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Obama Taps FP Regina Benjamin, M.D., M.B.A., for Next U.S. Surgeon General

By Cindy Borgmeyer

Family physician Regina Benjamin, M.D., M.B.A., has spent the past 20 years caring for some 2,500 of Alabama's working poor in the Bayou La Batre Rural Health Clinic she founded along the state's Gulf Coast. But President Obama's announcement in July that Benjamin is his choice for the nation's top physician post could mean she'll spend the next few years focusing on a much larger patient population.

Obama formally introduced Benjamin, an Academy member since 1987, as his nominee for U.S. surgeon general during a press briefing in the White House Rose Garden. The president praised Benjamin's commitment to caring for patients regardless of their ability to pay for their health services. And he lauded her perseverance in rebuilding her clinic after Hurricane Georges destroyed it in 1998,



Lawrence Jackson/White House photographer

President Obama listens as Regina Benjamin, M.D. M.B.A., his nominee for U.S. surgeon general, speaks at a White House press briefing at which Benjamin is introduced.

again after Hurricane Katrina leveled it in 2005, and yet again when it burned to the ground on the eve of its reopening.

"For nearly two decades, Dr. Regina Benjamin has seen in a very personal way what is broken about our health care system," Obama said. "She's seen an increasing number of patients who've had health insurance their entire lives suddenly lose it because they lost their jobs or because it's simply become too expensive. She's been a relentless promoter of prevention and wellness programs, having treated too many costly diseases and complications that didn't have to happen. And she's witnessed the shortage of primary care physicians in the rural and underserved areas where she works."

AAFP President Ted Epperly, M.D., of Boise, Idaho, greeted the

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CMS Proposes Rule to Increase Primary Care Payments

By James Arvantes

The AAFP strongly supports a proposed CMS rule that would increase Medicare payments for family physicians by 8 percent in 2010 via key changes to the Medicare physician fee schedule.

"This is outstanding," said AAFP President Ted Epperly,

M.D., of Boise, Idaho, in an interview with *AAFP News Now*. "The proposed rule finally shows that the federal government is serious about making primary care and family physician practices stronger. It is about investing in the services of primary care and family physicians for what we do

for the health care system and for the care of our patients."

CMS assigns relative values to CPT codes for medical, surgical and diagnostic services. These codes determine the level of payment medical professionals receive for providing such services. Under the proposed

rule, CMS would no longer pay for nearly all consultation codes, which pay more than office visits billed under standard evaluation and management, or E/M, codes, although both represent essentially the same activities.

CMS proposes using the savings

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The CDC is urging physicians to immediately reinstate the Hib booster dose for children ages 12-15 months.

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The FDA recommends that prescription drugs containing acetaminophen and certain painkillers come off the market.

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news enthusiastically. "Here is a wonderful example of a family physician who has worked in the trenches all her life, and for her to get picked — it's a dream come true," he told *AAFP News Now*.

"The AAFP could not be prouder to have a family physician like Dr. Benjamin be the next surgeon general," Epperly added. "She is exactly the type of person that our health care system needs at this critical time of health care transformation. She will bring a family physician's touch and sensitivity to our nation's most pressing health care problems and is exactly 'what the doctor has ordered' to move the United States to a better health care system."

Naming a number of her own family members who have perished from preventable diseases, Benjamin said during the press briefing that she welcomed the opportunity to help create a health system that better serves Americans. "I want to ensure that no one — no one — falls through the cracks as we improve our health care system," she said.

"These are trying times in the health care field. And as a nation, we have reached a sobering realization: Our health care system simply cannot continue on the path that we're on. Millions of Americans can't afford health insurance, or they don't have the basic health services available where they live," said Benjamin, who served in the National Health Service Corps to repay her medical school debt.

"My hope, if confirmed as surgeon general, is to be America's doctor, America's family physician," she said. "As we work toward a solution to this health care crisis, I promise to communicate directly with the American people to help guide them through whatever changes may come with health care reform." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090713reg-benjamin.html>.

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generated by this change in payment policy to bolster payments for E/M codes.

The agency, which issued the proposed rule July 1, also would use more recent data to calculate practice expense relative values. This would result in higher payments for primary care services.

In addition, CMS would revise malpractice CPT work values, thus triggering a further increase in payments for primary care physicians. If implemented, the changes suggested by CMS would result in an average increase of 8 percent in total Medicare allowed changes for family physician practices, according to impact analysis tables in the proposed rule.

CMS published the proposed rule in the July 13 *Federal Register*; the agency will accept public comments on the proposal

through Aug. 31. The final rule will be published on Nov. 1 and would go into effect on Jan. 1, 2010.

"It is just a proposal right now," said Epperly. "CMS will

"The proposed rule finally shows that the federal government is serious about making primary care and family physician practices stronger."

— Ted Epperly, M.D., AAFP President

gather feedback from all sorts of entities who will likely push back on this."

However, Epperly added, it is significant that CMS has put the proposed rule in writing at the same time that Congress is debating health care reform legislation. "It is an indicator of changes in the government that could favor primary care," said Epperly.

If enacted, the proposed rule would bolster family medicine practices while also "sending a very strong message to medi-

cal students about the viability and importance of primary care," Epperly told *AAFP News Now*.

By law, the CMS proposal has to be budget-neutral, and certain subspecialty groups, whose payments would be negatively affected by the proposed changes, oppose the proposed rule. For example, the American College of Cardiology, describes the proposed rule as "a grave threat to cardiology practices and the patients they serve." The association has vowed to "wage an aggressive campaign to prevent implementation of these damaging policies."

"I would tell the subspecialists that, 'We are all in this together for the good of taking care of patients,'" said Epperly. "What this proposed rule does is to help the primary care part of the equation become whole." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090708cms-cpt-rule.html>.



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AAFP President Takes Message to Capitol Hill

Primary Care Has Critical Impact on Health Care Outcomes

By James Arvantes • Washington

Legislation that underscores the critical role of primary care by providing support for the patient-centered medical home, aligning incentives to embrace value over volume, and ensuring the adequacy of the primary care workforce is vital to health care reform. That was the message delivered by AAFP President Ted Epperly, M.D., of Boise, Idaho, during his testimony before the House Ways and Means Committee here on June 24 and a House Energy and Commerce health care subcommittee here on June 25.

"Achieving quality, affordable health care coverage for all will require a significant invest-



AAFP President Ted Epperly, M.D., right, visits with Rep. Charles Rangel, D-N.Y., chair of the House Ways and Means Committee, before testifying before the committee on the importance of primary care.

ment in the health care system," said Epperly before the Ways and Means Committee. "However, simply paying for more of the

same fragmented, uncoordinated, procedure-based health care will not make us healthier and will not begin to control health care costs."

"Primary care is the only form of health delivery charged with the long-term care of the whole person and has the most effect on health care outcomes," Epperly told the Energy and Commerce health care subcommittee.

The three committees in the House responsible for drafting health care reform legislation released an 852-page draft of a health care reform bill on June 19. That bill, said Epperly, "goes a long way toward providing quality, affordable health care coverage for everyone in the United States."

