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2011 Match Results Again Spotlight Family Medicine Gains

Number of U.S. Seniors, Fill Rate Jump

By Barbara Bein

For the second year in a row, the number of medical students choosing to enter family medicine has risen. That's according to the results of the 2011 National Resident Matching Program, or NRMP. Known as the Match, preliminary figures from this year's NRMP show that family medicine residency programs filled 2,576 positions of the 2,730 offered, for a record-high fill rate of 94.4 percent.

That fill rate is 3 percent higher than last year's figure and comes at a time when family medicine residency programs offered an additional 100 positions in this year's Match. Included in this category are family medicine-psychi-

atry, family medicine-emergency medicine, family medicine-preventive medicine and family medicine-internal medicine programs.

Moreover, of those 2,576 candidates who selected family medicine, 1,317 of them are U.S. medical school graduates — an increase of 133 compared with 2010.

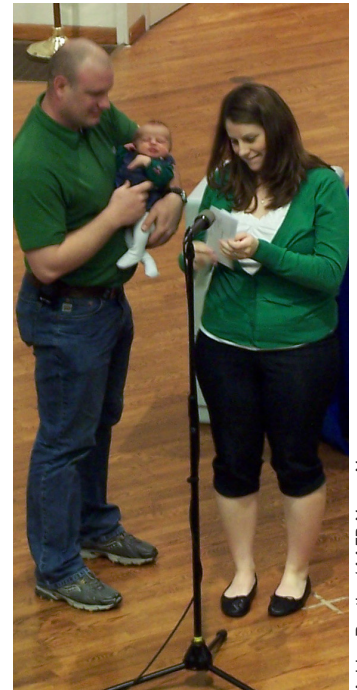
The demographics of the applicant pool also have changed, with more U.S. seniors and D.O. candidates applying through the Match in 2011. Overall, the percentage of U.S. seniors who chose family medicine rose from 7.9 percent in 2010 to 8.4 percent this year.

AAFP President Roland Goertz, M.D., M.B.A., of Waco,

Texas, welcomed the news, saying in a prepared statement that the increases suggest an upswing in interest in the specialty among U.S. medical school graduates.

"This year's results mark the second consecutive year of increased interest in family medicine," Goertz said. "Although several factors likely contribute to the increase, we believe an important element is recognition that primary care medicine is absolutely essential if we are to improve the quality of health care and help control its costs.

"Of course, sustaining this interest will require continuing changes in the way America pays
See 2011 Match, page 2



Ashley Bentley/AAFP News Now

The envelope, please: Courtney Huhn, a fourth-year student at the University of Kansas School of Medicine in Kansas City, finds out that she matched into KU's family medicine residency. Huhn is joined by her husband, T.J., and their infant daughter, Madeline.

Online Tool Spells Out Impact of Health Care Reform Law

Health Care and You Website Provides Resources FPs Can Give Patients

A lot of family physicians and their patients are confused about what is in the Patient Protection and Affordable Care Act and how the law will affect them. In response, the Health Care and You Coalition, of which the AAFP is a founding member, has launched a website to help physicians and patients understand the impact of the health care reform law.

Although the HealthCareandYou.org website is aimed primarily at

consumers, physicians can use it to help their patients make the right health care decisions for themselves and their families, according to AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas. "Our patients often look to (us) for more than just a diagnosis and a prescription. By teaming up with our colleagues in the coalition, we offer a valuable resource that doctors can share with patients," said Goertz.

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APRIL HIGHLIGHTS



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Pertussis Recommendations page 7

New CDC recommendations are focusing on the need for health care personnel to receive pertussis immunizations.

The Payment Battle page 12

The AAFP continues to battle for better payment for members, and in 2010, it had some wins — and averted disaster.

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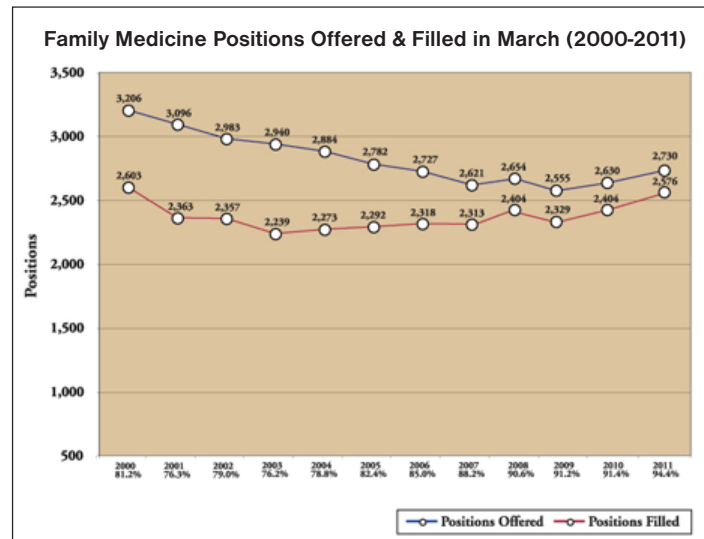
for and delivers health care to patients," he added.

In addition to family medicine, two other primary care specialties saw increases in the number of U.S. seniors filling their residency positions. Twenty-six more residency positions were filled in internal medicine-primary compared with 2010, with 10 more positions than last year going to U.S. seniors. Seven more positions were filled in internal medicine-pediatrics compared with 2010, and 10 more U.S. seniors chose the specialty than did last year.

"Primary care has become much more visible as a result of the discussion about improving our health care system," said Goertz. "More people understand that if we're to have high-quality care at a controllable cost, we need to balance our system on a foundation of primary medical care."

According to an AAFP Division of Medical Education summary of the 2011 Match results, the increased percentage of medical students matching into primary care, and especially into family medicine, may reflect the impact of health care reform discussions that have been focusing on the crucial need for a primary care-based health care system in the United States to improve access and cost-effective medical care.

A recent report from the Council on Graduate Medical Education said that the U.S. physician workforce needs to be made up of at least 40 percent primary care physicians — up from the current 32 percent. Moreover, said the report, primary care physicians' average incomes should be increased to at least 70 percent of the median incomes of all



other physicians.

