More ACR Updates to Come

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to warrant new guidelines," said Dr. Daniel Solomon, chief of clinical research in rheumatology at Brigham and Women's Hospital in Boston and a member of the ACR's Quality of Care Committee (QCC), the group that oversees guideline development for the college.

These plans suggest a flurry of activity in comparison with a relatively unproductive period from 2002 to 2007. The last guideline before the RA-drug recommendations were released last June was on preventing and treating glucocorticoid-induced osteoporosis, which was released in July 2001.

That gap primarily was caused by a restructuring of the ACR committee that was responsible for overseeing the process, as well as the inherent lag time between the college's decision that guidelines on a topic are needed and its request for proposals, and the completion and release of those guidelines. The current QCC was formed in late 2004, and the group's first request for proposals to create the RA-treatment guidelines went out in 2005, Ms. Miller explained.

ACR Employs a New Approach

The multiyear gestation of the RA-drug guidelines reflected new standards the college applied to creating practice recommendations. "In contrast to past efforts by the ACR, the process used [for the RA guidelines] was the most rigorous to date," said Dr. Kenneth G. Saag, professor of medicine and epidemiology at the University of Alabama at Birmingham, and chairman of the QCC. Dr. Saag also was the lead author of the 2008 RA-drug guidelines.

The QCC plans to review and, if necessary, update guidelines more frequently than in the past, about every 2 years.

A notable element of the 2008 RA-drug guidelines was a series of citations that identified the level of evidence supporting each recommendation. Roughly half of the recommendations were based on direct findings from trials and studies, rated as either level A or B evidence. The other half, however, were based on level C evidence, such as consensus of expert opinion, case studies, or extrapolation from randomized controlled trials.

Debating the Evidence

Some guideline-writing experts find fault with recommendations that are based on expert opinion. "I think expert opinion is quite misleading" when used as the basis for a practice recommendation, said Dr. Diana B. Petitti, professor of biomedical informatics at Arizona State University in Phoenix and vice chair of the U.S. Preventive Services Task Force (USPSTF), a panel organized by the federal Agency for Healthcare Research and Quality to formulate practice recommendations for clinical preventive services.

"There is a tendency to make guidelines and recommendations seem authoritative. I believe that physicians think that there is a great deal more behind authoritative recommendations than there might be when you lift the lid of the box and see what's underneath," she said in an interview.

The USPSTF approach segregates opinions from evidence-based recommendations, and labels such opinions "statements" to further distinguish them from recommendations, Dr. Petitti said.

But those involved in the ACR's process defended including expert opinion alongside evidence-based recommendations.

"Expert opinion alone and expert opinion following a review of the evidence and using a formal group process, which is used for the ACR guidelines, are not the same things," Dr. Saag said. The ACR uses an appropriateness and review process developed by researchers at the Rand Corp. in Los Angeles and at the University of California, Los Angeles.

"Considerable literature shows that this method performs as well as standard clinical tests in leading to consistent and better outcomes" in the writing of practice guidelines, he said. A member of the Rand and UCLA guidelines-development group participated in writing the 2008 RA-drug guidelines.

ACR's review process 'performs as well as standard clinical tests in leading to consistent and better outcomes' in the writing of practice guidelines.

"There are certainly gaps in the evidence that preclude all guidelines for RA from being evidence based according to the strictest letter of the law. But clinicians are forced to make clinical decisions in many disciplines that don't conform to clinical trials," said Dr. Saag, who also directs the center for education and research on therapeutics of musculoskeletal disorders at UAB.

He gave the example of ways to manage RA patients who develop an infection while they undergo treatment with a biologic agent, which is essentially impossible to study in a randomized way and, hence, necessitates extrapolation.

"We rely on experts to interpret the evidence… and come up with a set of recommendations. I think this is probably more valuable than when [the evidence] is clear cut. When there isn't clarity, it is often quite helpful to point out differences in the literature," Dr. Solomon said.

"A criticism of past guidelines was that they didn't go into expert opinions enough," said Ms. Miller. Every day, rheumatologists "need to decide how to treat patients even if there isn't the highest level of evidence." Rheumatologists rely on the ACR to gather expert opinion for these situations.