The draft legislation includes a 5 percent bonus for primary care services and as much as a 10 percent bonus for primary care services provided in a health professional shortage area. The payments would be provided for services to ensure "accessible, continuous and comprehensive care." Moreover, the draft legislation specifies that to qualify for the bonus, at least 50 percent of a physician's services must be primary care.

"We estimate that 68 percent of family physicians would qualify," Epperly said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090702epperly-house-test.html>.

Primary Care Physician Shortages Imperil Health Care Reform, Says AAFP President-elect

Health care reform will not succeed without an adequate supply of primary care physicians, making it incumbent upon Congress to enact policies that increase the nation's primary care physician workforce. That's what AAFP President-elect Lori Heim, M.D., of Vass, N.C., said during testimony before the House Small Business

Committee on July 8.

Heim told the committee that the current supply of primary care physicians is "far from adequate," and future projections about upcoming shortages are "truly alarming."

"Primary care has been described as the base of the health care workforce pyramid," said Heim, who spoke during a hearing on physician workforce shortages. "But the U.S. physician profile is only 31 percent primary care and 69 percent (sub) specialty care."

The AAFP supports steps to make primary care physicians at least 45 percent of the nation's health care workforce, said Heim, who urged Congress to adopt workforce policies that would train primary care physicians in the patient-centered medical

home model of care.

"To realize the quality and efficiency benefits of the patient-centered medical home, we must have an adequate supply of primary care doctors, particularly family physicians," said Heim.

Heim told the committee that the vast majority of family physicians are small business people, delivering care to communities across the nation. "Nearly 38 percent of family doctors practice in solo or two-physician practices," she said. "Studies indicate that more Americans depend on family physicians than on any other specialty. We see up close the hardship of the uninsured, and we struggle along with those patients who are insured but who then face coverage denials.

"The status quo is not working, neither for the physicians

nor for patients," said Heim. "We urge Congress to invest in the health care system that we want, not the one we have now."

Rep. Nydia Velazquez, D-N.Y., chair of the Small Business Committee, agreed with Heim's points, saying, "the current physician shortage is already posing a significant threat to (health care) reform."

"Reform will bring more uninsured Americans into the fold, but it won't create more doctors to treat them," said Velazquez. "Take the 46 million newly insured, add in an aging baby boomer population, and you could very well have a recipe for disaster." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090715heim-sbc-tstmy.html>.



AAFP President-elect Lori Heim, M.D., left, and American Osteopathic Association President Carlo DiMarco, D.O., testify before the House Small Business Committee.

CDC Reinstates Hib Booster Dose for 12- to 15-month-olds

Children Deferred During Shortage Should Be Vaccinated at Next Visit

After more than a year and a half of deferrals, the booster dose of *Haemophilus influenzae* type b, or Hib, vaccine should again be considered a routine part of the childhood immunization schedule.

The CDC — in consultation with its Advisory Committee on Immunization Practices, or ACIP; the AAFP; and the American Academy of Pediatrics — is recommending that physicians immediately reinstate the Hib booster dose for children ages 12-15 months who have completed the three-dose primary series.

“Through appropriate vaccination, family physicians rarely encounter children with serious and life-threatening infections



Read more vaccine-related stories in the Special Report on Vaccines & Immunizations on pages 7-10 of this issue of *AAFP News Now*.

caused by *Haemophilus influenzae*,” said Jonathan Temte, M.D., Ph.D., an associate professor in the department of family medicine at the University of Wisconsin School of Medicine and Public Health, Madison, and a member of the ACIP. “Full immunization for protection against *Haemophilus influenzae* type b is dependent on the appropriate initial series and the booster dose. As supplies of vaccine have increased, clini-

cians need to resume this booster dose routinely at age 12 to 15 months.”

Temte said a booster dose should be given to older children in whom the booster was deferred (i.e., those as old as age 59 months) at the next routinely scheduled office visit.

The CDC said in a *Morbidity and Mortality Weekly Report* released June 25 that although supply has increased sufficiently

to resume on-time administration of the booster dose in infants ages 12-15 months and begin catch-up vaccination, “supply is not yet ample enough to support a mass notification process to contact all children with deferred Hib booster doses.”

Instead, the agency recommended that physicians

- review medical records or immunization information systems to identify children in need of the booster dose before office visits,
- evaluate children’s vaccination status during visits, and
- share immunization schedules with parents and make them aware of the plan for Hib boosters. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090701hib-reinstated.html>.

New ACIP Provisional Recs Cover Multiple Immunization Topics

Panel Expresses ‘General Preference’ for Combination vs. Component Vaccines

The CDC’s Advisory Committee on Immunization Practices, or ACIP, produced several provisional recommendations during its June 24-26 meeting in Atlanta, including one expressing an overall preference for combination versus component vaccines. Other recommendations ACIP members voted on range from changes in the postexposure rabies vaccination protocol to expanding meningococcal immunization recommendations for at-risk individuals.

Although committee members approved a recommendation stating a general preference for the use of combination vaccines rather than separate injections of equivalent component vaccines, they said clinicians should consider various factors when making such decisions, including patient preference, the potential for adverse events, comparative vaccine storage costs and availability, and the likelihood of patient compliance.

The committee made an exception in its recommendation for the combined measles, mumps, rubella and varicella, or MMR-V, vaccine. Compared with separate injections of MMR and varicella vaccines, administration of MMR-V vaccine has been associated with one more febrile seizure per 2,000 children immunized.

ACIP members said that for children ages 1 year through 3 years, either the combination MMR-V or MMR plus varicella separately were acceptable, but they noted that physicians should discuss the risks and benefits of both options with parents. For children ages 4 and older, the committee deferred to its aforementioned preference for combination products.

The ACIP also recommended reducing the number of doses of postexposure rabies vaccinations from five to four based on vaccine shortage and evidence that the fifth dose is not necessary.

In addition, ACIP members voted to remove “physician-diagnosed disease” as evidence of MMR immunity for health care workers and replace it with a requirement for laboratory-confirmed diagnosis of disease.

The ACIP is recommending that individuals ages 7 through 55 who remain at increased risk for meningococcal disease five years after vaccination with meningococcal polysaccharide diphtheria toxoid conjugate vaccine, or MPSV, should be revaccinated with quadrivalent meningococcal conjugate vaccine, or MCV4. Children at high risk who received their first dose at ages 2 through 6 years should be revaccinated after three years.

The committee updated its recommendations for immunization against Japanese encephalitis to include Ixiaro, a vaccine that was approved by the FDA in March, for travelers to Asian countries where the disease is endemic. ACIP members also said travelers should be advised of the risks of Japanese encephalitis and how to avoid mosquito bites.

The current recommendations for polio vaccine were amended to stress that the last dose should be given after 4 years of age and six months after administration of the previous dose. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090708acip-rndup.html>.

CDC's Advisory Committee Gives Thumbs-up to New Antiviral Recs

Agency Gearing Up for Possible H1N1 Vaccine Distribution

Members of the CDC's Advisory Committee on Immunization Practices, or ACIP, approved new antiviral treatment recommendations during the committee's June 24-26 meeting in Atlanta. The recommendations originally were released as interim guidance last year in the wake of oseltamivir resistance among circulating seasonal influenza A (H1N1) viruses.