However, although the family medicine match rate among U.S. medical school graduates has increased, most positions offered and filled in the NRMP, especially among U.S. graduates, continue to be in nonprimary care subspecialties.

According to the AAFP summary, a recent analysis of the link between physicians' starting salaries and specialty choice showed that U.S. seniors are choosing the more highly compensated specialties. Another troubling trend in recent years, says the summary, is "a dramatic increase in the income gap between primary care and other specialties."

"Until this issue is appropriately addressed, the AAFP believes that many excellent physicians will be deterred from a rewarding career in family medicine where patients and communities receive effective, equitable and efficient patient-centered care." ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20110317thematch.html>.

Health Care Reform Law, *continued from page 1*

The site provides tailored information for users. For example, it explains provisions of the Affordable Care Act currently in place and provisions scheduled to take effect in the future. The site also describes nearly every facet of the health care reform measure and provides information on how the law handles medical treatments, disease prevention and coverage for pre-existing conditions. In addition, the site contains a state-by-state listing of health care coverage options available now and in the future and describes the extent of coverage in individual states.

The Health Care and You Coalition, which includes the AAFP, the AMA, the American College of Physicians, the American Nurses Association, the National Community Pharmacists Association and AARP, introduced the website during a March 1 press event. The coalition noted it will continue to work to educate Americans about the health care law through ongoing activities, including state-level outreach and presentations at member events. ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20110302hcandyou.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between Feb. 19, 2011, and Mar. 15, 2011.

AAFP Responds to Obama Administration's 2012 Proposed Budget *Proposal Pays for Two-year SGR Fix, Lays Groundwork for Primary Care*

A two-year extension in Medicare physician payments and funding for training future FPs are some key components for family physicians in the Obama administration's 2012 fiscal year budget. The proposed budget is a "step in the right direction (in) reinforcing the foundation of fam-

ily medicine and the health care system that it supports," said AAFP President Roland Goertz, M.D., M.B.A. of Waco, Texas, in a prepared statement.

The Obama administration released its proposed budget for the 2012 fiscal year, or FY 2012, on Feb. 14. Among other things, the proposal would pay for a two-year extension of the sustainable growth rate, or SGR, formula and increase money for health professions training programs, including Section 747 of Title VII of the Public Health Service Act. Section 747 is the only federal program specifically for the training of family physicians.

"By proposing a two-year, paid-for moratorium on the mandatory Medicare pay cuts under the sustainable growth rate formula, the budget, if enacted, would provide respite from the monthly and sometimes

bimonthly threats to the financial stability of family physician practices," said Goertz.

In addition, he noted, the budget would "lay the groundwork for an eventual legislative solution to the dysfunctional Medicare physician payment formula that has destabilized elderly and disabled Americans' access to the health services they need."

Goertz pointed out, however, that the AAFP has called for a payment differential for primary care, and he expressed disappointment that the budget does not include that request.

The Obama budget actually proposes a 10-year fix to the SGR, at a cost of about \$370 billion, according to HHS Secretary Kathleen Sebelius. However, the budget only lays out payment remedies for a two-year SGR fix, which would cost about \$62 billion. The administration proposes combin-

ing several measures to pay for the two-year fix, including using more generic drugs and recouping money from Medicare and Medicaid efforts to halt fraud and abuse.

Additionally, the administration's proposed budget seeks a \$101 million increase for Section 747 of Title VII. "Budget recommendations for Title VII of the Public Health Service Act ... would support innovative programs that would produce an additional 2,500 physicians and physician assistants over five years," said Goertz.

In the final analysis, said Goertz, the administration's budget represents a "recognition that ensuring access to family physicians is integral to better health for Americans and controlled health care spending nationwide." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110223budgetproposal.html>.



James Arvantes/AAFP News Now

HHS Secretary Kathleen Sebelius answers questions about the Obama administration's proposed budget, which offers ways to pay for a two-year extension to the Medicare physician payment program.

CMS Postpones April 1 Implementation of Medicaid RAC Programs

After hammering CMS to improve its proposed Medicaid Recovery Audit Contractor, or RAC, program, the Academy and a number of other national physician organizations were pleased to learn that CMS is delaying implementation of the state-based RAC programs.

The Patient Protection and Affordable Care Act requires that state Medicaid programs contract with RACs to identify and recoup or resolve overpayment and underpayment of fees to physicians and other service providers. The program was scheduled to begin on April 1, but on Feb. 1, CMS issued an informational bulletin announcing it would delay the implementation date.

"Out of consideration for state operational issues and to ensure states comply with the provisions of the final rule, we have determined that states will not be required to implement their RAC programs by the proposed implementation date of April 1, 2011," says the CMS bulletin.

Instead, the final rule on the Medicaid RAC program will be issued later in 2011, along with a new implementation deadline for the states.

CMS' action comes on the heels of a Jan. 10 letter sent to CMS Administrator Donald Berwick, M.D. The letter, which was signed by the AAFP and more than two dozen other national physician organizations and medical organizations representing all 50 states and the District of Columbia, was initiated by the AMA.

"We continue to have concerns about the perverse incentive structure and burdensome nature of the Medicare Recovery Audit Contractor (RAC) program and firmly believe that the best way to reduce improper coding is through education and outreach," says the letter.

The letter urges CMS to issue Medicaid RAC program requirements "that are consistent with the Medicare RAC program requirements, thereby empowering states to avoid problems already encountered and addressed in the Medicare RAC program."

The organizations also urge CMS to "set forth clear appeals processes requirements using past lessons learned in the Medicare RAC program to aid states in administering Medicaid RAC appeals." The letter asks for protections to help guard against duplicative audits and urges CMS to focus on education and outreach to the physician community.

The letter also addresses "underpayment" in the RAC program and notes that, in the proposed rule, CMS confirms that its "experience with Medicare RAC contractors is that overpayment recoveries exceed underpayment identification by more than a nine-to-one ratio." The medical organizations strongly urge CMS to set forth Medicaid RAC underpayment fee structure requirements. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110223racdelay.html>.