The act of writing a guideline also provides an opportunity for experts to systematically review the evidence in a field and to highlight those areas that require more research, Dr. Solomon and Dr. Saag noted.

The ACR vs. the EULAR Model

The pace with which ACR released guidelines earlier this decade contrasts with that of the European League Against Rheumatism (EULAR): 12 recommendation sets released since December 2003. Dr. Saag noted, however, that the ACR and EULAR have significant differences in their guideline development approaches.

The ACR issues requests for proposals and then waits for research groups to respond, a process that takes time. EULAR assembles expert panels and uses a well established infrastructure that allows for much faster turnaround, he said.

ACR and EULAR have collaborated on developing treatment-response criteria for gout, and other similar collaborations may occur. A limitation in developing joint practice guidelines, however, is that European practice differs from U.S. standards in many cases, Dr. Solomon noted.

Practice recommendations guide clinical care and establish state-of-the-art best practices, an important mission because much of rheumatologic care is delivered by nonspecialists. In addition, recommendations and guidelines are now converted into quality and performance indicators by hospitals and payers. These facts make it particularly critical for the ACR to play a major role in determining rheumatologic standards of care, Dr. Saag said. ■

Retail Health Care Clinics Still Poised for Growth

BY ALICIA AULT

Retail clinics are projected to increase at a healthy 20%-30% per year over the next 6 years, with sales rising from $548 million in 2008 to $2 billion in 2013, according to a market research report from New York–based Kalorama Information.

Dr. Yul Ejnes, a member of the American College of Physicians' Board of Regents, called the projected boom in retail clinics "just a symptom of a bigger problem," and a sign of a dysfunctional health care system.

In an interview, he conceded that the retail clinic is a model that's here to stay. But if the medical home concept were "executed to its fullest, on the flip side, the need for retail clinics could diminish."

Alternatively, retail clinic leaders, such as MinuteClinic President Chip Phillips, see the clinics as successfully filling a gap left by the dwindling number of primary care physicians.

MinuteClinic, the Minneapolis-based subsidiary of CVS Caremark Corp., now claims more than 560 locations in 25 states.

Typically, the clinics offer a menu of services for common ailments such as allergies, bladder infections, pink eye, ear infections, and strep throat. Many also offer screening tests for cholesterol, hypertension, and diabetes. Vaccines are also a significant offering.

The prices for these services are publicly available, with most diagnostic and treatment services running at about $62. Services are provided by nurse practitioners, who are supervised by physicians on contract with MinuteClinic. The clinics are considered in-network providers with 60 insurers.

As of now, "it's hard to tell what impact the recession will have" on the growth of clinics, Mr. Phillips said in an interview.

According to the Kalorama report, the economic downturn could indeed propel people to retail clinics, but it's also possible that as Americans rein in spending, health expenditures also may see a reduction.

"Over the next few years, retail clinics may capture a portion of the business currently serviced by physicians," the report said.

Some physicians have expressed concern that the retail clinics could supplant or interfere with the attempts to establish a health delivery model based on the patient-centered medical home.

Mr. Phillips disagreed. "We don't see ourselves as competition to the primary care medical home concept," he said, adding that MinuteClinic's role "is different than, and can be supportive of, the medical home."

Dr. Ejnes agreed that clinics can fit in with the medical home if lines of communication are kept open between the clinics and primary physicians.

ACP aims to ensure that the clinics adhere to principles it adopted for the sector.

For instance, there should be physician supervision and 24-hour coverage to answer questions that may arise, said Dr. Ejnes, who is also chairman of the ACP's medical service committee.

The American Academy of Family Physicians and the American Medical Association also adopted guidelines for retail clinics in 2006.

The American Academy of Pediatrics specifically stated its opposition to the retail clinic model in a policy statement (Pediatrics 2006;118:2561-2).

Recent market indicators also suggest that reliance on retail clinics may be seasonal in nature. In mid-March, MinuteClinic said that it would shutter 89 clinics until the next cough, cold, and flu season. Over time, it has become clear that the company "didn't need as many of the clinics as we had opened," Mr. Phillips said. These locations could be taken off line for part of the year without reducing access in those markets. ■