The recommendations call for use of

- zanamivir or a combination of oseltamivir and rimantadine (or amantadine if rimantadine is not available) for treatment of seasonal influenza A (H1N1) virus infection; and
- oseltamivir or zanamivir for treatment of seasonal influenza A (H3N2), novel influenza A (H1N1), or influenza B virus infection.

According to the CDC, all currently circulating influenza viruses, including novel influenza A (H1N1), are sensitive to zanamivir.

During a June 26 media briefing after the ACIP meeting concluded, Anne Schuchat, M.D., director of the CDC's National Center for Immunization and Respiratory Diseases, or NCIIRD, advised physicians to focus their use of antiviral medications on people in high-risk groups, as well as the elderly and young children. Although the majority of cases and hospitalizations are in younger patients, she said, when people 65 and older contract the novel H1N1 virus, their chance of dying is greater.

Five vaccine manufacturers are working to develop a vaccine for the novel H1N1 virus, but Schuchat said no decision has been made to go forward with a national immunization program for the pandemic flu. The vaccine still must be tested and approved by FDA.

CDC officials told ACIP members during the meeting that the agency is confident that vaccine – possibly as much as 60 million doses – will be available by October. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090701acip-h1n1.html>.

Infected Workers Pose Risk to Patients, Colleagues

At least 81 health care workers across the country have confirmed or probable cases of novel influenza A (H1N1), evidence that some workers are not following CDC guidance for personal protection from infectious disease.

Michael Bell, M.D., associate director for infection control in CDC's Division of Healthcare and Quality Promotion, said in a June 18 news conference that health care workers should use fit-tested respirators, gloves and eye protection when caring for a patient with probable H1N1 infection.

He also said that such patients should be placed in single-patient rooms to reduce the risk of transmission, and they should be instructed about proper respiratory hygiene and cough etiquette. Good hand-washing hygiene also is a standard precaution.

Aerosol-generating procedures should be performed in rooms with negative-pressure air handling to prevent spread to other parts of the facility, said Bell. And it is critical that infectious patients be identified "at the front door" in order to protect health care workers and other patients. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090623h1n1-hcws.html>.

In Brief *Clinical Care and Research*

Three Intranasal Cold Medications Linked to Anosmia

The FDA is warning consumers to stop using three Zicam intranasal products. The warning comes after the agency said it had received more than 130 reports linking the cold medications to the loss of sense of smell. The three OTC products involved, along with each product's unit size and product number, are Zicam Cold Remedy Nasal Gel (15-ml, NDC 62750-003-10); Zicam Cold Remedy Swabs (20 swabs, NDC 67250-003-20); and Zicam Cold Remedy Swabs, Kids Size (20 swabs, NDC 67250-003-21). <http://www.aafp.org/news-now/news-in-brief/20090618news-brf-clinupd.html>

Leukotriene Modifiers Linked to Neuropsychiatric Events

The FDA is advising patients and physicians to be aware of the potential for neuropsychiatric events with the use of the leukotriene modifiers montelukast, which is marketed as Singulair; zafirlukast, which is marketed as Accolate; and zileuton, which is marketed as Zyflo and Zyflo CR. The agency also has requested that manufacturers include precautions in the drugs' prescribing information. FDA officials said neuropsychiatric events reported include agitation, aggression, anxiousness, dream abnormalities and hallucinations, depression, insomnia, irritability, restlessness, suicidal thinking and behavior, and tremor. <http://www.aafp.org/news-now/news-in-brief/20090618news-brf-clinupd.html>

FDA Approves Injectable Ibuprofen Product

The FDA has approved Caldolor, which is manufactured by Nashville, Tenn.-based Cumberland Pharmaceuticals Inc. and is the first injectable form of ibuprofen, to treat pain and fever. For acute pain, the medication may be administered in 400- to 800-mg doses, given as a 30-minute course every six hours. To treat fever, an initial 400-mg dose should be administered as a 30-minute course, followed by 400 mg every four to six hours, or 100-200 mg every four hours, as necessary. <http://www.aafp.org/news-now/news-in-brief/20090618news-brf-clinupd.html> ■

Diabetes Experts Recommend A1c Testing for Diabetes Diagnosis

An international committee of diabetes experts has recommended that the hemoglobin A1c assay, which now is routinely used to monitor the course of disease in patients with diabetes and signal the pending development of diabetic complications, should become the new “gold standard” for diagnosing diabetes.

The committee, which was assembled by the American Diabetes Association, the International Diabetes Federation and the European Association for the Study of Diabetes, presented its recommendations June 5 during the ADA’s 69th Scientific Sessions conference in New Orleans. The committee’s report was published in the July issue of *Diabetes Care*.

According to the committee, hemoglobin A1c values vary less than fasting plasma glucose, or FPG, levels, and A1c measurement has technical advantages compared with glucose testing. In addition, whereas both the FPG test and the less commonly used oral glucose tolerance test, or OGTT, require patients to fast, the A1c test does not.

“It’s going to be easier for family physicians to make a diagnosis,” said Michael Parchman, M.D., the AAFP representative to the National Diabetes Education Program convened by NIH’s National Institute of Diabetes and Digestive and Kidney Diseases and the CDC.

Parchman, who is the Mario E. Ramirez Endowed Distinguished Professor in the department of family and community medicine at the University of Texas Health Science Center at San Antonio, said physicians often must schedule a second appointment for patients they suspect may have diabetes if the FPG test or OGTT is used as the diagnostic tool.

“Sometimes, that could be a problem because of (patients’ issues with) transportation, mobility or scheduling,” he said. “Now, if you suspect diabetes, you can draw blood and send it to the lab right then. You don’t have to have them come in at a future date, which they might not be able to do. You don’t have as much problem with follow-up, and fewer patients fall through the cracks.”

A1c testing measures a person’s long-term (i.e., preceding two to three months) blood glucose exposure. That aspect of the test, said Parchman, gives physicians a more comprehensive understanding of a patient’s overall health than other commonly used tests. According to the committee report, it also makes the A1c test a better predictor of a patient’s risk for complications than single or episodic measures of glucose levels.

“It shows the degree of glucose exposure over time better than a one-point-in-time glucose tolerance test,” he said. “It’s not the kind of thing where a person can change (his or her) diet and level of exercise for a short period of time and have a good test. You can’t fudge it.” ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090624a1c-diab-dx.html>.

Treatment of Depression in Adults Should Consider Children

By David Mitchell

Physicians and other health care professionals who treat adults with depression also should consider the effects of the illness on their patients’ children, according to a new report from the National Research Council and the Institute of Medicine.

One in five adults suffers from a major depressive disorder during his or her lifetime, and far more suffer from mild depression, said Mareasa Isaacs, Ph.D., executive director of the Washington, D.C.-based National Alliance of Multi-Ethnic Behavioral Health Associations.



Isaacs, a member of the committee that developed the study report, said during a June 10 news conference announcing the report’s release that 7.5 million American parents suffer from depression each year, and nearly 16 million children live with those parents.

“Depression interferes with quality of parenting and puts children of all age levels at risk for poor health and development,” she said. “The message is that it’s really important to look at depression as something that affects not only the individual, but the children and other members of the family.”

