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EDITORIAL

Electronic Records Offer Raises Questions

The theory behind offering an electronic health records system to all physicians is solid. In practice, however, having every physician adopt an EHR may prove to be complicated.

Early this month, the federal government announced that VistA-Office EHR, a high-quality, low-cost electronic health record (EHR) system for use in physician offices with one to eight practitioners, will be made available to any physician interested in using the system. The EHR has been developed through a collaborative effort of the federal Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA). The system works on an open, standards-based foundation that will allow vendors to develop value-added enhancements, such as installation, training, and support for physicians. The chief concern for physicians is that the high cost of implementing an electronic record system can be a significant impediment.

Medicare officials say the lack of electronic records is one of the biggest impediments to improving health care, according to *The New York Times*. By using the give-away software, an office of five physicians could save more than $100,000, Medicare officials say.

This prediction sounds too good to be true. The American Academy of Family Physicians Center for Health Information Technology (www.centerforhit.org) says the give-away system lacks several important components included in other EHRs, including pharmacy, radiology, and laboratory results reporting and modules for scheduling visits, billing, and practice management functions. Also, the database that is part of the system must be licensed at a cost of about $2,700, according to some estimates.

The Vista system does not include the CPT codes necessary to generate claims. These must be purchased from the American Medical Association at $89.95 per year. The cost of integrating the system with other office software may total hundreds to thousands of dollars.

By some estimates, the cost of installing and maintaining the Vista system may be higher than installing and maintaining other EHR programs. It is likely that the system will cost $10,000 per doctor in the first year, not including hardware, training, or other software needed to make the system work in a small office.

Allen Wenner, MD, a family physician in Columbia, S.C., and information technology expert, says making the Vista system work with other programs could be expensive. Also, the Vista system doesn't address the expensive problem of how physicians can enter patient data. Furthermore, the system does not include methods for handling task analyses and workflow changes. While the Vista system seems quite attractive, these important questions remain unanswered.

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New Technology Expands Options

Virtual colonoscopy has received much press in the gastroenterology media. But in fact, a number of colonoscopy advancements will have a meaningful effect on gastroenterology practice, either by fostering the adoption of new technology or prompting referrals to centers that can afford the more expensive equipment.

"Many new technologies have the potential to improve quality of care for gastroenterology patients," says David Rubin, MD, assistant professor of medicine and director of clinical education for gastroenterology at the University of Chicago. Rubin also holds an associate appointment at the University of Chicago's Cancer Risk Clinic. "At least initially, these high-cost technologies will be adopted only by academic medical centers or large endoscopy centers. But when costs come down, these advancements can be more broadly adopted."

Practice Improvements

Certainly, some advancements in care have occurred at the practice level. One that is being debated is the use of an intravenous sedative agent. "This agent achieves sedation quite rapidly, and achieves a deeper level of sedation than agents typically used during colonoscopy," says Rubin. "Because of this, patients given this agent tend to tolerate the procedure better than those given the standard, titrated sedatives."

This agent also has the advantage of having an extremely short half-life, so patients experience no psychomotor retardation after recovery.

The problem is that some gastroenterologists and many anesthesiologists wonder whether gastroenterologists should administer this agent without the assistance of an anesthesiologist. "Clinical research studies of thousands of colonoscopies found that patients sedated with this agent experienced no significant adverse outcomes," Rubin says. "But concerns remain, centering around the risks inherent in the deeper level of sedation."

As a result, Rubin notes that while it remains a topic of debate, the agent is not widely used in colonoscopies when anesthesiologists are not present. But Rubin believes its used will grow if it continues to be proven safe. He adds that the American College of Gastroenterology is lobbying the federal Food and Drug Administration to review and potentially expand the agent's indications and availability.

New Technology

The use of new colonoscopy technologies also is growing. Variable flexibility scopes are gaining popularity; the tension of these scopes can be adjusted throughout the procedure to facilitate passage through the colon. "These scopes have been around for a while," Rubin observes. "Now are we seeing more widespread use, simply because it takes a while for doctors to invest in new equipment."

