Policy & Practice

Home Test Coverage Expanded

The Centers for Medicare and Medicaid Services issued a final decision to expand coverage of home prothrombin time (or International Normalized Ratio) testing for patients taking anticoagulation therapy for chronic atrial fibrillation and venous thromboembolism. Patients have to meet certain other criteria, and the home tests can't be used more than once a week. Medicare has covered home testing since 2002, but only for patients with mechanical heart valves.

The request for expanded coverage was made in June 2007 by the three main manufacturers of home testing devices (Roche Diagnostics, International Technidyne Corp., and HemoSense Inc.). The companies said there was plenty of new evidence to support home testing for the two other conditions. The CMS agreed. "Medicare's coverage extension of home blood testing of prothrombin time…is based on current evidence for these two conditions," CMS Acting Administrator Kerry Weems said in a statement. Currently, PT testing is conducted about every 4-6 weeks, primarily in physicians' offices, according to the CMS. Fewer than 5% of patients on anticoagulation therapy monitor PT at home.

"Those Medicare beneficiaries and their physicians managing conditions related to chronic atrial fibrillation or venous thromboembolism will benefit greatly through the use of the home test," Mr. Weems said. In a statement, Roche estimated that Medicare beneficiaries would pay $35 for training in use of at-home devices, and about $30 a month for test strips. Patients who have supplemental insurance might not have any out-of-pocket costs, the company said.

Inquiry Request on Stolen NIH Data

A National Heart, Lung, and Blood Institute researcher had the misfortune of having his laptop stolen out of the trunk of his car in late February. More unfortunately, the laptop held confidential information from ongoing cardiac studies of about 3,200 patients, including unsecured Social Security numbers for about 1,200 patients. Most unfortunately, among those whose data are at risk is Rep. Joe Barton (R-Tex.), ranking minority member of the House Energy and Commerce Committee.

Rep. Barton was informed of the breach on March 28 and quickly wrote to the Department of Health and Human Services' Inspector General seeking an inquiry into why the data were not secure and why the NHLBI took almost a month to inform patients of the breach.

The data in the researcher's computer were from ongoing studies of MRI's potential to quickly determine the source of chest pain in the emergency department, and to determine the impact of myocardial infarction on heart structure and function, according to the NHLBI. A spokesman said in an interview that for now, it appears no data were lost, as they were backed up shortly before the theft on an institute server. Also, the NHLBI has offered free credit monitoring and up to $20,000 in identity theft insurance to those whose Social Security numbers were on the laptop.

The National Institutes of Health is now taking steps to ensure encryption of all data storage devices, said the spokesman. The theft and the NHLBI response are being investigated by the Energy and Commerce Committee and the panel's Oversight and Investigations Subcommittee.

Gene Group to Look at Long QT

A new global collaboration led by the NIH and Japan's Center for Genomic Medicine will explore how genes may play a role in drug-induced long QT syndrome, among its first projects. The Global Alliance for Pharmacogenomics will identify genetic factors that influence individuals' responses to pharmaceuticals. The collaborative will also work with the International Warfarin Consortium to develop dosing recommendations based on patients' genetic profiles. Other initial projects include looking at how genes influence the effectiveness of aromatase inhibitors for breast cancer, and side effects from gemcitabine and bevacizumab.

"We expect this international agreement to speed scientific discovery and the translation of results into improved treatments for cancer, heart disease, and other serious conditions," Dr. Elias Zerhouni, NIH director, said in a statement. The alliance is supported by public funds.

Health Sector Biggest Lobby

The health care industry was the biggest spender when it came to lobbying Congress in 2007. Pharmaceutical, medical device, physician, and hospital groups spent $227 million, a larger tally than for any other sector, according to the Center for Responsive Politics, a Washington-based watchdog group.

Of individual lobbying concerns, the U.S. Chamber of Commerce was number one, spending $53 million on in-house and external personnel, the center reported. Close behind was General Electric ($24 million), followed by the Pharmaceutical Research and Manufacturers of America ($23 million), the American Medical Association ($22 million), and the American Hospital Association ($20 million).

Broken out by industries, the pharmaceutical sector has spent more than any other industry in the last decade, laying out an accumulated $1.3 billion since 1997, said the center.

The data are taken from official lobbying reports that are submitted to the Senate Office of Public Records. The figures do not include other spending that is still aimed at influencing policy, according to the center.

—Alicia Ault

Institute of Medicine Panel Details Geriatric Care Ills

BY KEITH HAGLUND

Senior Editor

WASHINGTON — The U.S. health workforce, including physicians, is "woefully unprepared" to deal with the coming onslaught of aging Americans, according to an Institute of Medicine panel that cited poor training and perverse payment incentives in geriatrics as among the chief problems.

Headed by Dr. John Rowe, a geriatrician and professor of health policy and management at Columbia University, New York, the interdisciplinary panel declared even the current workforce "not prepared to deliver the best possible care to older patients." The panel said in its statement accompanying the report, "All health professional schools and health care training programs should expand course work and training in the treatment of older individuals." Furthermore, "virtually all" health care workers are or will be treating an elderly population and so should be required to demonstrate competence in that area as a criterion of licensure and certification, the group asserted.

Dr. Harvey Fineberg, head of the Institute of Medicine, said the government-advisory body created the 15-member panel in January 2007 to address the "major demographic shift" looming in this country. He added, "Too few health professionals are well prepared, especially to handle the multiple medical problems that are seen in old age, including such geriatric concerns as dementia and falls and incontinence."

The work force shortage in geriatric care is especially dire because of remarkably high turnover among nurses' aides (71% annually) and other workers, the panel concluded after more than a year of study. Among physicians, Medicare's low reimbursement rates are mainly to blame for low incomes for doctors choosing elder care: "Medicare should increase its reimbursement rates for services delivered by geriatric specialists," the report urged. In fact, the panel declared that Medicare currently "hinders the provision of quality of care to older adults" not only with low payment rates, but also with its focus on acute illness and its lack of coverage for preventive services and care coordination.

In a press conference, Dr. Rowe said that ironically, physicians with extra training in geriatrics actually reduce their private-practice incomes. Geriatricians and specialists in nursing and other fields should be offered incentives in the form of increased incomes, loan forgiveness, scholarships, and other awards, according to the report. Nonphysician providers and caregivers face both the disincentives of poor funding from Medicare and Medicaid and "the fact that these workers have not been recognized as the pivotal health care workers that they are," said panel member Carol Raphael, president and chief executive officer of the Visiting Nurse Service of New York. The panel called specifically for states to boost Medicaid payments that cover these workers' services and benefits.

Warning, as others have, that the health care system isn't close to being prepared for the 78 million aging baby boomers, the panel called for "new models" of long-term and geriatric care that include increased delegation of responsibilities within the health workforce hierarchy, the greater use of interdisciplinary teams, and increased involvement of patients and their families in elders' care. Many good models have been developed, said the panel, but too often have been put on the shelf for lack of funds for implementation.

Too few health professionals are well prepared to handle the multiple medical problems seen in old age.

DR. FINEBERG

Members of Congress have turned their attention to the geriatric care workforce. On April 16, the Senate Special Committee on Aging held a hearing on the subject, focusing on the new report. Dr. Rowe testified, and committee members echoed many of his panel's concerns. For instance, Committee Chairman Sen. Herb Kohl (D-Wis.) said, "We know that few nursing programs require coursework in geriatrics and that in medical schools, comprehensive geriatric training is a rarity."

Sen. Kohl announced plans to introduce a bill later this spring to "expand, train, and support all sectors of the long-term care workforce," including physicians. ■

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