Isaacs said that 75 percent of adults who suffer from depression have comorbid conditions, including other mental health and substance use issues. Two-thirds of adults with depression are not treated for the condition because of lack of insurance, inability to access care and other factors, she said.

Mary Jane England, M.D., president of Regis College, Weston, Mass., and past president of the American Psychiatric Association, served as chair of the committee that wrote the report. She said during the news conference that 2 percent to 4 percent of children born to parents with depression themselves suffer from depression as young children; as many as 40 percent of adolescents living with parents suffering from depression also have depression.

Although numerous factors influence child development, England said adolescents in this group also are at a higher risk for substance abuse.

Acknowledging that most treatment options available currently focus on the individual, the report advocates a two-generation approach to benefit the family as a whole. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20090701depress-study.html>.

Managing Vaccine Costs Ensures FPs Can Offer Patients Access to Needed Immunizations

By Sheri Porter

Family physicians know all too well that providing immunizations to their patients is an expensive service. That's why FPs — especially those who are running solo and small practices — need to make sure they have explored every avenue to reduce their immunization costs.

That's the mindset of James Cunnar, M.D., the sole proprietor of DuPage Family Medicine in Naperville, Ill.

He estimates that in his practice, expenses associated with vaccine costs, including purchasing, storing and administering the vaccine, run about \$60,000 a year. That's nearly eight percent of his monthly practice expenses.

About 18 months ago, however, Cunnar discovered a way to

trim at least 3 percent of his vaccine purchasing costs — or about \$1,800 a year — from his budget. He joined a comprehensive vaccine program called Atlantic Health Partners.



The company, which is based in Farmington, Conn., offers a purchasing program that provides participants with vaccines at lower prices than they would typically get buying directly from vaccine manufacturers or from third-party distributors.

Although there's no cost to

join the program, when physicians sign on they agree to abide by the company's purchasing requirements. "We ask that practices first look to use sanofi (pasteur) and Merck," said company CEO Jeff Winokur. That policy changes, however, in the event of product shortages and when physicians purchase sole-source vaccines, such as Wyeth's infant vaccine, Prevnar.

Participating physician practices continue to make purchases directly from sanofi pasteur and Merck, but they receive Atlantic's more favorable pricing and purchasing terms.

"The nice part was that our workflow didn't change," said Cunnar.

Under the Atlantic program, physicians receive the negotiated contract price regardless of how many vaccines are included in an order. Winokur said partici-

pating physicians receive product updates and special promotions, as well as assistance with vaccine inventory management, coding and billing.

Other options physicians can explore include the Vaccines for Children program, an initiative that provides children through 18 years of age with vaccines in their medical homes via private providers and other sources.

In addition, FPs can take advantage of the free expertise offered by Kelson Physician Partners, a vaccine savings program based in Aurora, Colo. The company offers lower vaccine prices through contracts with GlaxoSmithKline and MedImmune, but it also counsels practices on their vaccine buying habits. ■

For more information, visit <http://www.aafp.org/news-now/vaccine/20090804vacc-costs.html>.

Immunization Registries Depend on Physician Participation

One way to increase immunization rates in the United States is via physician participation in state and regional immunization registries. According to the CDC, however, only about one-third of private practice physicians participated in these programs in 2008.

America's physicians need to embrace vaccine technology and view it as a valuable resource that will make medical practices more efficient and keep patients healthier, according to Anne Cordon, M.P.H., president-elect of the American Immunization Registry Association.

"We need to get private providers who are outside of the public health realm using the registries; that's our big population we need to get in the next five years," said Cordon.

According to the CDC, only 37 percent of physicians in the private sector participated in registry programs in 2008. However, registry enrollment percentages may be deceptive because some individuals enroll but don't actively participate in the system.

Private practice physicians may not be aware that these registries exist, said Cordon, or they may not realize the efficiencies registries provide. She added that the registry sys-

tem offers physicians free training and support. "Their end of the deal is to enter data and to use it," she said.

And what do physicians who take the time to enter data into the system get in return? Registries have evolved to become much more than just data repositories that collect individual immunization records for children. Most registries now receive data on patients of all ages, and physicians are able to extract data that

- provides statistics on individual immunization coverage rates;
- helps physicians pinpoint where their practices are underimmunizing and overimmunizing;

- supplies ready access to the latest guidance from the CDC's Advisory Committee on Immunization Practice on new vaccines, vaccine combinations and immunization schedules;
- forecasts what shots a patient is due to receive at an office visit; and
- ensures the physician receives credit for patient immunizations given outside of the practice. ■



Brenda Reidenbach/AAFP News Now

For more information, visit <http://www.aafp.org/news-now/vaccine/20090804vacc-registries.html>.

Adolescent Vaccination Rates Climbing, but Fall Short of HHS Goals

By David Mitchell

Tetanus, diphtheria toxoids and acellular pertussis, or Tdap, vaccine is recommended for all 11- and 12-year-olds, but only 30.4 percent of eligible American adolescents received the combination vaccine in 2007, according to the CDC.

Although that figure represented nearly a 20 percent increase compared with 2006 coverage rates, physicians still need to do more to ensure this elusive cohort receives its recommended immunizations, according to Jonathan Temte, M.D., Ph.D, an associate professor in the department of family medicine at the University of Wisconsin School of Medicine and Public

Health, Madison, and a member of the CDC's Advisory Committee on Immunization Practices, or ACIP.

Adolescents make far fewer physician visits than younger children, so it is important to review their recommended immunizations at every visit and vaccinate teens and preteens whenever possible, according to Temte.

Family physicians are uniquely positioned to reach the parents of teens, he said. Parents should be reminded during their own office visits or during those of their younger children about the need to vaccinate their adolescent children.

With school about to start again, many adolescents will

be visiting physicians for school physicals, which provides a perfect opportunity to update needed immunizations.

In addition to Tdap, two other recommended adolescent vaccines had vaccination rates well below 50 percent in 2007. Quadrivalent meningococcal conjugate vaccine, or MCV4, also is recommended for all 11- and 12-year-olds, but only 32.4 percent of adolescents had received the vaccine in 2007, according to the CDC.

That was an increase from 11.7 percent in 2006, but Temte said the incidence of meningococcal disease begins to increase in early adolescence, and MCV4 can protect adolescents during

years of peak risk.

Also in 2007, 25.1 percent of adolescent girls had received at least one dose of the quadrivalent human papillomavirus, or HPV, vaccine that is recommended starting at age 11 or 12. That vaccine, which was approved in June 2006 and recommended by the ACIP later that fall, is given in a three-dose series.

Temte also emphasized the importance of seasonal influenza vaccine, which is recommended for all children from ages 6 months through 18 years. ■

For more information, visit <http://aafp.org/news/news-now/vaccine/20090804teen-shots.html>.

FPs' Personal Touch Can Persuade Parents to Vaccinate Kids

By Barbara Bein

Although immunization rates among infants and young children are at an all-time high, some parents still are reluctant to vaccinate their children. According to CDC immunization experts, however, family physicians are in a prime position to educate reluctant parents because of their ongoing relationship with those parents.