Another colonoscopy procedure that has received considerable attention is chromoendoscopy, in which blue dye is used to stain the bowel so that smaller lesions can be seen more effectively. The technique is promoted mainly for IBD patients, who develop pre-cancerous lesions that are often located in flat mucosa and are difficult to detect. "The general approach to colorectal cancer surveillance in IBD patients has been to perform random biopsies," states Rubin. "By spraying the colon with a dye, the contours and changes associated with these lesions can be identified more accurately." Gastroenterologists can use existing equipment and spray the dye using a syringe or catheter passed through the scope, he adds.

Still, chromoendoscopy may not be adopted quickly. "Standard IBD patient surveillance exams are time consuming, due to the number of biopsies that must be taken," Rubin observes. "The extra steps involved in spraying the dye and performing the associated washing and suctioning will add time to an already long exam. Furthermore, the diagnostic value of chromoendoscopy is truly enhanced when scopes with magnification lenses are used, but these scopes are expensive. Because of

> **"Wide-angle scopes are still being studied and not yet used in clinical practice. Several studies noted that the wide-angle scope picked up lesions that had been missed by the standard scope. These types of studies are needed to support and justify the expense of this new technology."**
>
> ***—David Rubin, MD, University of Chicago***

(Continued on page 4)

Expert Sees Value in Virtual Colonoscopy

Possibly the most talked-about advancement in gastroenterology today is virtual colonoscopy. David Rubin, MD, director of Clinical Education for Gastroenterology at the University of Chicago, has been studying the technology since 1997, and says virtual colonoscopy is superior to barium enema in symptomatic patients who have an incomplete colonoscopy (due to technical limitations or an obstructing mass) and who must complete their screening. The University of Chicago has participated in two of the four large virtual colonoscopy trials.

"Virtual colonoscopy can be performed the same day as the attempted colonoscopy, so the patient does not have to re-prep," Rubin explains. "Furthermore, if a cancerous lesion is found, a staging CT scan can be performed at the same time."

Medicare carriers in the Midwest support this use, Rubin continues. "Very recently, these carriers have approved reimbursement for virtual colonoscopy for symptomatic patients undergoing a diagnostic colonoscopy that cannot be completed," he says.

However, the value of widespread use for population-based screening remains questionable, Rubin continues. "The biggest problem revealed by clinical trial data was the wide variation in the readings by different radiologists," Rubin notes. "If a radiologist is inexperienced or untrained in virtual colonoscopy reading, the quality of the test cannot be verified. A second problem is that, because the technique and imaging software are not uniform, there may be considerable inter-center variability. As a result, virtual colonoscopy results can be highly variable and often incorrect. Before virtual colonoscopy can be accepted for widespread screening, we must be comfortable that it offers reliable sensitivity and specificity for asymptomatic patients."

In a trial being conducted at the National Naval Medical Center, researchers are using techniques that may prove more reliable. But for now, virtual colonoscopy is not ready for adoption by community gastroenterologists or radiologists, Rubin says, adding, "Virtual colonoscopy should still be considered an experimental technology. The software and technology will likely evolve to the point where the images are so specific that radiologist variability will become less of an issue," he adds. "This will improve the standardization of results," he says. "But we are not there yet."

Some community gastroenterologists are wary of virtual colonoscopy, believing that it will have a negative effect on revenue. Rubin disagrees, saying, that even with the development of less invasive screening tests, individuals will still be referred for colonoscopy. "Biopsies cannot be performed during virtual colonoscopy, so a patient whose virtual colonoscopy reveals suspicious mucosa will still have to undergo conventional colonoscopy," he explains. "Furthermore, virtual colonoscopy may result in increased compliance with screening recommendations, driving greater referrals of positive cases that require polypectomy. So the nature of gastroenterology practice may change, but patient flow will remain strong."

—DJN

(Continued from page 3)

these considerations, IBD patients may be referred for their surveillance to a center that offers the technique."

Looking Ahead

Some exciting advances are still in the realm of research but hold great promise for gastroenterologists and their patients.

A significant advancement will be achieved when new scopes with a wider-angle of view are adopted widely in gastroenterology practice. "Current scopes have a viewing angle of 140 degrees, but the newer scopes offer a view of 170 or 180 degrees," Rubin explains. "One of the limitations of colonoscopy is that we can miss areas behind folds unless we methodically turn and look behind each fold. A wider angle of view will likely mean that we will miss fewer lesions."

