Certification May Be Required

Residency *from page 1*

The guidelines, released by the American Board of Family Medicine and the American Board of Emergency Medicine, cover the objectives of a joint residency program, core curriculum requirements for each specialty, and training director requirements.

Dr. Mary Jo Wagner, who corepresented the American College of Emergency Physicians (ACEP) on the guidelines writing committee, said, "The curriculum we developed took [out] what we felt was an overlapping year of training for each residency program, so rather than two 3-year programs, these residents would do 5 years total."

For example, "both family practice and internal medicine do a 1-month orthopedics rotation," said Dr. Wagner, director of the emergency medicine residency program at Michigan State University, East Lansing. "So you wouldn't need to repeat that month in residency training. We selected several months like that where we felt it was appropriate" to eliminate the duplication.

While the number of institutions that would be interested in offering a joint residency is not known, Dr. Perry Pugno, director of medical education at AAFP, noted that the academy surveyed family medicine residency programs a few years ago and asked how many would be interested in a joint residency program with emergency medicine.

"We got 84 positive responses, so that may be somewhat indicative of an interest level," Dr. Pugno said. "There are many people who might be interested in emergency medicine but also interested in the continuity of care perspective and might gravitate toward a combined program."

Dr. Cherri D. Hobgood, an emergency physician at the University of North Carolina, Chapel Hill, agreed.

"This new dual training will provide practitioners who have a very unique set of skills, both the training in acute care and stabilization and aggressive resuscitation techniques that the emergency medicine physician brings, as well as the long-term care that the family practice paradigm brings," Dr. Hobgood said.

"These are going to be a very unique set of practitioners who are going to be incredibly well trained, and they really will be people capable of working in a rural environment with a limited amount of subspecialty backup," she continued in an interview.

Controversy about the combined residency surfaced at the AAFP House of Delegates meeting last October, when a joint AAFP/ACEP statement was proposed that included an emphasis on residency training in emergency medicine or a combined family medicine/emergency medicine residency as the ideal training for physicians who work in emergency departments.

"I don't think the AAFP should support the belief that a family physician needs additional training in a given area in order to practice the best care," Dr. Elston said.

"Then the same argument would be applied to obstetrical care, pediatric care, and sports medicine. Where do you draw the line then? I do my family practice residency and 2 years of emergency medicine, and then I need 2 years of orthopedics and 2 years of general surgery? I'll guarantee you there are [family physicians] out there who can take on any specialist."

The delegates rejected the proposed statement, but Dr. Elston said he is happier with a new statement on the subject that the board of directors adopted in March.

The statement says that "Family physicians are trained in the breadth of medical care, and as such, are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care."

The statement goes on to say that "Emergency department credentialing should be based on training, experience, and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit."

"That's not an unreasonable policy, on the surface of it," Dr. Elston said in an interview. "I [just] don't want it to bar family practice residency–trained physicians from practicing their specialty, which includes emergency medical services, with their patients."

He added that one concern with the new residency program is that now that this dual residency will be available, more hospitals might start requiring board certification in emergency medicine for physicians who want to work in emergency departments.

"As training of that nature becomes available, more hospitals will require it and more plaintiff's attorneys will use it against physicians who don't have that training," he said.

If hospitals do start requiring all emergency department physicians to be board certified in emergency medicine, "who will suffer is the American public, because they'll be missing some very good emergency physicians who happen to be family physicians," Dr. Chamberlain said.

"Some family physicians who have practiced emergency medicine for 15 or 20 years are very afraid of losing their jobs. If we can help family doctors who want to do emergency medicine by providing a dual residency, that's a very positive step." ■

As training 'becomes available, more hospitals will require it and more plaintiff's attorneys will use it against physicians who don't have that training.'

The guidelines are available online at https://www.theabfm.org/about/guidelines combinedresidencytraining.pdf.