AAFP to White House: Hold the Line on Supporting FPs, Primary Care in 2012 Budget

Academy, Other Groups Press for Favorable Payment Differential

Even as the AAFP and other family medicine organizations recently applauded the Obama administration's efforts to "provide appropriate payment for primary care services and support primary care workforce programs," the groups specifically called for a "multiyear Medicare schedule (that) narrows the payment differential between primary care and other physicians."

In a March 7 letter, AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, and the presidents of four other family medicine organizations praised the administration's 2012 fiscal year, or FY 2012, budget request, which would pay for a two-year extension of the sustainable growth rate, or SGR, formula. That, in turn, would prevent mandatory reductions to Medicare payment rates through the end of 2013.

CMS now estimates that physicians will face a 29.5 percent reduction under the SGR on Jan. 1, 2012, unless Congress acts to block the cut.

According to the letter, which, in addition to Goertz, was signed by the presidents of the Society of Teachers of Family Medicine, the Association of Family Medicine Residency Directors, the North American Primary Care Research Group and the Association of Departments of Family Medicine, the FY 2012 budget request, if enacted, would provide "two years of relief for physicians from devastating reductions in payments resulting from the SGR."

"The House of Representatives approved an example of differential payment when it passed the Medicare Physician Payment Reform Act

in 2009," the groups said. "The bill would have created a conversion factor of GDP (gross domestic product) plus 2 percent for primary care services, while specifying a conversion factor of GDP plus 1 percent for all other physician services."

In addition, the groups pointed out that the Council on Graduate Medical Education, or COGME, has called specifically for improving payment for practicing primary care physicians to achieve the desired ratio of primary care to subspecialty care. In its December 2010 report, COGME said the average incomes of primary care physicians "must achieve at least 70 percent of median incomes of all other physicians." Modification of current payment policies would ensure qualified medical students could afford to choose to train as primary care physicians, said the report.

Acknowledging the budgetary pressures facing the nation, the organizations nevertheless expressed regret that the president did not request funding for the new National Health Care Workforce Commission or the Primary Care Extension Program, which aims to provide support and assistance to FPs and other physicians on evidence-based therapies and techniques. In their letter, they vowed to "continue to advocate for an effective National Health Care Workforce Commission and a robust Primary Care Extension Program." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110314budgetletter.html>.

Academy Teams Up With AMA, Other Groups Calling to Eliminate SGR

Broad Payment, Delivery Reforms Needed, Says AAFP

In the ongoing battle to convince Congress to eliminate the sustainable growth rate, or SGR, formula used in calculating Medicare physician payment rates, the AAFP has joined the AMA and scores of other medical groups in calling on House and Senate leaders to enact legislation this year that will accomplish that goal. At the same time, say the groups, Congress should lay the groundwork for the adoption of broader physician payment and delivery reforms.

"Last year, Congress was required to act five times to pass short-term measures (for as short as one month) to stop Medicare physician payment cuts sched-

uled for 2010," says a March 10 letter circulated by the AMA and signed by the AAFP and 130 other medical organizations and societies. "On three occasions, Congress failed to act before cuts were implemented, causing disruptions in processing Medicare payments. These payment uncertainties and delays created serious problems for many physician practices and jeopardized seniors' access to care."

The letter, which was sent to Senate Majority Leader Harry Reid, D-Nev.; Senate Republican leader Mitch McConnell, R-Ky.; House Speaker John Boehner, R-Ohio; and House Democratic leader Nancy Pelosi, D-Calif.,

acknowledges that, ultimately, lawmakers came to a bipartisan accord in passing the Medicare and Medicaid Extenders Act of 2010, which stabilized Medicare payments through 2011.

However, CMS now estimates that physicians will face a 29.5 percent reduction under the SGR on Jan. 1, 2012, unless Congress acts to block the cut. "It is our hope that Congress can again work together this year to end the cycle of temporary patches once and for all and develop a long-term and meaningful solution to this issue," says the letter.

In addition, the groups say, "The physician community is committed to taking a leading role in

developing and pilot testing payment and delivery reforms that can provide a foundation for replacing the SGR and improving the Medicare physician payment system.

"We look forward to building upon last year's bipartisan effort to permanently replace the SGR with a workable system that keeps pace with practice costs and ensures that seniors, the disabled and military families receive the high-quality care that they have been promised for years to come," the letter concludes. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110316sgletter.html>.

Amount of Prescribed CME Credit for ABFM SAMs Drops

Family physicians who complete a self-assessment module, or SAM, in 2011 as a component of the American Board of Family Medicine's Maintenance of Certification Program for Family Physicians, or ABFM MC-FP, will receive 12 AAFP Prescribed CME credits instead of the 15 Prescribed credits previously awarded.

According to Kathleen Marian, M.Ed., AAFP manager of CME Compliance and Systems, the Academy's Division of Continuing Medical Education made the change after the ABFM provided the Academy with information that indicated learners, on average, completed the modules in slightly less than 12 hours.

The AAFP awards CME credit on an hour-for-hour basis for time spent in formal educational activities.

The SAMs are required under MC-FP Part II — self-assessment and lifelong learning — and include two parts: a knowledge assessment and a clinical simulation. The knowledge assessment evaluates an ABFM diplomate's knowledge in a particular care domain, such as asthma, coronary artery disease or diabetes. The clinical simulation presents patient care scenarios corresponding to that care domain. ■

For the complete story, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20110303samscredit.html>.

Unapproved Prescription Drugs Prompt FDA Crackdown

By David Mitchell

Family physicians and other health care professionals may be surprised to learn they have been prescribing medications — perhaps for years — that have not been approved by the FDA. The agency took action recently to stop such drugs from being dispensed to patients, ordering manufacturers to remove about 500 cough, cold and allergy products from the market.

"This action is necessary to protect consumers from the potential risks posed by unapproved drugs because we don't know what's in them, whether they work properly or how they were made," said Deborah Autor, J.D., director of the office of compliance in the FDA's Center for Drug Evaluation and Research, during a news conference.

When the Federal Food, Drug and Cosmetic Act was enacted in 1938, new drugs were required to be reviewed by the FDA for safety. The law was amended in 1962, requiring that new drugs be proven effective for their labeled indication, as well as safe. The amendment also required that thousands of drugs approved as safe between 1938 and 1962 be evaluated for effectiveness.

However, Autor said some products remained on the market illegally, and others have since entered the market illegally.