"Many parents have never seen a case of a vaccine-preventable disease, so they don't understand how serious these diseases can be," said Kris Sheedy, Ph.D., associate director of communication science for the CDC's National Center for Immunization and Respiratory Diseases, or NCIRD. "(Health care) providers are the most trusted sources (of information) for parents. A recommendation from a physician goes a long way."

According to a recent study, "Parental Refusal of Pertussis Vaccination Is Associated With an Increased Risk of Pertussis Infection in Children," evidence suggests that the number of parents who refuse immunizations has steadily increased during the past decade, and the consequences can be distressing. In this case, children of parents who refused pertussis immunizations were at increased risk for pertussis compared with children of parents who accepted the vaccinations.

"These findings stress the need to further understand why parents

refuse immunizations and to develop strategies for conveying the risks and benefits of immunizations to parents more effectively," said the study in the June *Pediatrics*.

In focus groups the NCIRD has conducted, parents who are

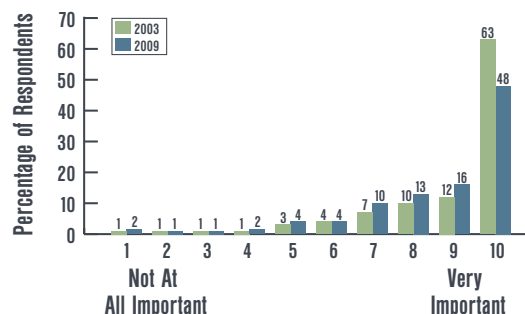
inclined to refuse vaccines or to spread them out can't be persuaded to change their opinions by physicians who use heavy-handed tactics. Such parents, said Sheedy, "want to feel like they are partners in the decision-making process. They want a provider who will work with them. So providers have to take the time to listen and understand the parents' concerns."

The CDC has developed various online resources physicians can download and hand out to concerned parents, including Vaccine Information Statements, or VISs,

that describe each vaccine's risks, benefits and possible adverse reactions. The VISs also provide information about the National Vaccine Injury Compensation program, a no-fault alternative to the traditional tort system for resolving vaccine injury claims. The program provides compensation to people who have been injured by certain vaccines. ■

For more information, visit <http://www.aafp.org/news-now.vaccine/20090804vacc-parents.html>.

How Important are Immunizations for Keeping Children Healthy?



Source: CDC.

Brenda Reidenbach/AAFP News Now

Poor Flu Vaccination Rates Among Health Care Workers Imperil Patients, Colleagues

By David Mitchell

Health care workers play a vital role in providing influenza vaccinations, but too many of those workers don't protect themselves, their patients and their co-workers from a disease that kills an average of 36,000 Americans a year.

A literature review of 32 influenza immunization programs conducted between 1985 and 2002 in the United States, Canada and Europe found that immunization campaigns achieved vaccination rates of less than 50 percent.

A 2004 report from the National Foundation for Infectious Diseases, or NFID, cited a 2003 CDC report stating that only 36 percent of the nation's health care workers were vaccinated against the annual flu, and that lack of immunization had been a source of flu outbreaks in health care settings.

The NFID report said health care workers should be provided convenient, affordable access to

influenza vaccine, and employers should demonstrate that immunization is a safety priority for patients and workers.

Doug Campos-Outcalt, M.D., M.P.A., the AAFP's liaison to the CDC's Advisory Committee on Immunization Practices, or ACIP, said health care workers need to be educated and motivated.

"Vaccine is usually covered by insurance," said Campos-Outcalt, who is associate head of the department of family and community medicine and assistant dean for outreach and multicultural affairs at the University of Arizona College of Medicine, Phoenix. "The issue for health care workers is not usually cost. It is seeing it as important."

AAFP President Ted Epperly, M.D., of Boise, Idaho, said the Family Medicine Residency of Idaho, where he is program director and CEO, has achieved annual influenza vaccination rates of more than 90 percent in each of the

past two years among its 145 employees.

"We talk with them and educate them," Epperly said.

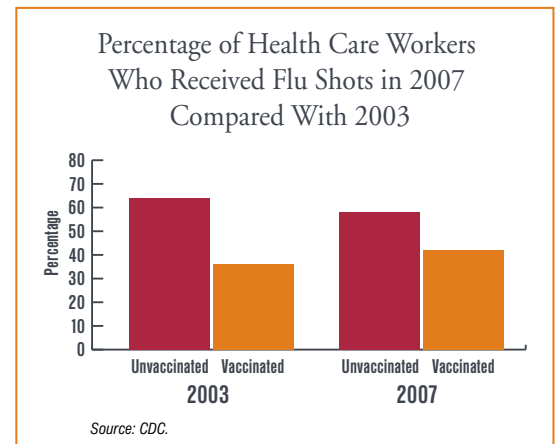
"We do this with handouts, information on our FMRI Web site, and I personally talk with the group as a whole. Employers do not emphasize the importance of this enough. They do not advocate, educate and market enough internally to their people. All employers need to make this a priority as they approach flu season."

Education of health care workers includes dispelling myths about the flu and the flu vaccine. A study from the County of San Diego Health and Human Services Agency Public Health Services Immunization Branch found that health care workers reported several unfounded reasons for not

receiving the vaccine, including that they thought they wouldn't get the flu because they were healthy; didn't know they were in a group recommended for vaccination; feared side effects or becoming ill from the vaccine; and thought the vaccine was ineffective.

According to the 2008 NFID report, immunization of health care workers significantly reduces the risk of outbreaks in all types of health care facilities and is 70 percent to 90 percent effective in preventing infection in healthy individuals ages 65 and younger. ■

For more information, visit <http://www.aafp.org/news-now/vaccine/20090804hc.workers.html>.



Brenda Reidenbach/AAFP News Now

Confusion, Safety Concerns Contribute to Low Seasonal Flu Vaccine Coverage Among Pregnant Women

It has been five years since the CDC's Advisory Committee on Immunization Practices, or ACIP, recommended that all women who are pregnant — and those who may become pregnant — during influenza season should be vaccinated. Yet immunization rates for this high-risk group remain alarmingly low.

According to the CDC, only 13 percent of pregnant women who did not have another condition that put them at risk for complications from flu — such as diabetes or heart disease — were vacci-

nated against seasonal influenza during the 2006-07 season.

Confusion among patients and physicians, as well as concerns about vaccine safety, have contributed to low vaccination rates among these women, said the CDC and other sources. However, a study from the Rhode Island Department of Health found that physicians can have a big influence on uptake.

The Rhode Island study, which spanned the 2005-06 and 2006-07 flu seasons, reported that 62.9 percent of pregnant

women who were offered the flu shot or whose physicians recommended they get the shot did so. Conversely, only 4.1 percent of pregnant women who were not offered vaccination or whose physicians did not recommend the vaccine were immunized during the same period.

The study found that less half of pregnant women — 46.6 percent — were offered the vaccination or were recommended for vaccination by their doctors.

