

POLICY & PRACTICE

Enbrel Sales Investigated

The New Jersey Attorney General's office is investigating Amgen for allegedly promoting Enbrel for off-label uses and for violating privacy laws to get access to potentially new patients. On Jan. 14, Attorney General Anne Milgram subpoenaed Amgen for all documents relating to the marketing, sale, and prescription of Enbrel between July 2002 and the present. The inquiry follows a lawsuit filed by two former sales representatives who alleged that the company encouraged them to search physicians' records for patients with mild psoriasis who might be potential candidates for Enbrel. The former employees also claimed to have directly contacted insurers to seek reimbursement for the drug. An Amgen spokeswoman said that the company will cooperate fully with the investigation and that the employees' claims "are completely without merit." The company expects salespeople to follow the Code of Conduct. "Amgen does not instruct sales representatives to proactively review patient files or promote off-label for any reason," said the spokeswoman.

NIH Research Centers Launched

The National Institutes of Health has funded three new centers to study translational research for lupus, posttraumatic osteoarthritis, and psoriasis. The lupus research efforts will be headquartered at the University of Texas Southwestern Medical Center in Dallas where researchers will use mouse models to identify the genetic background of developmental stages of the disease. The researchers received \$5 million from the NIH to fund their work. Researchers at the University of Iowa, Iowa City, will work on new methods to delay the onset of osteoarthritis. Officials at the NIH awarded \$7.5 million to fund that research. At the Center for Psoria-

sis Research Translation at Case Western Reserve University and the University Hospitals of Cleveland, researchers will conduct a preliminary efficacy study to test novel photodynamic therapy for psoriasis. The NIH awarded \$6.37 million to fund the work on psoriasis.

Arthritis Prevalence On the Rise

The overall prevalence of arthritis is expected to rise by 40% by the year 2030, however, the prevalence of rheumatoid arthritis may be starting to fall, according to a recently published study (*Arthritis Rheumatism*. 2008;58:15-25). The analysis, which was conducted by the National Arthritis Data Workgroup, relies on a variety of surveys and databases to estimate the prevalence and number of affected individuals with rheumatic conditions. The work group is a consortium of experts in epidemiology that was formed to help provide a single source of national data on the impact of rheumatologic diseases. The researchers estimate that about 1.2 million adults in the United States (roughly 0.6%), have rheumatoid arthritis, based on 2005 data. But these figures are down from the 2.1 million adults who were estimated to have the condition in 1998. While the decline in rheumatoid arthritis identified in this study is consistent with other recent findings, the researchers could not point to a clear explanation. However, the researchers identified the aging population as the factor driving up overall arthritis prevalence figures. "This increase suggests that overall arthritis will have a growing impact on the health care and public health systems in the future, one that needs to be anticipated in order to provide the early diagnosis and interventions that could help reduce that impact," the researchers wrote.

—Mary Ellen Schneider

Preappointment Assessments Can Optimize Clinical Care

BY DIANA MAHONEY
New England Bureau

BOSTON — Streamlining the preappointment assessment and management of new patients in clinical rheumatology settings can boost efficiency and improve care, according to Dr. J. Timothy Harrington Jr. of the University of Wisconsin, Madison.

Reviewing prospective patients' medical records, laboratory results, and imaging studies prior to scheduling an appointment ensures the most productive use of clinic time, Dr. Harrington said at the annual meeting of the American College of Rheumatology. The goal, he said, "is to distinguish between those patients who really need to see a rheumatologist and those who might be best served by seeing another specialist, such as an orthopedist, or who might be able to get the care they need from their primary care physician."

Limiting "unnecessary" appointments—which can be as many as half of all appointment requests, said Dr. Harrington—substantially minimizes the wait time for new rheumatology appointments. By further classifying patients with appropriate rheumatologic indications as "routine" or "urgent," and allocating the earliest available appointments to those with the most pressing conditions, rheumatologists are able to see new arthritis patients earlier in the disease process, when preventive interventions for joint damage are likely to have the most benefit, he said. The preappointment review of patient data also enables rheumatologists to determine how long an appointment to schedule for a given patient and reduces the likelihood of duplicity in terms of laboratory testing and imaging after the appointment, he added.

