POLICY & PRACTICE

Better Appeals Process Needed

Analysis by the Government Accountability Office has pointed out deficiencies related to Medicare Part D. The watchdog agency says that the Centers for Medicare and Medicaid Services has improved its efforts to inform beneficiaries about sponsors' performance, but its oversight of sponsors is hindered by poorly defined reporting requirements. To improve the process, CMS should allow independent reviewers to conduct reviews without the standard "appointment of representative" form, and also should provide the plans with standardized definitions for data that they must provide, the GAO report said. A bipartisan statement from Senate Finance Committee members said that the lawmakers back simplification of the process. "Patients and their doctors should not have to navigate an impossible maze of bureaucratic red tape in order to get the prescription drugs they need," said Sen. Jay Rockefeller (D-W.Va.) in a statement.

FDA Issues Food Co. Injunction

Two food companies and their top executives have signed a consent decree that effectively prohibits them from manufacturing and distributing any products that claim to cure, treat, mitigate, or prevent diseases, the Food and Drug Administration said last month. The consent decree against Brownwood Acres Foods Inc., Cherry Capital Services Inc., and two of their top executives is the result of unapproved drug claims and unauthorized health claims such as "Chemicals found in cherries may help fight diabetes," the FDA said. Eastport, Mich.–based Brownwood Acres Foods, and Cherry Capital Services, which is based in Traverse City, Mich., manufacture and distribute various products, including juice concentrates, soft fruit gel capsules, fruit bars, dried fruits, liquid glucosamine, and salmon oil capsules.

Copays, Caps May Reduce Use

Copayments and caps on drug expenditures—common methods used by drug plan sponsors to control costs—may discourage patients from using those drugs, potentially leading to adverse health effects, a new review of existing research showed. The Cochrane Library review of 21 studies that looked at a variety of prescription drug payment policies found that, among insurers that tried to keep costs down through copayments and caps, "reductions in drug use were found for both life-sustaining drugs and medications that are important in treating chronic conditions," said Astrid Austvoll-Dahlgren, a research fellow with the Norwegian Knowledge Centre for the Health Services, in a statement. Although the review did not provide clear evidence that patient health suffered under the cost-sharing policies, plans designed to make patients shoulder some of the cost of prescriptions reduced both the amount of medication used—including life-sustaining drugs—and medicine expenditures. Ms. Austvoll-Dahlgren suggested designing policies in which people pay directly for only nonessential drugs, or in which exceptions are built in to ensure that people receive needed medical care.

Medco Launches e-Rx Drive

As Congress considers legislation that would tie physicians' Medicare payments to their use of e-prescribing technology, Medco Health Solutions Inc. said it was launching a national initiative to assist physicians of Medicare Part D patients in switching to electronically generated prescriptions. The pilot program also will be used to study the effect of e-prescribing on patient safety, increased generic drug use, and formulary compliance, the prescription drug manager said. Initially, the study will include 500 physicians currently treating enrollees in the Medco Medicare Prescription Plan. Medco will provide these physicians with free e-prescribing software and training, and Medco will compare the physicians' rate of generic drug dispensing, formulary compliance, and generated safety alerts with that of a control group. Ultimately, 2,000 physicians—mostly primary care doctors—will participate in the e-prescribing program, Medco said. Estimates have shown that e-prescribing could save up to $30 billion in the Medicare program, and Medco said it hopes its study will help to quantify how much the technology actually will help reduce medication errors and lower costs.

CVS Caremark Settles Suit

CVS Caremark last month agreed to a $38.5 million settlement in a multistate civil lawsuit that accused pharmacy benefit manager Caremark Rx of engaging in deceptive business practices. Caremark encouraged doctors to switch patients to different brand-name prescription drugs and represented that the patients and/or their health plans would save money by switching, according to the complaint, which was filed by attorneys general in 28 states. But Caremark did not adequately inform doctors of the effects that switching would have on costs to patients and health plans, and did not clearly disclose that rebates would be retained by Caremark and not passed directly to health plans, the complaint said. Under the settlement, Caremark must significantly alter the practices it uses to ensure that patients, physicians, and health plans have the information needed to make the most cost-effective purchasing decisions, said Illinois Attorney General Lisa Madigan, who led the investigation with Maryland Attorney General Douglas Gansler. Caremark also is prohibited from soliciting drug switches under a variety of circumstances.