POLICY & PRACTICE

Uninsured Get Inefficient Care

The uninsured not only face a "downward spiral" in health, they also experience inefficiencies in care, a report from the Commonwealth Fund found. Uninsured persons are more likely to go without the care or screening tests that could prevent serious health problems, are less likely to have a regular doctor (41% vs. 86% of insured adults), and are more likely to face fragmented care. "Nearly one-quarter (23%) of adults who are currently uninsured or had a time uninsured reported that test results of records were not available at the time of a doctor's appointment, compared with 15% of insured adults. Nearly one-fifth (19%) of uninsured adults had duplicate tests ordered, compared with 10% of insured adults," the study said. Researchers found that an "alarmingly high proportion (59%) of adults" with chronic illnesses such as diabetes and asthma who were uninsured for a time in the past year went without their medications because they couldn't afford them. The findings are from the Commonwealth Fund Biennial Health Insurance Survey, a nationally representative sample of 4,350 U.S. adults aged 19 years and older, conducted via phone August 2005-January 2006. This analysis focuses on the population aged 19-64.

Glaucoma Screening

Hispanic Americans aged 65 years and older are now eligible for glaucoma screening under Medicare. Medicare will pay for glaucoma screening exams provided by (or under the direct supervision of) an ophthalmologist or optometrist who is legally authorized to perform the services under state law. At least 11 months must have passed since the last covered screening. In 2002, Medicare began covering glaucoma screening for patients with diabetes, those with family history of glaucoma, and for African American beneficiaries aged 50 years and older—all of whom are considered to be at high risk for the disease.

FDA Eyes Phase IV

The Food and Drug Administration has hired a contractor to conduct a thorough evaluation of the postmarketing study process for collecting information about drugs, devices, and biologics, the agency said in a statement. Such phase IV studies help to further define a product's safety, efficiency, or optimal use, the agency said. "Greater internal consistency across the medical centers at FDA for requiring, requesting, facilitating, and reviewing postmarketing study commitments" is the goal. Booz Allen Hamilton was awarded the contract last month, and is expected to take about a year to finish, according to the FDA.

Part D Cash Flow Woes

Administrative improvements in Medicare Part D have not eased cash flow pains for independent pharmacists, a survey found. The National Community Pharmacists Association surveyed 5,000 of its members; one-third said the Part D cash flow crisis may threaten the viability of their businesses. During the program's initial days, pharmacists nationwide dispensed millions of dollars in emergency prescriptions when eligibility could not be verified, and claims could not be processed due to problems with plan databases. Even now, payment procedures for low-income seniors eligible for both Medicare and Medicaid have "drastically slowed payment schedules," the NCPA said. Under Medicaid, pharmacists were reimbursed weekly; under Medicare Part D, prescription drug plans issue reimbursement checks generally only once every 4 weeks and prescription claims filing may delay payment by additional weeks. Some 525 independent pharmacies (10.5%) responded to the faxed survey.

Prescribing Scooters, Wheelchairs

Prescribing power wheelchairs and scooters for patients should be easier under a new Medicare rule. The final rule, published in the Federal Register, requires a face-to-face evaluation, but also extends the time allowed to submit the prescription and other paperwork to the supplier from 30 days to 45. Also, a requirement that a specialist physician such as an orthopedic surgeon or rheumatologist assess the patient's ability to operate the equipment has been removed. An additional payment has been provided via an add-on CPT code to recognize the additional work and resources required to document the patient's need for a power device. A beneficiary being discharged from the hospital does not need to have a separate face-to-face exam. If a physician has an established treatment relationship with a patient, a face-to-face exam is not required, but documentation of need based on previous visits must be provided, according to the rule.

Tobacco Settlement Funds Waning

States will likely receive $400 million less tobacco settlement funds in fiscal year 2006 than in 2005, a Governmental Accountability Office study has found. GAO said the decline occurred because states have been selling bonds based on expected revenue from tobacco companies. States are "selling proceeds for pennies on the dollar," and will have less to spend on health care, said Eric Lindblom, director for policy research at the Campaign for Tobacco-Free Kids. Tobacco settlement money was supposed to be spent on public health, especially to prevent smoking and treat its effects, he said, adding that when states have million of dollars coming in from tobacco companies, it is easier for health advocates to push for spending on smoking-related health matters. A recent paper from the campaign said that California and Massachusetts were saving as much as $3 in smoking-related health-care costs for every dollar spent on tobacco prevention when their programs were adequately funded. This is the last such report the GAO is set to perform under current federal law.

—Nancy Nickell