Tony Fiore, M.D., M.P.H., medical officer in the CDC's

Influenza Division, said confusion may stem from the fact that most other vaccines aren't routinely recommended for pregnant women. In fact, varicella; zoster; and measles, mumps and rubella vaccines are contraindicated during pregnancy, while pneumococcal, hepatitis A, hepatitis B and meningococcal vaccines are recommended during pregnancy only when other risk factors are present. ■

For more information, visit <http://www.aafp.org/news-now/vaccine/20090804preg-women.html>.

Family Medicine Residencies Teach Many Strategies to Boost Immunization Rates

By Barbara Bein

Located in a state with one of the lowest immunizations rates in the country, the Oregon Health & Science University family medicine residency program in Portland has its work cut out for it. Its 36 physicians-in-training learn strategies that help them talk to parents about immunizations, educate those parents about the need for their children to be vaccinated and devise ways to make immunizations part of each visit.

Perhaps most importantly, they learn to understand the origins of parents' concerns about having their children vaccinated.

"These parents are not people who will respond to edicts," said program director Roger Garvin, M.D. Physicians "need to listen to them, understand what their concerns are, help them to see there is an ongoing need for immunizations."

Garvin told *AAFP News Now* that he's found it is essential to put vaccine-preventable diseases in context for parents — and that's what residents in his program are trained to do. It's precisely because vaccines have been so successful, he said, that people don't see certain diseases.

Garvin said he tells parents about his own experiences seeing children in the hospital with Haemophilus influenzae type b, or Hib, disease who suffered terrible brain damage and died. Since the introduction of Hib vaccine, he said, "I haven't seen a case of that. It's almost eliminated as a significant problem."

The mindset of parents doesn't stem from a lack of caring, Garvin said. Instead, these parents are trying to do everything right for their children. They see forgoing immunizations, or spacing them out, as healthy choices, similar to paying careful attention to diet, he said.

Outside of Oregon, other family medicine residencies also are working to boost their immunization rates.

In Macon, Ga., a state that generally has high immunization rates, the Mercer University School of Medicine/Medical Center of Central Georgia Family Medicine Residency has more than doubled its compliance rate for the series of 15 childhood immunizations needed to start school from 42 percent in 2004 to 91 percent in 2008.

According to program director Roberta Weintraut, M.D., the residency accomplished that goal using a multifaceted approach that included joining the Vaccines for Children program; tapping into the Georgia Registry of Immunization Transactions and Services, or GRITS, electronic tracking system; and educating parents, physicians, residents and staff.

"Some parents have resistance to having so many vaccines at once. Some babies get three, four, five immunizations in one day, and many parents will resist that. We say we'll do three today and another three in three or four weeks. GRITS tracks that for us," said Weintraut.

In addition to parents, physicians, residents and office staff members receive education and mentoring through Educating Physicians in their Communities, an immunization initiative of the Georgia AFP and the Georgia Academy of Pediatrics. ■

For more information, visit <http://www.aafp.org/news/news-now/vaccine/20090804residencies-vacc.html>.

Federal Officials Prepare for Resurgence of H1N1 Virus

By James Arvantes

Children and teenagers are two of the population groups most at risk from an expected resurgence of novel influenza A (H1N1) virus infection this fall. Because of this risk, the federal government is making plans to distribute through schools and daycare centers vaccine against the virus as soon as it becomes available, according to health care experts and Obama administration officials who spoke during a July H1N1 Influenza Preparedness summit at NIH headquarters in Bethesda, Md.

The federal government expects to have a limited supply of H1N1 flu vaccine ready by mid-October. According to HHS Secretary Kathleen Sebelius, the government is looking at different kinds of sites for vaccine distribution, including daycare centers and schools.

"There will be some access through traditional doctors' office and community health centers," said Sebelius in a response to a question posed by *AAFP News Now*. "But we may look at more community-wide vaccination programs to try and get this in the arms of the targeted populations as quickly as possible."

Sebelius said, "We are anticipating not doing this through the traditional vaccination system."

The Obama administration has released \$350 million in H1N1 preparedness grants to all states and territories; \$260 million will go directly to state health departments to prepare for a vaccination campaign, and \$90 million will go to help hospitals handle an expected surge in patients if an outbreak occurs in their community.

The emergence of the H1N1 virus has underscored inherent deficiencies in the U.S. health care system, deficiencies that make it more difficult for the federal government to achieve the concurrent goals of reducing illnesses and deaths while minimizing social disruptions caused by the virus, according to health care officials.

"We have a very erratic and inappropriate delivery system," said Sebelius. "There are literally millions of folks whose only access to health care is through the doors of emergency rooms, and we need hospitals to be prepared to deal with folks who are truly in desperate shape and who need to be hospitalized."

H1N1 has "put a spotlight on the fact that we currently don't have a system where every American has access to preventive care, doesn't have a health home and doesn't have a doctor to call," said Sebelius. ■



HHS Secretary Kathleen Sebelius, far right, discusses the novel influenza A (H1N1) virus. She is joined by Department of Homeland Security Secretary Janet Napolitano, far left, and CDC Director Thomas Frieden, M.D., M.P.H.

James Arvantes/AAFP News Now

For more information, visit <http://www.aafp.org/news-now/vaccine/20090804flu-prep-summit.html>.

Medical Organizations Urge HHS to Consolidate All Vaccines Under Medicare Part B

Many family physicians know all too well that Medicare beneficiaries' access to preventive vaccines covered under Medicare's Part D retail pharmacy benefit has been a complicated process since the Part D benefit was initiated late in 2005.

In an effort to remove the obstacles, the Academy, the AMA and more than 20 other medical specialty organizations are calling on HHS to include all recommended preventive vaccines under Medicare Part B.

In a June 25 letter to HHS Secretary Kathleen Sebelius, the organizations point out that Medicare beneficiaries have ready access to the influenza, pneumococcal and hepatitis B vaccines under Medicare Part B. However, access to vaccines under Part D is "complex and problematic"



because Part D is designed as a retail pharmacy benefit.

That means patients usually purchase Part D vaccines in their physician's office — which is considered an out-of-network provider — and then file a claim for reimbursement from their Part D plan.

"This creates a significant barrier to access, especially for

low-income beneficiaries," says the letter.

Furthermore, according to results from a recent national CDC survey of physicians that looked at physicians' practices with respect to herpes zoster vaccine, patients are skirting the dilemma with a technique known as "brown bagging." These patients purchase the vaccine from an in-network pharmacy and then transport the product to their physicians' office for administration.

The letter points out that the practice is dangerous because many vaccines must be frozen or refrigerated until immediately before use. "It is difficult for the physician to verify the storage chain from the pharmacy to his or her practice," says the letter.

The medical organizations urge Sebelius to act quickly to review the issue and use the

authority granted to her by Section 101 of the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA, to include all recommended preventive vaccines within the "additional preventive services" eligible for coverage under Medicare Part B.

"CMS' actions to consolidate all vaccines under Medicare Part B will promote the interests of Medicare beneficiaries by further advancing Medicare's focus on prevention. We further urge that such consolidation be considered the result of a change in law (under the MIPPA) so that the resulting costs to Medicare Part B are appropriately accounted for in the calculation of the sustainable growth rate going forward," concludes the letter. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090707vaccine-partb-consolidate.html>.