Another strategy is distributing the workload whenever possible "so the rheumatologist is not responsible for tasks that can easily be completed by support staff or even the patients themselves," said Dr. Harrington. "This represents an enormous opportunity for us to transfer our resource use and efforts from low-value care to high-value care."

For example, in a busy practice, rheuma-

tologists should not be conducting narrative patient histories themselves, stressed Dr. Harrington. Instead, practices should implement a standardized data collection process with a history form that uses branching logic. "Typically, the top portion of these forms can be completed by patients while they are in the waiting room—that alone can save perhaps 40% of the time rheumatologists might spend just finding out what is going on," he said. Physician assistants or nurse practitioners, when available, can help the patients with these forms and can provide the rheumatologist with a summary of the patients' history, he added.

The patient information can be used to generate an immediate disease activity score, such as the Global Arthritis Score, "which offers the rheumatologist an immediate sense of the patient's status and insight into optimal management," Dr. Harrington noted.

Switching to electronic medical records and the use of standardized dictation templates, which replace word for word narratives, can also markedly reduce documentation time per patient. The end result is that "we can get more information in a more useful format and in less time than was previously possible," said Dr. Harrington. "These measures change our focus from being information collectors to being problem solvers."

The continuous application of process improvement methods is one of the most practical ways to address the growing deficit in the supply of rheumatologists relative to demand, said Dr. Harrington. "It's obvious, given the numbers, that we won't be able to provide care dependably to the population that needs it if we continue doing what we're doing. We have to play an active role in the scope of our practices, and we need to negotiate and plan with colleagues and other specialists so that we are involved primarily only in those services that we alone can capably provide."

Dr. Harrington disclosed being a member of the Consortium of Rheumatology Researchers of North America (CORRONA) and receiving honoraria and grant support from Abbott Laboratories. ■

MD-Owned Hospitals Lack Emergency Care

BY ALICIA AULT
Associate Editor, Practice Trends

Physician-owned specialty hospitals are largely unprepared to handle emergencies, according to a report from the Inspector General of the Department of Health and Human Services.

The IG's office reviewed written policies for managing medical emergencies, staffing schedules, and staffing policies for 8 days at 109 physician-owned facilities. Overall, 66 of these were surgical, 23 were orthopedic, and 20 were cardiac hospitals. Eighteen of the cardiac hospitals had an emergency department; only 11 of the 23 orthopedic hospitals and 31 of the surgical hospitals had an ED. Thirty-three of the 109 hospitals were in Texas, 15 were in Louisiana, 9 in Oklahoma, 9 in Kansas, and 8 in South

Dakota. The rest were spread elsewhere.

While half of the physician-owned hospitals surveyed had an ED, more than half of those only had a single bed. Only 45% of had a physician on site at all times.

In all, 93% of the hospitals met Medicare staffing requirements: having a registered nurse on duty at all times and a physician on call at all times. But seven hospitals did not have an RN on duty, and one hospital did not have a physician on call or on duty on at least 1 of the 8 days.

Two-thirds of the hospitals told staff to call 911 in case of emergency. Although transferring a patient to another hospital's ED is acceptable, it might be a violation of Medicare conditions of participation if a hospital uses 911 to obtain medical assistance to stabilize a patient.

A hospital also is not in compliance if it

uses 911 as a substitute for providing services required by Medicare, noted the IG.

Almost 25% of hospitals did not address in written policies the "appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients."

The CMS issued a response saying it would look at current compliance through its routine hospital surveys. But as many as 42% of the 109 would not have been subject to CMS oversight, as they were accredited by the Joint Commission or the American Osteopathic Association. The CMS also said it would use its authority to require hospitals to have written policies and procedures on managing emergencies, but that would also consider whether regulatory changes are needed to establish specific requirements for equipment and staff qualifications. ■

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