those in need. It was refreshing to be working with fellow family physicians. I knew one of the physicians, Michael Hogue, MD, from childhood. He and I had grown up together in New Orleans.

Soon, an onslaught of patients arrived and we had lines of people waiting to be seen. With no previous experience in such a disaster, we did what we could to treat and street. Early

**On Sept. 2, we made a sign from discarded roofing material and donated spray paint, and started seeing patients. Little did we know that we would keep the office open 24 hours a day, seven days a week, for three weeks.**

discarded roofing material and donated spray paint, and started seeing patients. Little did we know that we would keep the office open 24 hours a day, seven days a week, for three weeks.

Working with this pair of volunteers was wonderful in many ways but I quickly learned that an orthopedist and a surgical assistant would require on-the-job training in how to deliver primary care. I found myself explaining, for example, that clonidine is for hypertension, but klonopin is for seizures and anxiety.

## Treat and Street

That morning, a group of volunteer nurses and family physicians joined us from the Mississippi towns of Fulton and Tupelo. Equally frustrated by the lack of coordination among local, state, and federal agencies, they did as I had done. Unable to reach authorities, they anticipated what they would

in my medical training I had learned the value of a good nurse and so assigned a nurse to triage. Those requesting tetanus booster shots were seen in one of my three exam rooms, while those wanting prescription refills were sent to another room. Patients with acute medical complaints were sent to the third exam room.

## 200 Patients a Day

Saturday, Sept. 3. During this first week, we saw nearly 200 patients each day. We kept no charts and filed no charges. Lacking electricity, we had the opportunity to practice pure medical care. We had no 21st century medical systems of any kind.

It was surprising to find that a large percentage of medication refills were for chronic pain. Even more surprising was the fact that almost all of these patients were on one of three medications. Patients were on either hydrocodone, carisoprodol, or alprazo-

*Editor's Note: Just three weeks before Hurricane Katrina tore through Louisiana and Mississippi, Ron Kellum, MD, and his wife Bitia Ghaffari, MD, opened a family practice in Diamondhead, Miss., a Gulf Coast town of 6,000 residents. In the first three weeks, they saw three or four patients each day. Ghaffari worked part time while also caring for their young daughter. Just before Katrina hit, Kellum took his family to Austin, Texas, to ride out the storm. On Thursday, Sept. 1, he returned to Diamondhead to do what he was trained to do: provide patient care. This is his story.*

lam regardless of injury or which chronic pain facility or physician they had seen before the hurricane. Many of these patients brought imaging reports with them showing mild conditions and some actually stated “normal study.” Yet for these patients, their pain or addiction was real. Lacking the training and experience with these conditions, I was unsure about how to manage their complaints. Where they legitimate? Is their pain or addiction real nonetheless?

Sunday Sept. 4. Patient complaints seemed to come in groups at a time. Today, we saw a number of cases of allergic reactions. How we managed these various cases can be attributed only to providence since we never had a case we couldn't treat. We thanked God that all patients with allergic reactions responded to methylprednisolone and diphenhydramine alone. None required cricothyrotomy or unavailable intubation and ventilation. Epinephrine was our only last defense.

### **Contributions Welcomed**

We saw a number of patients with lacerations on this day as well. Some of these patients were treated inside the building while others were treated outside under makeshift tents, MASH style. The nurses provided aid by dispensing tetanus booster shots or filling

were forthright and forthcoming with everything they could supply. This discrepancy is unexplainable.

All supplies donated to us during these first three weeks came from unknown sources. It was amazing to see that volunteers would simply

**Monday Sept. 5. Today the Fulton and orthopedic teams departed. Using our only form of communication with the outside world (text messaging), I hear that new volunteers are coming tomorrow. Our practice has become a revolving door for patients and physicians.**

drive up to our door unannounced with a van full of supplies. From the van drivers, we heard the same story many times: They had no prior authorization or any assistance from the local, state, or federal authorities. They just packed up what could and drove it to us.

Our supply room, exam rooms, and halls began to swell with supplies, volunteers, and people seeking some form of medical, emotional, or other support. From each patient, of course, we heard heart wrenching and courageous stories.

Monday Sept. 5. Today the Fulton and orthopedic teams departed.

without these vital services.

But now the volume of patients with severe injuries is rising. EMS brought us patients two to three times today and each day for the next three weeks. We began seeing patients with blunt trauma, crush injuries, fasciitis,

and amputations. Some were ambulatory. Some were not.

### **A Return to Normalcy**

While the office remained open 24 hours a day, seven days a week, we slept in shifts when we could. Over the next two weeks, normalcy started to return. In these two weeks, power came back on, then our phone service returned. My mentor and previous program director Randall Richard, MD, of Diamondhead arrived toward the end of week three to lend needed aid, experience, and support.

During the first three weeks in September, I had more than 50 volunteers see patients in my practice. We had one orthopedist (Kennedy), an internist, one emergency physician, an ophthalmologist, and an obstetrician. The remainder were nurses and family physicians. For me, the experience of being a family physician and being able to help people in need under such trying circumstance was fulfilling and rewarding.

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

*Editor's note: While the effects of the storm linger in the Gulf Coast, Kellum's practice is growing. By October, he and his wife were seeing about 20 patients per day.*

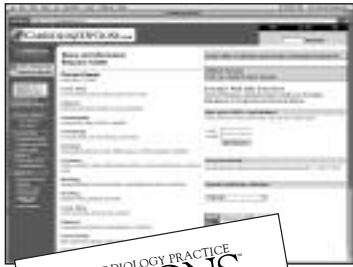
**We began seeing patients with blunt trauma, crush injuries, fasciitis, and amputations. Some were ambulatory. Some were not.**

prescriptions, which were reviewed and then approved by physicians.

Other nurses were on what we called permanent scrounge duty. Initially, the federal Emergency Management Agency (FEMA) had appeared useless. Every request for help from our nurse-run scrounge patrol was denied. But when I met with FEMA officials personally, they

Using our only form of communication with the outside world (text messaging), I hear that new volunteers are coming tomorrow. Our practice has become a revolving door for patients and physicians. Also today, the hospital and emergency medical response services came on line. Again, providence is the only explanation for how we had managed

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