Family Medicine Leaders Urge ACGME to Resist Call for More Limits on Residents' Duty Hours

By Barbara Bein

The AAFP, along with the other academic family medicine organizations, have asked the Accreditation Council for Graduate Medical Education, or ACGME, to resist putting additional restrictions on residents' duty hours because such restrictions may harm family medicine training programs and the quality of patient care.

In testimony delivered during the ACGME National Congress on Duty Hours and the Learning Environment, held June 11-12 in Chicago, AAFP President Ted Epperly, M.D., of Boise, Idaho, recommended that the ACGME

- commission research studies to examine whether additional restrictions on resident duty hours would lead to improved clinical outcomes in various patient care settings;
- not support additional duty-hours restrictions without the economic support necessary to prevent program closures; and
- devise a process to assess technical violations of the duty-hours standards in which the resident has acted in the patient's best interest.

The testimony from Epperly — who also is program director and CEO of the Family Medicine Residency of Idaho — and others came in response to recommendations contained in a report released by the

Institute of Medicine, or IOM, in December 2008. In the report, the IOM recommended that continuous on-site duty periods for residents not exceed 16 hours unless a five-hour uninterrupted sleep period is provided between 10 p.m. and 8 a.m.

In his testimony, Epperly noted that family medicine has lost more than 5 percent of its residency programs in the past 10 years because of "perceived fiscal insolvency," a situation that has only worsened during the nation's recent economic downturn. Additional pressures, he said, could lead to more closings.

"The impact of additional resident duty-hour restrictions — which, effectively, are an unfunded mandate — could certainly accelerate the loss of family medicine residencies," Epperly said.

He explained that according to a recent survey by the Association of Family Medicine Residency Directors, two-thirds of family medicine training programs could not implement new restrictions without additional financial resources, and one-fourth of them indicate that attempting to do so would result in their closing. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20090702acgme-tstmny.html>.

IOM Compiles List of Comparative Effectiveness Research Priorities

The Institute of Medicine, or IOM, has identified 100 health-related topics that it says should get priority attention from a new federal investment in comparative effectiveness research.

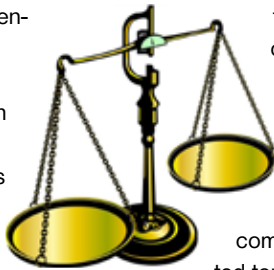
The June 2 IOM report is intended to provide independent guidance to Congress and the secretary of HHS on how to spend \$400 million allotted for comparative effectiveness research in the recently enacted American Recovery and Reinvestment Act.

The IOM divides the 100 comparative effectiveness research recommendations into four quartiles, with 25 recommendations in each quartile. The report also lists each of the four quartiles in descending order of importance. For example, in the first quartile, the report recommends research on the comparative effectiveness of care-coordination programs, such as the medical home and usual care in managing children and adults with severe chronic disease.

Another recommendation, this one in the fourth quartile, calls for comparing the effectiveness of coordinated, physician-led, interdisciplinary care provided in a patient's residence with usual care in managing advanced chronic disease in community-dwelling patients with significant functional impairments.

"This is an initial list only, and it is going to require sustained efforts to build on the work of this committee to provide (a) national research program with good ideas for studies to recommend and encourage," said Harold Sox, M.D., co-chair of the IOM committee that developed the recommendations, during a telephone news briefing on July 1.

Sox said one of the goals of comparative effectiveness research is to provide patients with the information they need to enter into discus-



sions with physicians regarding their plan of care.

"Hopefully, armed with that information, more patients will feel they can speak up and really assert themselves in talking with their doctors to be sure their preferences are reflected in whatever treatment or testing is eventually decided on," said Sox.

Sox pointed out that key stakeholders, including patients, physicians, professional organizations and insurers, heavily influenced identification of the 100 priority areas. Although the stakeholders nominated topics through an Internet-based questionnaire, the IOM used its own definition of comparative effectiveness research to determine whether submitted topics met the criteria for recommended topics. According to the IOM, comparative effectiveness research weighs the benefits and harms of various ways to prevent, diagnose, treat or monitor clinical conditions to determine which work best for particular types of patients and in different settings and circumstances.

The committee also applied other criteria to determine whether the topics submitted qualified for the list. That criteria included identifying gaps in evidence required for good decision making and the potential for research to actually change practice, according to Sox.

"The most frequently nominated and selected topic was actually methods to improve the delivery of evidence-based health care to patients," he said. "In other words, methods to improve the translation of research findings into actual patient care."

The second most identified topic involved health care disparities based on race and gender, said Sox. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090707iom-cer-report.html>.

Medical Home Can Help Combat Health Disparities

The ability to access a medical home represents one way to reduce health disparities between minority and nonminority patients, according to HHS Secretary Kathleen Sebelius, who testified before the House Appropriations Subcommittee on Labor, HHS, and Education on June 2.

Minorities are more likely to be uninsured or underinsured compared with their nonminority counterparts, according to Sebelius. However, "having an opportunity for a health home and an ongoing treatment protocol for every American is a step in the right direction" in reducing health disparities, she said.

Sebelius told the subcom-

mittee that workforce issues, including the number of minority physicians, directly affect such disparities because a health care professional's level of cultural proficiency can determine whether a patient feels comfortable seeking care. Sebelius, who testified to the subcommittee about the administration's 2010 fiscal year budget proposal for HHS, said the budget "invests \$354 million to combat health disparities (and) improve the health of racial and ethnic minorities and disadvantaged populations."

"The budget recognizes that if we want to ensure that millions of Americans get quality and affordable care, we need to increase the number of health care provid-

ers in this country," said Sebelius.

Sebelius also alluded to a report released by the White

cent of our gross domestic product," she said.

Without health care reform,

"The budget recognizes that if we want to ensure that millions of Americans get quality and affordable care, we need to increase the number of health care providers in this county."

— Kathleen Sebelius, HHS Secretary

House Council of Economic Advisers on June 2 that outlines how health care reform can strengthen the nation's economy. "The report found that if we continue on the path we are on today, by the year 2040, 72 million Americans will be uninsured, and health care costs will account for more than 34 per-

Sebelius added, the federal deficit will continue to grow, and more Americans will see their wages eaten away by health care costs. "This is a problem we can avoid if we act now," she said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090616sebel-housecmte.html>.

FDA Panel Recommends Acetaminophen Restrictions

By David Mitchell

An FDA advisory panel has recommended that the agency remove prescription drugs that combine acetaminophen and powerful painkillers — such as Percocet, which is formulated with oxycodone, and Vicodin, which is formulated with hydrocodone — from the market because of the risk of liver injury associated with misuse of the products. The panel also voted to lower dosage recommendations for over-the-counter, or OTC, acetaminophen products.

Gerald Dal Pan, M.D., M.H.S., director of the Office of Surveillance and Epidemiology in FDA's Center for Drug Evaluation and Research, or CDER, said during a June 30 media briefing that the agency would review the discussions and votes from a two-day joint meeting of its Drug Safety and Risk Management, Nonprescription Drugs,

and Anesthetic and Life Support Drugs advisory committees.

However, the FDA is not bound to accept the recommendations of its expert committees.