Rubin notes that although the value of wide-angle scopes is intuitive, they are still being studied and are not yet used in clinical practice. "Several studies have been completed in which two colonoscopies—one with a standard scope and one with a wide-angle scope—were performed back-to-back in each patient," he says. "The studies noted that the wide-angle scope picked up lesions that had been missed by the standard scope. These types of studies are needed to support and justify the expense of this new technology."

Quantitative Assessment

Another exciting approach is four-dimensional elastic light scattering spectroscopy (4D-ELF), which enables rapid and extraordinarily accurate quantitative assessment of the nano/micro-scale architecture of the colon. "The light reflecting off the mucosa provides information about the molecular and cellular structure of the bowel lining," explains Rubin. "This allows gastroenterologists to essentially perform optical biopsies, sampling tissue by shining a light on it." The

National Institutes of Health are funding research on 4D-ELF, Rubin notes. “But how the technique will affect our approach to colonoscopy is not yet being discussed,” he adds.

High Technology

Another interesting technological development is called narrow-band imaging, which uses a scope that filters out all except blue light wavelengths. The blue light emphasizes features of the colon wall and highlights mucosal differences.

“In preliminary research, narrow-band imaging has been shown to identify suspicious mucosa as effectively as chromoendoscopy,” Rubin explains. “However, high costs mean these scopes may not be adopted widely. Still, narrow-band imaging may offer a viable alternative to chromoendoscopy for some patients.”

In fact, narrow-band imaging and chromoendoscopy may have a growing application as flat lesions are being increasingly recognized in asymptomatic patients. “These lesions grow down into the bowel wall; they are harder to find and may have greater malignant potential,” Rubin says. “The true prevalence of these lesions in Western populations has not been completely determined, but because of our growing understanding of these lesions, chromoendoscopy and narrow-band imaging may become the preferred way to scan the colon.”

Also in development is a high-definition (HD) colonoscopy scope. “HD scopes are based on the same concept as HD televisions: more lines of resolution on the monitors and in the video processors,” Rubin says. “Again, HD scopes will involve a significant capital expense, but high-definition will be the wave of the future.”

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

Center Emphasizes Virtual Colonoscopy

Gastroenterologists at the National Naval Medical Center (NNMC) in Bethesda, Md., believe that virtual colonoscopy is the wave of the future with regard to general screening.

“The National Naval Medical Center plans to emphasize virtual colonoscopy, which will be our primary method of screening for colon cancer in the national capital area,” says Commander Brooks D. Cash, MD, FACP, chief of the gastroenterology division and chief of the Colon Cancer Initiative at the NNMC. “While we will still perform many conventional colonoscopies, virtual colonoscopy will allow us to significantly increase our number of annual screenings, perhaps by 300% to 400%. Because of the less invasive nature of virtual colonoscopy, more people will seek and comply with screening. Furthermore, screening with this method will require less time, allowing us to accommodate more patients.”

This confidence is spurred by positive findings of research performed at NNMC and published in the *New England Journal of Medicine*, Dec. 4, 2003. In the largest study to date that compared virtual with conventional colonoscopy in a screening population, NNMC used a novel technique for virtual colonoscopy in which computer software recreated a three-dimensional “fly-through” that mimicked what a gastroenterologist would see during an optical colonoscopy. The results indicated that virtual colonoscopy had equal or better diagnostic power than optical colonoscopy for polyps greater than 8 mm in size.

A new eight-year NNMC study involving 3,000 patients is built upon the positive findings of the December 2003 study. Early data suggest that this study will also validate the sensitivity and specificity of virtual colonoscopy compared with optical colonoscopy in a screening patient population. The research effort, led by Cash, will also attempt to define the natural history of small polyps of 5 to 9.9mm (a topic previously unstudied) and determine the prevalence of small polyps showing advanced features under a microscope.

Cash believes that virtual colonoscopy will eventually be approved for population-based screening in asymptomatic patients, once the technology improves and the technique is standardized. Until then, virtual colonoscopy will remain at tertiary medical centers and research institutions.

“The practice must be standardized and codified in terms of required radiologist and gastroenterologist training, software usage, clinical recommendations, and resolution of other issues, before this technique can be adopted by community gastroenterology practices nationwide,” he notes.

