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Policy and Health Issues in the News

Permanently Adopting Increase in Primary Care Payments Could Save Medicare Billions

Extending a temporary provision in the health care reform law that increases payment for primary care services could save Medicare billions of dollars, according to a study published by the Commonwealth Fund and conducted by researchers at the Center for Studying Health System Change and Mathematica Policy Research. The five-year, 10 percent payment boost for evaluation and management services in ambulatory settings could reduce total Medicare spending by approximately 2 percent per year if adopted permanently. The 10 percent increase would increase primary care visits by 8.8 percent in the long term and raise the overall cost of primary care visits by 17 percent. However, these increases would lead to considerably lower Medicare costs for other services, such as inpatient and postacute care. The temporary payment increase outlined in the Patient Protection and Affordable Care Act began in 2011 and is set to expire in 2015. For more information, visit http://www.aafp.org/news-now/government-medicine/20120328permpayboost.html.

Medical Students Aware of Daily Challenges of Physician Work Life

A study published in the January 2012 issue of *Family Medicine* reveals that medical students have negative views of the work life of physicians, especially those in primary care. Between 2006 and 2008, students at three medical schools were surveyed about their perceptions of physicians' work life. Of the 983 respondents, 15 percent were planning careers in primary care, with first-year students showing the least interest in primary care and fourth-year students showing the most interest. Students were asked to agree or disagree with statements covering topics such as physician autonomy, administrative work, and patient relationships. Respondents generally agreed that physicians spend too much time on administrative work and are pressured by the pace of work, and that payers restrict quality of care and conflict with physicians' clinical judgments. Researchers also noted that students who had completed a family medicine clerkship were less likely than those who had not finished the clerkship to think that time pressures kept physicians from developing good patient relationships. The study authors suggest that students' primary care–oriented values should be reinforced during medical school to increase the number of primary care physicians. For more information, visit http://www.aafp.org/news-now/education-professional-development/20120404studentworklifestudy.html.

Vaccine Safety Curriculum Prepares Residents to Address Patients' Concerns

To prepare resident physicians for immunization pushback from patients, the California Academy of Family Physicians and other partners are helping the American Academy of Pediatrics, California, develop and distribute a vaccine safety communication curriculum designed for primary care residency programs nationwide. The curriculum uses an online case-based format to put residents in real-life vaccination communication scenarios. Additionally, it guides residents through Web sites that offer evidence-based information about vaccine safety, and explains how to differentiate these sources from those that propagate misinformation about vaccines. The project began in response to the growing number of parents who reject vaccinations for their children, as well as adults who choose to forgo their own vaccinations. By identifying gaps in vaccine safety communication training for residents, the groups hope to combat negative vaccine messages and increase the number of persons getting vaccinated. For more information, visit http://www.aafp.org/news-now/education-professional-development/20120409vaccinesafetycurriculum.html.

Deadline Approaching to File Hardship Exemption for Medicare E-Prescribing Rules

Physicians who provide health care services to Medicare beneficiaries but who are not yet prescribing electronically have until June 30, 2012, to request a hardship exemption that would exclude them from the 2013 penalty (a 1.5 percent cut in Medicare payment) related to the Centers for Medicare and Medicaid Services' electronic prescribing (e-prescribing) incentive program. Physicians and group practices can apply for a hardship exemption if they are unable to e-prescribe because of local, state, or federal regulations; experience limited prescribing activity; have insufficient opportunity in their practice setting to use the required *Current Procedural Terminology* (CPT) codes; practice in rural areas with limited high-speed Internet access; or work in areas where few pharmacies have implemented e-prescribing. Those not requesting an exemption must report code G8553 signifying e-prescribing for at least 10 billable Medicare Part B services provided between January 1 and June 30, 2012. Physicians who did not demonstrate

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e-prescribing capabilities by June 2011 are already experiencing a 1 percent reduction in their 2012 Medicare payments. For more information, visit http://www.aafp.org/news-now/practice-professional-issues/20120328epreescribepenalties.html.