According to Autor, physicians' confusion about the issue has been exacerbated by the fact that some of the unapproved drugs are marketed in medical journals and listed in the *Physicians' Desk Reference*.

"Most family docs, at some point, have prescribed some of these medications," said Carrie Nelson, M.D., of Wheaton, Ill., who is chair of the AAFP's Commission on Health of the Public and Science. "We've generally assumed them to be FDA-approved, not recognizing they came on the market before the more strict guidelines for FDA approval."

The FDA said it was particularly concerned about two types of unapproved cough, cold and allergy medications, namely

- products with pediatric labeling, including some marketed for use in children as young as 1 month old; and
- extended-release products.

Unapproved extended-release products could put patients at risk by releasing their active ingredients too quickly, Autor said. Alternately, the products could release their medication too slowly or not at all.

Also of particular concern are products with "irrational" combinations of ingredients, she added, including medications that contain multiple antihistamines.

OTC cough, cold and allergy products are not affected by the FDA's action. Autor said products that are in compliance with an OTC monograph have been proven safe and effective. She also noted that patients should not be adversely affected by the removal of the unapproved prescription products because prescription and OTC alternatives are available.

Still, patients may need some convincing.

"Sometimes patients feel better getting a prescription," said Nelson, who also is medical director of the Illinois Medicaid program, Your Healthcare Plus. "You're trying to minimize the use of antibiotics for viral respiratory symptoms, so you instead prescribe a cough and cold medication. Patients often feel there's something more effective about a prescription than something sold over the counter, though that's not necessarily the case."

But, said Nelson, physicians and their patients should instead rely more on OTC medications for coughs, colds and allergies, and physicians should reinforce the fact that those products have been proven safe.

The FDA's action is the 17th in less than five years since the agency launched its Unapproved Drugs Initiative, which aims to bring all unapproved drugs into the agency's approval process.

The FDA requires manufacturers to list their products with the agency, whether or not those products have received approval. Autor said companies that previously listed products subject to the FDA's action must stop manufacturing them within 90 days and stop shipping within 180 days. Companies with unlisted unapproved products were ordered to stop manufacturing and shipping immediately. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20110302fdaprescripckackdown.html>.



Get to Know Your Academy Through New Online Guide

By Barbara Bein

New family physicians and other AAFP members who want to know more about their Academy membership benefits and how to get the most out of them now have a new electronic guidebook, "New Physicians: You and the AAFP."

The 38-page e-guide, which also can be downloaded as a PDF, walks members through — among other topics — the Academy's organization and structure, including information about its constituent chapters, its mission and objectives, and various ways members can become involved in the AAFP.

The new guide also describes the AAFP's wide array of membership benefits, including

- My Academy — members' personal Web portal on the Acad-

emy's website from which they can manage their CME, register for a course, pay dues or even build their practice website;

- *American Family Physician* — the AAFP's highly respected clinical journal;
- *Family Practice Management* — a management journal that focuses on family medicine practice needs;
- *AAFP News Now* — the Academy's online news publication; and
- FamilyDoctor.org — the AAFP's consumer/patient education website.

In addition, the guide provides details on advantage partner discounts for members, AAFP e-mail discussion lists and the Academy's presence on social media outlets such as Facebook

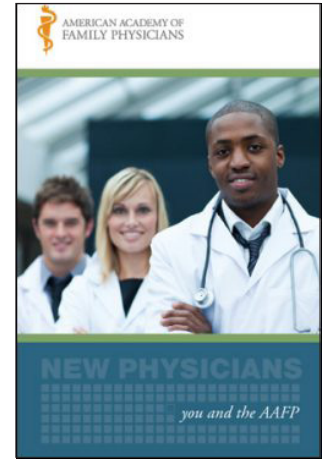
and Twitter.

New physicians will be especially interested to learn about "Experience the AAFP," a program that offers discounts and information targeted to physicians in their first seven years of practice.

Students and residents will find information about career services — including CareerLink, an employment search engine dedicated to family physicians and employers seeking candidates for clinical and faculty positions — and about making career, practice and contract decisions.

Other sections of the guide discuss the AAFP's advocacy activities as well as the many leadership opportunities the Academy offers.

"The nice thing about the guide is that it provides incred-



ible resources within the AAFP to assist members in getting started and throughout their careers," said AAFP Member Relations Strategist Callie Castro. ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20110223e-guide.html>.

In Brief *Health of the Public*

Risk to Newborns Leads FDA To Require New Labels for All Antipsychotic Drugs

The potential risk for extrapyramidal signs and withdrawal symptoms in newborns whose mothers received antipsychotic drugs during the third trimester of pregnancy has led the FDA to subject the entire class of drugs to a labeling update. The update is designed to inform pregnant women and their physicians about the potential side effects of the medications. More than two dozen products are affected by the action, including aripiprazole, which is marketed as Abilify; clozapine, which is marketed as Clorazil; haloperidol, which is marketed as Haldol; and chlorpromazine, which is marketed as Thorazine. Also included are medications that combine an antipsychotic and an antidepressant, such as the combination of olanzapine and fluoxetine, which is marketed as Symbyax. <http://www.aafp.org/news-now/health-of-the-public/20110223antipsychotics.html>

Terbutaline Poses Severe Risks to Pregnant Women

The FDA is notifying health care professionals that it is requiring the addition of a new boxed warning and contraindication to terbutaline's drug labeling to warn health care professionals about the severe cardiovascular and other risks these products pose for pregnant women. Terbutaline is approved to prevent and treat bronchospasm associated with asthma, bronchitis and emphysema,

but the drug also has been used off-label for obstetric purposes, including treating preterm labor and uterine hyperstimulation. However, new safety information reviewed by the FDA indicates that death and serious adverse reactions, including increased heart rate, transient hyperglycemia, hypokalemia, cardiac arrhythmias, pulmonary edema and myocardial ischemia, have been reported after prolonged administration of oral and injectable terbutaline to pregnant women. <http://www.aafp.org/news-now/health-of-the-public/20110223terbutaline.html>