Radiologists’ ability to read and interpret the images is an important issue. “Clearly, to optimize results, radiologists need to develop significant experience in analyzing the scans,” Cash says. “In our experience, expertise can be developed after interpretation of 100 to 150 of these examinations.”

Cash notes that current FDA-approved uses of virtual colonoscopy are to complete a failed conventional colonoscopy and to screen patients who have an obstruction in the distal colon that prevents examination of the proximal colon. “A failed colonoscopy could occur in an asymptomatic patient in whom we can’t push the colonoscope all the way around, but this scenario is relatively uncommon,” Cash says.

—DJN

Book Says Experts Support Reform

For a new book published this year, some 40 health care experts were interviewed about what ails the health care system. Their answers are illuminating about what needs to be done to reform the system.

Written by Richard L. Reece, MD, editor-in-chief of the *Practice Options* newsletters, the book shows that consensus exists among the 40 health care experts he interviewed for the book. The experts cite the rising cost of health and the growing number of uninsured Americans as two factors that are intensifying the need to reform the system.

Reaching Consensus

The experts agree that if reform measures are going to succeed, then those who are organizing those efforts need to foster collaboration among all parties on such issues as basic insurance coverage for all Americans. The experts also agree that management processes must be developed to monitor the performance of major health care organizations. While these two needs seem self evident, the 40 experts in the book also agree on a more controversial topic: the need for medical liability reform.

Reece is a physician and editor who over the past nine years has interviewed hundreds of health care experts in his role as editor-in-chief of *Practice Options*. For this book, he conducted interviews separate from those he has done for the newsletter with 40 prominent leaders who are engaged in health care and represent a range of industry segments and points of view.

The interviews are organized into six parts:

1. Private-public consensus as a solution
2. Government-assured coverage
3. Consumer-driven solutions
4. Vested interests of physicians and hospitals
5. Vested interests of health plans
6. Support and supply chain interests

Following the interviews, Reece gives 11 conclusions that one would reach from the interviews.

A Range of Opinions

Among the health care leaders Reece interviews are hospital administrators, practicing physicians, consultants, heads of reform think tanks, advocates of a single-payer system, consumer-driven care enthusiasts, health plan executives, academics, disease management experts, physician innovators, medical directors of large multispecialty clinics, government insiders, and leaders of some large organizations. Among the organizations that are represented are the American Medical Association, American Academy of Family Physicians, the Medical Group Management Association, and the Blue Cross Blue Shield Association.

Health plan leaders say consumer-driven health plans will have a more significant effect on health care than managed care has had.

Reece conducted the interviews over the telephone and allowed each interviewee to edit the final transcript. Since he is a physician and practiced for many years as a pathologist, Reece says he is sympathetic to physicians but still attempts to maintain his objectivity and professes to have remained neutral during the process. "These interviews reflect the true views of each of the experts," he says. "In other words, I ground no ideological ax. Instead, I sought to engage in straight talk about what these leaders thought. I waited until the end of the book before I developed the conclusions."

Indeed, the conclusions are compelling. "In general, the health care leaders interviewed thought the system was hurtling toward an economic abyss," Reece comments. "They agree that we cannot continue to spend two to eight times the general inflation rate on health care. The typical premium has risen by a total of 60% over the last five years. That's unsustainable. The system is pricing itself out of business. Health insurance now covers fewer than 50% of private American employees and private coverage is eroding at 2.5% per year. The numbers of uninsured and underinsured are rising."

Those suffering the most include consumers, hospitals, and general-practice physicians such as family physicians, general internists, pediatricians, and those in emergency medicine, Reece says. Safety-net hospitals also are suffering. In July, for example, the St. Vincent's Health System in New York City, one of that city's largest health systems, filed for bankruptcy. Over the past 10 years, more than 65 emergency rooms in California have closed.

Consumer-Driven Care

One of the trends discussed in the book is consumer-driven health care. Reece says some industry experts, such as George Halvorson, president

At a Glance

Voices of Health Reform: Interviews with Health Care Stakeholders at Work was published this year by Practice Support Resources, Inc., a publisher and book store in Independence, Mo.