Social Security Disability Application Process Moves to Electronic Signatures

Social Security Commissioner Michael Astrue asked for the cooperation of physicians and others in acknowledging an improvement in the Social Security disability application process that allows applicants to electronically sign and submit their application forms. Quicker access to disability benefits may help decrease the number of uninsured and underinsured patients that physicians serve. Physicians may have begun to see electronically signed SSA-827 forms in April 2012, but likely will continue to see pen-and-ink signatures as well for the foreseeable future. For more information, visit http://www.aafp.org/news-now/news-in-brief/20120328wklynewsbrfs.html.

MedWatch: FDA Reclassifies Insulin Detemir Injection to Pregnancy Category B

The U.S. Food and Drug Administration (FDA) has approved a pregnancy Category B classification for insulin detemir (Levemir) injection, making it the only basal insulin analogue in this category. Previously, Levemir carried a pregnancy Category C designation, and neutral protamine Hagedorn (NPH) insulin was considered the therapeutic standard for management of diabetes mellitus during pregnancy. The change is based on a review of a randomized controlled trial that compared the safety and effectiveness of Levemir with NPH insulin in pregnant women with type 1 diabetes. Study findings indicated that patients who used Levemir, a long-acting insulin, achieved similar A1C reduction at 36 weeks' gestation and lower fasting plasma glucose levels at 24 and 36 weeks' gestation compared with those using NPH insulin, an intermediate-acting insulin. There was no difference in the safety profiles between the two groups in terms of pregnancy outcomes or health of the fetus and newborn. For more information, visit http://www.aafp.org/news-now/news-in-brief/20120404wklynewsbrfs.html.

Studies Show Bariatric Surgery Is Successful in Managing Type 2 Diabetes Mellitus

Two studies recently published in the *New England Journal of Medicine* suggest that some bariatric surgical procedures, either alone or in combination with medical therapy, can be more effective in achieving key treatment goals than medical therapy alone in some patients with type 2 diabetes. In one trial, 150 patients were randomized to undergo intensive medical therapy (i.e., lifestyle counseling, weight management, frequent home glucose monitoring, and use of newer drug therapies) alone, or intensive medical therapy plus Roux-en-Y gastric bypass or sleeve gastrectomy. The results showed that surgery in conjunction with 12 months of medical therapy achieved glycemic control (i.e., A1C level of 6 percent or less) in significantly more patients with obesity and uncontrolled type 2 diabetes than did medical therapy alone. In the second study, bariatric surgery led to better glucose control than medical therapy in patients with severe obesity and type 2 diabetes. This trial included 60 patients randomized to receive conventional medical therapy or to undergo gastric bypass or biliopancreatic diversion. All patients in the surgical groups were able to discontinue pharmacologic diabetes treatment within 15 days after the operation. At two years, none of the patients randomized to receive medical therapy had achieved diabetes remission, compared with 15 of 20 patients who had gastric bypass and 19 of 20 patients who had biliopancreatic diversion. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120404bariatric.html.

MedWatch: FDA Clarifies Citalopram Warnings Linked to Heart Rhythm Issues

The FDA has revised the label of citalopram (Celexa) to include restated guidelines regarding QT interval prolongation and torsades de pointes issues, as well as new drug dosage and use recommendations. Changes to the packaging information include the following: (1) changing the wording from "contraindicated" to "not recommended" in patients with congenital long QT syndrome, because there may be patients with this condition who could benefit from a low dose of citalopram and who lack viable alternatives; (2) recommending electrocardiography and electrolyte monitoring in patients with certain conditions because of the risk of QT prolongation with citalopram use; (3) changing the maximum recommended dosage of citalopram to 20 mg per day for patients with hepatic impairment, adults older than 60 years, patients who are CYP2C19 poor metabolizers, and those who are taking cimetidine (Tagamet) or another CYP2C19 inhibitor concurrently; and (4) recommending that citalopram be discontinued in patients with persistent QT measurements (corrected for heart rate) greater than 500 milliseconds. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120329citalopramupdate.html.

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