Topiramate Linked to Infants' Risk for Oral Birth Defects

Family physicians need to be aware of an increased risk for oral clefts in infants born to women who use the anticonvulsant medication topiramate during pregnancy, say FDA officials. According to new safety data, topiramate, which is marketed as Topamax, increases the risk for cleft lip and cleft palate in these infants, and the agency is urging physicians to educate women of childbearing age about those risks. In a March 4 safety announcement, the FDA said physicians also should be aware of the potential for a decrease in hormonal exposure and a possible decrease in contraceptive efficacy in patients who use estrogen-containing birth control while taking topiramate. <http://www.aafp.org/news-now/health-of-the-public/20110308topiramate.html> ■

Health Care Personnel Are Focus of ACIP's Revised Pertussis Recommendations

By David Mitchell

Health care personnel and their immunization needs were a chief focus of the CDC's Advisory Committee on Immunization Practices, or ACIP, during its Feb. 23-24 meeting in Atlanta. And, in recognition of multiple ongoing outbreaks of pertussis, committee members voted to bring guidance for health care personnel in line with pertussis recommendations the ACIP made for the general population last year.

The new ACIP recommendation specifically calls for all health care personnel who have not previously received tetanus, diphtheria and acellular pertussis, or Tdap, vaccine to receive a single dose as soon as feasible — regardless of the interval since their last dose of tetanus and diphtheria toxoids, or Td, vaccine. Furthermore, health care facilities should take steps to

encourage such immunizations, including providing Tdap to their personnel at no cost.

Health care personnel already were recommended to receive Tdap, but the precise wording of the new recommendation — to disregard the interval since receiving Td — adds a sense of urgency, according to one FP expert.

"Because of the pertussis outbreak and the resurgence of pertussis, the recommendation is to do it as soon as possible," said Doug Campos-Outcalt, M.D., M.P.A., the AAFP's liaison to the ACIP and associate head of the department of family and community medicine at the University of Arizona College of Medicine, Phoenix.

California, for example, had more than 8,600 reported cases of pertussis throughout 2010, and many other states have reported high rates of the disease.

The ACIP also voted to recommend post-exposure prophylaxis against pertussis for all health care personnel — regardless of vaccination status — who have unprotected exposure to pertussis and are likely to expose high-risk patients, including infants and pregnant women.

Personnel who do not have contact with high-risk patients can either receive postexposure prophylaxis or be monitored for 21 days after pertussis exposure and treated at the onset of symptoms of pertussis.

All of the committee's existing policies regarding immunizations for health care personnel will be included in a compendium committee members approved for dissemination during last month's meeting.

According to Jonathan Temte, M.D., Ph.D., a member of the



ACIP and a professor in the department of family medicine at the University of Wisconsin School of Medicine and Public Health, Madison, the compendium likely will be published as a *Morbidity and Mortality Weekly Report* supplement by the end of the year.

"There are recommendations for health care personnel in other documents," Temte said. "This is an effort to put everything in one unified document. It provides stakeholders with a go-to source of information." ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20110304hpc-pertussis.html>.

Hypomagnesemia Linked to PPIs Can Cause Serious Adverse Effects

Docs Advised to Check Serum Magnesium Levels Before, During Treatment

Long-term use of prescription proton pump inhibitors, or PPIs, can depress serum magnesium levels and, possibly, lead to serious adverse events, the FDA announced recently. Such adverse events can include tetany, arrhythmias and seizures.

According to the agency, about 21 million patients filled prescriptions for PPIs at U.S. retail pharmacies in 2009. Patients stayed on the medications — which reduce the amount of acid in the stomach and are used to treat such conditions as gastroesophageal reflux disease, stomach and small intestine ulcers, and esophagitis — for an average of 180 days.

In a March 2 safety announcement, the FDA said prolonged use — longer than one year — of the medications was associated with adverse events.

Eight prescription PPIs were included in the FDA's safety announcement:

- esomeprazole magnesium, which is marketed as Nexium;
- dexlansoprazole, which is marketed as Dexilant;
- omeprazole, which is marketed as Prilosec;
- omeprazole and sodium bicarbonate, which is marketed as Zegerid;
- lansoprazole, which is marketed as Prevacid;
- pantoprazole sodium, which is marketed as Protonix;

- rabeprazole sodium, which is marketed as AcipHex; and
- the combination drug naproxen and esomeprazole magnesium, which is marketed for arthritis relief as Vimovo.

Physicians writing prescriptions for PPIs first should consider obtaining serum magnesium levels, the agency advised. In addition, levels should be checked periodically after beginning PPI therapy in a patient who is expected to need prolonged treatment or who also is taking a medication that causes hypomagnesemia, such as a loop or thiazide diuretic.

The FDA said checking serum magnesium levels was particularly important in patients taking the heart medication digoxin because low magnesium can increase the likelihood of serious side effects associated with that drug.

Magnesium supplements can be used to treat hypomagnesemia. However, patients who develop the condition may need to discontinue PPI therapy in addition to supplementing their magnesium levels. In one-fourth of the cases reviewed by the FDA, supplementation alone did not improve low serum magnesium levels. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20110309ppi-hypomag.html>.

Geography Challenges Hawaii AFP's Ability to Grow Family Medicine

Collaboration With Medical School, Residency Aids Chapter's Efforts

By Sheri Porter • Honolulu

The legendary surfer's paradise known as the Banzai Pipeline is located on the north shore of the Hawaiian island of Oahu. However, a very different kind of pipeline is the topic of the day – every day – at the Hawaii AFP.

Hawaii desperately needs to expand its primary care pipeline so that the state can provide medical care to its residents, says family physician Allen Hixon, M.D., an ardent supporter of the Hawaii AFP's efforts to address the state's physician shortage.

A past president of the Hawaii chapter, Hixon currently is an associate professor and vice chair of the department of family medicine and community health at the University of Hawaii at Manoa John A. Burns School of Medicine in Honolulu.

"We're an island state, and so we have populations that live on seven islands," he told *AAFP News Now*. "Those island populations range from 400 to 850,000 people. The primary care shortage on the neighbor islands is quite extreme."

According to Hixon, who also serves on the AAFP Commission on Education, the health care challenges in Hawaii, particularly in rural parts of the various islands, are very different from the rural health challenges in the rest of the United States. "Distances to care may be great (on the mainland) but you can get in a car and drive to get the services you need. That just doesn't exist here," said Hixon. "Geography is really a very defining issue for our health system."