For more information visit Practice Support Resources on the Web (at www.practicesupport.com). The book contains 210 pages and costs $49.

and CEO of Kaiser Permanente, is profoundly skeptical about the commercial viability, social desirability, and ultimate sustainability of consumer-drive care. Some of the CEOs of the nation's major national health plans, however, such as UnitedHealthCare, Cigna, and Aetna, say consumer-driven health plans will have a more significant effect on health care than managed care has had. Also, they say, consumer-driven care may replace HMOs and PPOs. "To these CEOs, consumer-driven care is the next big thing," Reece comments.

When speaking with industry experts, Reece was surprised how positive employers, insurance brokers, bankers, and other financial professionals are about consumer-driven care. "The banks see these plans as a golden opportunity to serve as repositories of health savings accounts (HSA), to use their information infrastructure to process claims, and to introduce debit and smart cards at the point of care," Reece says. "One health plan executive says HSA plans will capture most of the market in two years. For physicians, the positive aspect of these developments is that they will be paid at the point of care with the swipe of a card."

Medicare Questions

On the issue of Medicare, the experts are not as positive. Reece says the Medicare system is not sustainable in its present form. "It's already costing $300 billion, and it will jump to $400 billion next year when the Medicare drug bill kicks in," he comments. "Medicare now has 42 million beneficiaries and takes 15% of the federal budget. By 2020, it will have 60 million beneficiaries and be responsible for 25% of the federal budget.

"The consensus is that Medicare can't keep rewarding all providers in the same way, whether the care is good or bad, regardless of patient outcomes," Reece continues. Therefore, Medicare needs to develop pay-for-performance, quality measurement, and quality-reward systems. Despite the need for such systems, most interviewees thought pay-for-performance for hospitals and doctors based on meeting quality indicators is a strategy aimed primarily at containing federal costs. "There's considerable skepticism among physicians about the fairness of such systems," Reece says. "They don't believe government can separate the good doctors from the bad on quality indicators or patient satisfaction surveys alone." Therefore, it may be necessary to introduce consumer-driven programs into Medicare. "In that way, we can let the consumers decide," Reece concludes.

Industry leaders were particularly pessimistic that Congress would reverse the 26% cuts in reimbursement scheduled to take effect in Medicare over the next five years.

Despite the problems of Medicare, Reece said he was surprised to learn what a powerful influence Medicare has on the health care system. "It sets the rules for the rest of the system, and other payers and all providers must follow its lead," he comments. "One person I interviewed called Medicare the sheriff of the system, and said nobody bucks the man with the badge. Any reform, therefore, will depend on interactions between Medicare and the private sector."

A Few Surprises

Reece also was surprised about the significant role American culture plays in shaping the health system. "Since our founding, Americans have believed in a relatively weak centralized federal government, in choices and freedom of action, and in equal opportunity, rather than equal results, for its citizens," he says. "Americans, for example, want choice and equal opportunities for access to the marvels of high medical technology. These cultural characteristics will dictate the direction and pace of health reform."

He was also surprised to learn about the tremendous strides being made in disease management. "When patients with chronic diseases are monitored closely and educated about their diseases, they respond intelligently and their health, and outcomes improve significantly," Reece says. "Readmission rates to hospitals for chronic heart failure, for example, often drop to near zero when patients are enrolled in effective disease management programs. Without disease management, we would not come close these results."

In conclusion, Reece is pessimistic about the future of the health care system because so many health care leaders are narrowly focused on solving their own problems and are not interested in addressing the problems that plague the health care system itself. But he also is optimistic because Americans tend to be entrepreneurial, innovative, and adaptable and can solve even the most difficult problems. "As a result, I think we'll end up with a uniquely American public-private collaborative with lots of innovation and multiple payers," he says.

—Written by editor Joseph Burns. More information on physician practice strategies is available on our Web site (see page 8).

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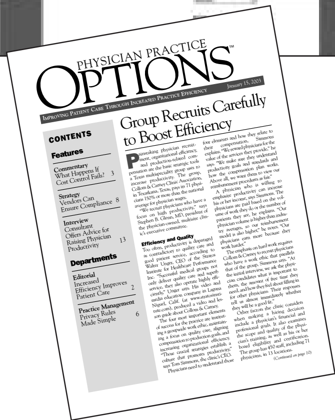

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