—Jane Anderson

Printed Forms Promote Cancer Care Teamwork

BY MIRIAM E. TUCKER
Senior Writer

WASHINGTON — Collaboration between oncologists and primary care physicians can ensure seamless care for cancer patients, according to a hematologist and a family practice physician who gave a joint presentation at the annual Community Oncology Conference.

Routine use of printed forms can facilitate exchange of important information, Dr. Leslie R. Laufman and Dr. Mary Beth Hall advised, outlining a blueprint for cooperation.

They counseled, however, that even when forms are used, there will be times when one provider or the other needs to pick up the phone and initiate discussion of a patient's medical treatment and/or psychosocial issues.

Communication between a cancer patient's oncologist and primary care physician is critical, but in many cases it isn't carried out effectively, said Dr. Laufman of Ohio State University, Columbus, who is also in private practice in oncology in Columbus, and Dr. Hall, a family physician in private practice in Newark, Ohio.

Many aspects of the "division of labor" were described as straightforward:

► The oncologist handles the cancer status definition, the cancer treatment plan, urgent care during treatment, the unique side effects of the chemotherapy agents, and possibly entering patients into clinical trials.

► The primary care physician provides ongoing medical care for noncancer health issues, helps manage psychosocial issues that either predate or accompany the cancer diagnosis, helps with family-related issues, and possibly plays a role in palliative care.

The primary care physician needs to receive timely information from the oncologist regarding the patient's initial consultation, including diagnosis, prognosis, treatment plan and objectives, likely toxicities or cancer-related problems, and plans for home care. "We are very anxious to hear how the patient is going to do," Dr. Hall said.

Access to educational materials—such as newsletters or links to Internet sites—would be very helpful, as would the oncologist's direct telephone number, she added. "I promise we won't abuse it. It just comes in handy to have it right there in the patient's chart so that we can do a rapid phone consult. …And it works both ways. The oncologist needs our phone number too."

Any hospitalization plans, as well as the patient's advance directive status, should be provided to the primary care physician. It is important to spell out ahead of time which physician will manage the patient in the hospital or whether the two will collaborate.

Some aspects of a cancer patient's care might present a conflict or be overlooked unless they are anticipated and addressed. Among these are the management of pain, depression, or insomnia that develops in response to the cancer or its treatment, hospitalization for acute toxicities, long-term follow-up, and screening for new primary cancers.

"Who tells the patient about needing a colonoscopy if they have breast cancer? One may assume the other is doing that," Dr. Hall noted as an example.

Both physicians should ask patients whether they are taking any type of alternative treatments that could interact with their prescribed agents, and should inform the other physician if they are. St. John's wort is a common one that some patients take for depression but that can also cause bleeding.

"Patients don't always tell you. You have to ask them," she said.

Much of the communication between the two physicians can be accomplished through printed forms.

A recommended template for such letters was developed by Dr. Ted C. Braun and his associates at the Tom Baker Cancer Centre, a large tertiary referral center in Calgary, Alta. (Can. Family Physician 2003;49:884).

Dr. Laufman discussed a single-page (front and back) "precertification" form that she uses both as an in-house communication tool within her three-oncologist practice and also with the patient's primary care physician.

The form includes items to be circled and lines to be filled in for treatment goals and options, patient status, and comorbidities, along with documentation of what the patient has been taught and of consent to treatment.

The physician fills out his or her part of the form, signs off, and then forwards it to the nurses who do the same when they conduct patient teaching. It then goes to the billing department to ensure likely coverage for treatment before it is sent to the pharmacy technician for drug dispensing.

Formal chemotherapy orders are listed for the entire duration of therapy, with information about doses, schedule, lab parameters, and premedications, along with a formal amendment procedure for any changes. The patient also signs it. The whole form also serves as a legal document, Dr. Laufman said.

A version of the form is then sent, along with a cover letter, to the primary care physician. "This is one of the things that makes our practice work very, very well," she said.

Although forms can go a long way in facilitating communication between providers, there will be urgent situations that require a phone call. These include a suicidal patient, a hospital admission, or when the oncologist starts a diabetic patient on steroids or changes the steroid dosage.

An atypical symptom that might represent a reaction to a nononcology drug also should signal the oncologist to pick up the phone, Dr. Laufman said. ■