Hawaii Chapter Sees Resurgence in 2010

By all accounts, the Hawaii AFP struggled for nearly a decade to regain the momentum it lost with the retirement of an active chapter executive in 2000 – not good news for a state with pressing health care needs.

FP Jill Omori, M.D., is director of predoctoral education at the medical school's department of family medicine. She said the Hawaii chapter officers – all busy family physicians – worked hard to keep the chapter going during those lean years. "It took a toll on all of us," said Omori, who has 12 years of service on the Hawaii AFP Board of Directors under her belt.

According to Hawaii AFP immediate Past President Andrew Nichols, M.D., the chapter began to turn around in January 2010 with the hiring of a new executive secretary, Ernel Roque, who took on the responsibilities of the previous chapter executive. "She's come in here with a lot of new energy and has been able to get the ball rolling in many areas," he said.

The Hawaii chapter is unique among AAFP constituent chapters, said Nichols, who also is a professor of family medicine and com-

munity health at the medical school, program director of the school's sports medicine fellowship and head team physician for the University of Hawaii at Manoa athletics department. "In our case, we have one medical school and we have one civilian family medicine residency program," he noted. (A military-affiliated program, also on Oahu, is run by Tripler Army Medical Center.)

"It's really the only show in town," said Nichols. "Many of our chapter activities are designed to help the medical school and to help promote primary care among the medical students." In fact, several of the chapter's board members also serve on the medical school faculty, and that makes

it easy to integrate some of the Hawaii AFP's activities right into the school, he said.

Residency Program Cranks Out FPs

According to Lee Buenconsejo-Lum, M.D., the family medicine residency program director at the University of Hawaii, her program pulls its weight when it comes to training family physicians for Hawaii.

The residency program trains a total of 18 residents each academic year. About 80 percent of the program's graduates stay in Hawaii, and, of those, 60 percent practice in rural areas – half of which are federally designated shortage areas.

Only once in the past 15 years has the residency program not filled during the National Resident Matching Program, known as the Match. Still, graduating six new family physicians each year isn't enough to fill the medical need in Hawaii.

Buenconsejo-Lum, who also is an associate professor of family medicine at the medical school, said her program, in conjunction with Hixon and the Hawaii AFP, is taking a lead role in workforce development in the state, and that includes growing physician populations on the "Big Island," Hawaii, and on the other neighboring islands.

She pointed out that the shortage of physicians on the neighboring islands overloads the health care system on Oahu.

"I really believe that if we had a well-trained cadre of primary care physicians (throughout the islands), many patients wouldn't have to be transported to Oahu, as is currently being done," said Buenconsejo-Lum.

Of the residency program graduates who elect to stay in the state, said Buenconsejo-Lum, "less than 20 percent are in a small group private practice." Most of the graduates work in community health centers or for Kaiser Permanente. That's because Hawaii's notoriously high cost of living takes a toll on physicians trying to run small practices, she said. ■



Sheri Porter/AAFP News Now

AAFP Makes Extra Effort to Equip Members for ICD-10

New Resources Available

By Sheri Porter

The date for implementing ICD-10-CM is on the horizon. And to ensure that family physicians are ready, the Academy has added to its cache of resources ahead of the Oct. 1, 2013, implementation date.

Materials new to the ICD-10-CM resource site include

- ICD-10 Codes for Signs and Symptoms;
- ICD-10 Codes for Hypertension and Hypotension; and
- a presentation titled "5010 & ICD-10 Overviews" created by Cynthia Hughes, C.P.C., an AAFP coding and compliance specialist.

According to Hughes, the change from ICD-9 codes to ICD-10 codes will affect just about every family physician.

Similarly, the change to the 5010 transaction standards — as mandated by the Health Insurance Portability and Accountability Act — will affect all parties that send health information in electronic formats. For example, the new standards will affect patient eligibility inquiries and claims submissions and, thus, software vendors and clearinghouses, claims processors and payers, and physicians and other health care professionals.

"This is a significant change, and physicians need to get their practices ready," says Hughes.

Debbie Kalthoff echoes Hughes' concerns regarding practice readiness for ICD-10 and for 5010 transactions that go into effect on Jan. 1, 2012. As the billing manager for Meritas Health Corp., Kalthoff oversees the billing for seven hospital-owned primary care clinics and three subspecialty clinics. She has been deeply involved in preparing the practices that rely on her expertise for the change.

"If you're not ready for it, your claims are not going to go through, and you're not going to get any money. Your cash flow is going to suffer," she says.

Kalthoff advises practices to be in close touch with their software vendors. "The key is your software vendor, because the vendor is going to have to guide you through and help you," she notes.

For example, Kalthoff says her organization's software vendor — who, in her case, also serves as the clearinghouse — is in the "testing mode" and has been sending some test claims through to payers in the new 5010 format.

"They started testing last fall, and as of December, they only had one payer that was accepting 5010 transactions," says Kalthoff. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110310icd10resources.html>.

CMS Creates Two Sets of Criteria for E-Prescribing Incentive Program

AAFP Dissects Rules for Incentive Payments, Penalties

Family physicians participating in CMS' electronic-prescribing, or eRx, incentive program must meet two different sets of criteria if they want to both avoid a penalty and earn an incentive payment, according to a recent *MLN Matters* article.

According to the article, physicians must

- submit 10 Medicare claims to avoid a 2012 e-prescribing penalty, and
- submit 25 Medicare claims to earn a 2011 incentive and avoid a penalty in 2013.

Additionally, physicians may use a qualified electronic health record, or EHR, or a registry to submit data to qualify for the 2011 incentive payment and avoid the 2013 penalty.

Confused? It all boils down to CMS' interpretation of Section 132 of the Medicare Improve-

ments for Patients and Providers Act of 2008, says Cynthia Hughes, C.P.C., an AAFP coding and compliance specialist and co-author of *Family Practice Management's* "Getting Paid" blog.

CMS specifies that to avoid a penalty against Medicare payments in 2012, physicians must submit 10 Medicare fee-for-service claims before June 30, 2011, that include the additional e-prescribing "G" code 8553 and specific CMS-designated codes in the denominator.

