AMA Releases How-to Manual on Emerging Physician Payment Models

The American Medical Association (AMA) has released a new how-to manual to help physicians evaluate, negotiate, and manage budget-based payment systems, which typically include payment bundling, pay-for-performance, withholds and risk pools, capitation, and shared savings. The manual, *Evaluating and Negotiating Emerging Payment Options*, provides information and tools to help physicians understand the differences between fee-for-service and budget-based systems; master concepts associated with budget-based systems; and estimate, monitor, and manage the financial risks and rewards of a budget-based system. The AMA plans to continually expand and update the manual to provide physicians with the most current information and tools on emerging payment arrangements. The manual is available for free at http://www.ama-assn.org/resources/doc/psa/payment-options.pdf. For more information, visit http://www.ama-assn.org/ama/pub/news/news/2012-02-24-emerging-physician-payment-models.page.

FDA Approves First Quadrivalent Vaccine to Prevent Seasonal Influenza

The U.S. Food and Drug Administration (FDA) has approved Flumist Quadrivalent, a vaccine to prevent seasonal influenza in persons two to 49 years of age. It is the first influenza vaccine to contain four strains of the influenza virus: two influenza A strains and two influenza B strains. Each year, the FDA-approved seasonal influenza vaccine includes three strains of influenza virus: two influenza A strains and one influenza B strain. During a typical influenza season, there may be two different influenza B strains circulating, or the B strain selected for inclusion in the trivalent influenza vaccine may not be the strain that eventually circulates. The inclusion of a second B strain in Flumist Quadrivalent increases the likelihood of adequate protection against circulating influenza B strains. The safety and effectiveness of Flumist Quadrivalent are supported by previous studies conducted for the Flumist trivalent formulation and by three new U.S. studies involving approximately 4,000 children and adults that demonstrated that the immune responses were similar between persons receiving Flumist Quadrivalent and those receiving Flumist. Adverse reactions were also similar between Flumist Quadrivalent and Flumist, with the most common being runny or stuffy nose in children and adults, and headache and sore throat in adults. For more information, visit http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm294057.htm.

Text4Baby, CMS Partner to Connect Women to Health Information

As part of activities marking the anniversaries of the signing of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 and the launch of a free national health texting service called Text4Baby, the Centers for Medicare and Medicaid Services (CMS) has announced that it will partner with Text4Baby to promote enrollment in Medicaid and CHIP, and to provide free text messages on important health care issues to pregnant women and new mothers. In 2011, Medicaid and CHIP covered 43.5 million children, and under the CHIP Reauthorization Act of 2009, CMS has awarded $90 million in grants to conduct activities to ensure eligible children are enrolled, and remain enrolled, in health coverage. More than 184,000 Text4Baby users are receiving a new message alerting them to the availability of free and low-cost health coverage through Medicaid and CHIP. The message will provide a connection to the InsureKidsNow telephone number and Web site for instructions about how to sign up. For more information, visit http://www.hhs.gov/news/press/2012pres/02/20120228c.html.

Next Stage for Health Care Professionals Adopting EHRs Announced

In February, Health and Human Services Secretary Kathleen Sebelius announced the next steps for health care professionals who are using electronic health records (EHRs) and receiving incentive payments from Medicare and Medicaid. These proposed rules will govern stage 2 of the Medicare and Medicaid EHR Incentive Programs. Under the Health Information Technology for Economic and Clinical Health Act, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it in a meaningful way, which is evolving in three stages. Stage 1, which began in 2011 and remains the starting point, indicates that meaningful use consists of transferring data to EHRs and being able to share information. Stage 2, which is to be implemented in 2014, indicates that meaningful use includes new standards such as online access for patients to their health information. Stage 3, which is expected be implemented in 2016, indicates that meaningful use

includes demonstrating that the quality of health care has improved. CMS' proposed rule specifies the stage 2 criteria that eligible participants must meet to qualify for Medicare or Medicaid EHR incentive payments. It also specifies Medicare payment adjustments that, beginning in 2015, health care professionals will face if they fail to demonstrate meaningful use or to meet other program participation requirements. For more information, visit http://www.hhs.gov/news/press/2012pres/02/20120224a.html.

New Report Identifies Eight Change Concepts for PCMH Transformation

A new report from the Commonwealth Fund, available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Feb/1582_Wagner_guiding_transformation_patientcentered_med_home_v2.pdf, provides eight change concepts to achieve patient-centered medical home (PCMH) status. These include engaged leaders; a quality improvement strategy; linking each patient with a responsible health care professional; continuous, team-based healing relationships; organized and evidence-based care; patient-centered interactions; enhanced access; and care coordination. For more information, visit http://www.aafp.org/news-now/news-in-brief/20120229wklynewsbrfs.html#NewsArticleParsys77710.

ACIP Votes to Expand Tdap Vaccine Recommendations for Older Patients

The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) made a new provisional recommendation during a February meeting in Atlanta, Ga., that will further alter the approach to tetanus, diphtheria, and acellular pertussis (Tdap) vaccination in older patients. According to the American Academy of Family Physicians' liaison to the ACIP, Jamie Loehr, MD, the committee voted to recommend that adults 65 years and older routinely receive one dose of Tdap vaccine if they have not previously received a dose. The Tdap vaccine dose would replace one booster dose of tetanus and diphtheria toxoids (Td) vaccine. The new recommendation removed the suggestion that Tdap vaccine be given when a patient is regularly scheduled to receive his or her 10-year tetanus booster, and instead indicates that Tdap vaccine may be given at the next available opportunity, no matter how much or little time has passed since the previous Td vaccine dose was given. The group also discussed which of the two versions of Tdap vaccine available in the United States should be recommended: Boostrix, which is approved for use as a booster in persons 10 years and older, or Adacel, which is indicated as a booster in persons 11 to 64 years of age. Although Boostrix is specifically approved by the FDA for use in adults 65 years and older, Adacel is licensed, but not approved, for use in this age group because it did not meet the predefined noninferiority criteria in the data submitted to the FDA. According to Loehr, the ACIP believed that the preference would be for Boostrix to be given to older persons if available, but that Adacel can be used if it is the only Tdap vaccine available. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120229acip-tdap.html.

Study Suggests That Statin Therapy Is Effective in Men and Women

A recent meta-analysis evaluating the effectiveness of statins in reducing cardiovascular events in men and women determined that statin therapy was associated with statistically significant decreases in these events and in all-cause mortality in both sexes. Previously, women had not participated in primary prevention trials to the extent men had, creating doubt about the effectiveness of statins for primary prevention in women. The study authors acknowledge this gap, stating that although previous studies showed improved outcomes with statins in men and women without significant interaction by sex, the results were not statistically significant in women. Researchers analyzed 18 randomized controlled trials that included sex-specific outcomes; eight were classified as primary prevention and 10 as secondary prevention. Rates of occurrence of primary end point as defined in each study, and all-cause mortality (when available) for intervention and control groups were calculated for each study as a whole, and by sex. Overall pooled treatment effects also were calculated for each study and by sex. Separate analyses were performed for primary and secondary prevention trials by level of baseline risk and type of end point. It should be noted that in five of the eight primary prevention studies, 14 to 87 percent of patients may have had cardiovascular disease, leaving only three studies with participants who were exclusively without previous cardiovascular disease. This discrepancy was addressed in the study's sensitivity analysis, but not in the overall analysis. Fifteen, 38, and 69 percent of the participants in the three studies involving patients with no prior cardiovascular disease were women. The study that included the highest percentage of women demonstrated the lowest drop in low-density lipoprotein cholesterol levels. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120306statinstudy.html.

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