The agency must receive the information from physicians by June 30, 2011, to determine which physicians will incur the penalty beginning Jan. 1, 2012. It's a timing issue, says CMS, noting that it will not even start to



receive and process data from EHRs and registries until after Jan. 1, 2012, the date that the agency will apply penalties to physicians' Medicare payments.

CMS will penalize physicians who are not deemed e-prescribers by reducing Medicare payments by

- 1 percent in 2012,
- 1.5 percent in 2013, and
- 2 percent in 2014.

Ironically, physicians who suc-

cessfully participate in the eRx program by submitting 25 claims within the calendar year via a registry or EHR — but who do not submit 10 claims with the G8553 code before June 30 — will be subject to the penalty in 2012, but they still will be eligible for the 2012 eRx incentive.

"Physicians who find themselves in this situation will break even, because they will pay a 1 percent penalty and earn a 1 percent incentive," says Hughes.

Hughes points out that physicians earning the 2011 eRx incentive will be exempt from the eRx penalty in 2013 because CMS will use the 2011 reporting period to determine which physicians incur a penalty in 2013. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110308erxprogram.html>.

Don't Think the ACO Model Works Within Primary Care? Think Again

By James Arvantes

As a staff physician for the WellMed Medical Group in San Antonio, Texas, which mostly employs family physicians and internists, FP Jose Salinas, M.D., is part of one of the few primary care-based accountable care organizations, or ACOs, in the country. And Salinas couldn't be happier. His participation in the model allows him to see 15-20 patients a day, a caseload that permits him to really focus on the needs of his patients.

"We don't have to worry about generating 30 or 40 patient visits a day to make ends meet," Salinas said of the ACO model, which is not based on fee-for-

service. Thus, he has time to address all of his patients' needs and manage their chronic conditions better, which leads to improved quality of care.

As an early adopter of the ACO model, WellMed has repeatedly demonstrated how primary care and the patient-centered medical home, or PCMH, can work in tandem to reduce costs and improve care while also enhancing and even saving lives.

"WellMed has shown that family physicians can lead and govern the development of ACOs and that these entities can, in turn, improve quality and save money with family physicians in the lead," said

Gary Piefer, M.D., M.S., a family physician and chief medical officer of WellMed Medical Management Inc., the parent company of WellMed Medical Group.

Unlike nearly every other ACO in the country, the WellMed ACO is not affiliated or dominated by a large hospital or insurance company. It is primary care-based and -driven, according to Robert Phillips, M.D., M.S.P.H., executive director of the AAFP's Robert Graham Center and the lead author of a case study on the WellMed Medical Group in the January/March 2011 issue of *The Journal of Ambulatory Care Management*.

One in five Medicare-eligible

seniors in the San Antonio area is a WellMed patient, and according to the Graham Center study, the mortality rate for WellMed patients is consistently and substantially lower than that of other seniors in Texas.

Meanwhile, WellMed's hospital admission rates average fewer than 200 patients for every 1,000 patients in San Antonio compared with 350-425 patients for every 1,000 patients 65 and older in Medicare fee-for-service programs, according to Piefer.

All of the clinics in the Texas and Florida markets operate as PCMHs, a cornerstone of the ACO, according to Piefer. He is convinced that the PCMH model must be the foundation of ACOs if they are to succeed and thrive in the long term.

"In the medical home, care coordination is seriously addressed and is managed in a manner that cannot be accomplished in an acute-care, fee-for-service productivity model," Piefer said.

WellMed patients "get used to the fact that they have a medical home," said Salinas. "When patients have a medical issue, they call our clinic first. They don't immediately go to the hospital emergency room or go see a specialist. They come to us first, and then we can determine what the best option is for that patient."

WellMed physician Chris Arnold, M.D., of San Antonio, described the WellMed ACO model as just good care. "If you provide good care, the patients will be happy. They will keep coming to you. I can't tell you of all the self-referrals we have gotten just because of the care we provide. The word gets out that patients are going to get taken care of." ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110316wellmedaco.html>.



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Primary Care Essential to Controlling Health Care Costs, Says AAFP President

Legislative Staff Members Get an Earful From Primary Care Leaders

By James Arvantes • Washington

Although "cause and effect are sometimes hard to prove, almost all data show an incredibly strong correlation between increased numbers of primary care physicians caring for a population and slower growth in costs and higher quality of health care." That was the message AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, delivered during a March 1 congressional staff briefing on Capitol Hill.

Primary care is essential to achieving the simultaneous goals of controlling health care costs and improving quality, said Goertz. As a result, federal lawmakers must continue to support primary care workforce programs and take steps to better reward the value that primary care and family physicians bring to the health care system.

Goertz spoke as part of a three-member panel at the briefing, which was convened by the Partnership for Primary Care Workforce, a nonpartisan, nationwide effort to strengthen and improve America's primary care workforce. The AAFP is a founding member of the partnership.

During his part of the presentation, Goertz described some of the programs that have strengthened the nation's primary care infrastructure, including health professions grants found in Section 747 of Title VII of the Public Health Service Act, which provide funds for training family physicians, and the National Health Service Corps, or NHSC.

Title VII funding has promoted primary care training in both community and academic environments and has played a major role in the development of family

medicine training programs, said Goertz. "The studies that have been done on medical schools and departments that have received funding from Title VII have a very good track record of producing more primary care physicians for needy areas in this country and more primary care physicians in general."

Goertz also praised the NHSC, which provides financial support for primary care physicians who agree to practice in underserved communities for a certain length of time. "Students look for a way to (pay off) debt as soon as possible, and the National Health Service Corps is a way to do so," he said. "It provides a valuable path for students to choose primary care."

Goertz decried the income disparities between primary care



AAFP President Roland Goertz, M.D., M.B.A., right, discusses workforce policies with Stephen Shannon, D.O., M.P.H., president of the American Association of Colleges of Osteopathic Medicine, during a congressional staff briefing on Capitol Hill.

and nonprimary care physicians. These income differentials are a major reason why the country is now facing a shortage of primary care physicians, said Goertz. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110307ppcwbriefing.html>.

Groups Worry CMS' Home Health Face-to-Face Rule Too Burdensome

The AAFP and a dozen other national health organizations are calling on CMS to delay the April 1 implementation date for the agency's face-to-face encounter rule that applies to patients needing home health care.

Enforcement of the rule should be delayed until no earlier than July 1, say the groups.

The rule stems from CMS' interpretation of section 6407 of the Patient Protection and Affordable Care Act and states that a physician who certifies a patient as eligible for Medicare home health services must see the patient in a face-to-face encounter within 90 days before the start of home health care or within 30 days after the start of care.

The provision went into effect on Jan. 1, but CMS agreed in December of last year to delay enforcement until April.

In a March 12 letter to CMS Deputy Administrator and Center for Medicare Director Jonathan Blum, the organizations — including, in addition to the AAFP, the AMA, the American Academy of Home Care Physicians, the American College of Physicians and the National Association for Home Care & Hospice, or NAHC — now are asking CMS to further extend the rule enforcement date to no earlier than July 1.

Since this story first posted online, CMS announced its decision to stand by the April 1 implementation date for the face-to-face encounter rule.

"Despite the extraordinary efforts to achieve a level of understanding and an intention to comply, all of the undersigned parties are very concerned that patients will lose access to vitally needed care," says the letter.

Among numerous reasons necessitating the extension of the transition period, say the groups, are the results of a comprehensive NAHC survey that documented

- confusion regarding the paperwork obligations for physicians,
- still-evolving policy interpretations and guidance, and
- the need for more time to ensure that physicians and non-physician providers understand the requirements of the face-to-face rule.

The letter specifically points to physician angst with an ever-growing documentation burden demanded by CMS and other agencies and notes that "physicians have voiced concerns that burdensome documentation procedures are often barriers to achieving compliance."

In particular, the letter takes issue with CMS' interpretive guidance that requires physicians to provide a "narrative" as to why a patient's clinical findings specifically support Medicare coverage.

"Many physicians see this added documentation component as unnecessary, duplicative and unduly burdensome," says the letter. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110316homehealthface.html>.

AS WE SEE IT

Voices From the AAFP

From the President

The Battle for Better Pay Continues

By Roland Goertz, M.D., M.B.A.

When it comes to improving payment for family physicians, we made incremental but significant progress last year and hope to make even more headway this year. But many members still ask me, *Why isn't it happening faster? Can't the Academy do more to help my practice reach firm financial ground?*

If you've felt the same concerns, I understand your frustration. We all yearn for appropriate rewards for what we do. Our payment problems have built up over time, and it will take time to correct them – especially given today's political wrangling over the federal deficit and a focus on "cost cutting." We'll keep fighting, but improvements will likely continue to come increment by increment, at least for now. The good news is that increments do add up.



Roland Goertz, M.D., M.B.A.

2010 Successes – and Averting Disaster

AAFP resources are finite, so we direct most of our payment efforts to where they can make the biggest difference. And that means focusing primarily on Medicare and Medicaid. Historically, when Medicare makes a change, the commercial market eventually follows.

In 2010, our most protracted battle was fending off the biggest threat to physician solvency – the looming 25 percent Medicare pay cut caused by the sustainable growth rate, or SGR, formula. Along with others in organized medicine, we kept up constant pressure to avoid the cut and fix the SGR, convincing Congress to act five times to pass payment patches.

Although the SGR battle likely was our biggest challenge, we also had clear victories such as these:

- **Incentive payment for primary care only.** This 10 percent bonus is relatively modest, but it's also enormously important because it shows the government's intent to support primary care. CMS included regulations for the bonus last July in its preliminary Medicare physician payment rule for 2011. Our analysis showed that the bonus regulations didn't go far enough: Only 59 percent of FPs would likely meet the eligibility criteria. In a letter to CMS, we proposed changes to boost the percentage of qualifying FPs to about 80 percent, and we also met with CMS Administrator Donald Berwick, M.D., to press our case. We were very pleased when CMS incorporated our proposals in the final rule.

- **Axed consultation codes.** CMS, of its own volition, announced it would stop paying for CPT codes for consultation services and would redistribute the relative values from those services to services FPs commonly perform. Others in organized medicine fought back

because their members often used those higher-paying consultation codes. We urged CMS to stick to its guns, and it did – resulting in yet another payment bump for you in the codes you use most often.

- **Medicaid payment boost.** Since the stinginess of Medicaid payments in many states is a huge issue for us, the AAFP strongly supported the health care reform law's requirement for parity between Medicare and Medicaid payments for primary care services.

- **Reprocessed claims.** Last December, CMS was still dragging its feet on reworking a slew of Medicare claims originally processed before the Affordable Care Act passed with provisions retroactive to Jan. 1, 2010. With other medical groups, we sent a letter telling CMS it was high time to make good on the money they owed doctors. It worked: CMS ordered its Medicare contractors to reprocess the claims and pay you the money you're due.

The Continuing Fight

In 2011, improved payment continues as one of our top priorities. I recently joined several other AAFP leaders on Capitol Hill for meetings with House leaders, new House members and their staffs. We gave them an earful about our payment concerns! I was elated to hear the chair of the Ways and Means Subcommittee on Health, Rep. Wally Herger, R-Calif., say he understood the issues we're facing.

I flew back to Washington just a few weeks later, speaking at a briefing for staff of new members of Congress that was convened by the Partnership for Primary Care Workforce. I told them that the data show an incredibly strong correlation between increased numbers of primary care physicians and slower growth in costs and higher quality of care, and I decried the income disparities between primary care and non-primary care physicians.

But the cost containment and deficit reduction climate in Congress makes our fight even more difficult this year. Every increase considered for us will have to be balanced by cuts somewhere else. However, we have a trump card: We're presenting policymakers with the only substantial model shown to bend the cost curve: the patient-centered medical home.

I'd like to close with my hope that all of us – conservative, liberal and in between – can look past our own political viewpoints and seize our opportunity to keep improving the circumstances for the specialty we love. If we're going to get the payment and workforce changes that need to happen, all of us have to band together to keep raising awareness – all the way up to the president – about what we family physicians can do to create a better health care system. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20110325paymentbattle.html>.