"Whatever we do on any of these options will affect how acetaminophen is prescribed or administered or purchased," Dal Pan said. "It will affect the whole health care system — pharmacies, pharmacists, physicians. It's a systemwide issue."

The FDA has been working for years to reduce the incidence of liver injury associated with acetaminophen misuse through such venues as labeling changes and educational programs. Dal Pan said the agency reviewed the results of those initiatives in 2007

and determined that additional action was necessary.

According to the FDA, more than 28 billion doses of acetaminophen-containing products are purchased each year in the United States, and acetaminophen-hydrocodone combination products have been the most frequently prescribed products for the past 12 years.

The expert panel voted 20-17 to remove the prescription combination products from the market.

That decision got mixed reviews from physicians in widespread media coverage. Randy Wexler, M.D., an assistant professor of clinical family medicine at Ohio State University College of Medicine, Columbus, and a health policy expert, told *AAFP*



News Now that although patient education and improved labeling are needed, the recommendation to eliminate the products went too far.

"It complicates treatment," he said, "and it doesn't educate the patient about what the problem is in the first place." If FDA officials accept the panel's recommendation, Wexler added, physicians will need to educate patients about their options.

"The first thing is we need to do is reassure the patient that medications will still be on the market that contain the same pain medications they have been taking — minus the acetaminophen," he said. "The second thing is that acetaminophen can still be taken with it, and we can discuss the dose with them." ■

For more information, visit <http://www.aaFP.org/news-now/clinical-care-research/20090702acetamin.html>.

In Brief *Health of the Public*

CDC Launches Public Health Tracking Network

The CDC has launched the Environmental Public Health Tracking Network, a Web-based surveillance tool that scientists, health professionals and the public can use to track environmental exposures and chronic health conditions. According to the CDC, the resource pairs environmental information from across the country, such as levels of air and water pollution, with prevalence information for certain chronic conditions, including asthma, cancer, childhood lead poisoning and heart disease, allowing localized comparisons of the two metrics. <http://www.aaFP.org/news-now/news-in-brief/20090715news-brf-clinupd.html>

Federal Agencies to Upgrade Food Safety Measures

Foodborne illness outbreaks remain an ongoing problem, with the CDC currently investigating multistate *Escherichia coli* outbreaks linked to cookie dough and beef products. In response, HHS and the U.S. Department of Agriculture, or USDA, announced that they will develop tougher standards for eggs and poultry to reduce incidences of *Salmonella* infection; the USDA will step up enforcement in beef facilities to reduce the risk of *E. coli* infection; the FDA will develop new industry

guidance to better protect leafy greens, melons and tomatoes from *E. coli*; the Obama administration will build a national traceback and response system that includes updated industry guidance, a unified incident command system and improved use of technology to deliver food safety alerts to consumers; and the administration will strengthen organization of federal food safety functions. <http://www.aaFP.org/news-now/news-in-brief/20090715news-brf-clinupd.html>

Chantix, Zyban to Add Boxed Warnings

The FDA is requiring manufacturers to put a boxed warning on the prescribing information for the smoking cessation drugs varenicline and bupropion, which are marketed as Chantix and Zyban, respectively, because of a risk of serious mental health events associated with their use. The agency said changes in behavior, depression, hostility and suicidal thoughts have been linked to the drugs. In addition, the FDA said similar warnings will be required for bupropion marketed as the antidepressant Wellbutrin, as well as for all generic versions of that product. The antidepressants already carry a boxed warning for suicidal behavior in treating psychiatric disorders. <http://www.aaFP.org/news-now/news-in-brief/20090702clin-upd.html> ■

Balance RUC with New Review Group

The Academy has voiced its support for creating an entity that would work separately from the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, to review and make recommendations to CMS on the value of codes for physician services.

In a letter to RUC Chair Barbara Levy, M.D., the AAFP said it agrees with the Medicare Payment Advisory Commission, or MedPAC, that RUC relies on physician specialty societies to identify and correct undervalued services, but that the system does little to identify services that may be overvalued.

In the letter, AAFP Board Chair Jim King, M.D., of Selmer, Tenn., wrote that the new panel should augment the work of the RUC. King expressed concern that CMS accepts about 90 percent of RUC recommendations regarding relative value units, or RVUs, but it has not examined the process by which those suggestions are made for more than 16 years.

King suggested that CMS undertake a study to analyze and determine whether current RUC pro-

cesses represent an objective and balanced procedure for obtaining input on the establishment, review and adjustment of RVUs. He said a review should focus on the degree by which existing processes

- include equitable representation of primary care physicians;
- provide CMS with expert and impartial input from physicians in medical specialties that provide primary care to patients with multiple chronic diseases;
- include equitable representation of medical specialties in proportions reflective of their contributions toward providing care to Medicare patients; and
- may unfairly disadvantage primary care physicians, who principally provide evaluation and management services.

King also asked for greater transparency in RUC voting, noting that RUC members currently cast "secret" votes electronically. ■

For more information, visit <http://www.aafp.org/news-now/news-in-brief/20090617news-brf-practupd.html>.

AAFP's Learning Link Launches Diabetes Series

The AAFP's online classroom, LearningLink, has launched the first activity of a new four-part CME series dubbed Type 2 Diabetes 2009.

The initial activity, Highlights of Current Evidence and Clinical Recommendations, offers an overview of the disease and encompasses three webcasts:

- "Epidemiology, Screening and Diagnosis of Diabetes and Pre-Diabetes";
- "Glycemic Goals and Risk Factor Management"; and
- "Treatment of Type 2 Diabetes."

The series reviews and applies evidence-based diabetes management guidelines for family physicians. In addition to the webcasts, delivery platforms include a slide-driven lecture, an expert panel discussion and video case dramatizations. Downloadable resources provide evidence-based recommendations, practice tools and point-of-care applications.

The program is supported by grants from GlaxoSmithKline, sanofi-aventis and Takeda Pharmaceuticals North America.

LearningLink debuted in July 2008 as a new direction in education – an alternative to the "one-off" programs in which participants are briefly exposed to a clinical topic. LearningLink focuses on one therapeutic area through a series of interconnected activities delivered during a 12- to 18-month period, providing comprehensive, longitudinal learning. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20090715diab-learnlink.html>.

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FDA Granted Authority to Regulate Tobacco Products

Congress has passed legislation giving the FDA the power to regulate tobacco products for the first time. The measure, H.R. 1256, allows the FDA to regulate nicotine levels and bar flavor additives in tobacco products, as well as require new warning labels on cigarette and other tobacco product packages and advertising.

President Obama has said he will sign the measure.

The legislation will create a new entity within the FDA called the Center for Tobacco Products to regulate the production, marketing and sale of tobacco products. The bill relies on user fees on tobacco companies and importers to pay for the new oversight.

The FDA does not have the authority to completely ban tobacco products under the legislation, but the agency will have the ability to restrict the sale, advertising or marketing of tobacco products as long as such restrictions do not violate the Constitution. Under the measure, tobacco product labels cannot carry descriptive information such as "light," "mild" or "low tar." The FDA also can establish content standards to eliminate harmful ingredients. ■

For more information, visit <http://www.aaFP.org/news-now/news-in-brief/20090619news-brf-govupd.html>.

Tar Wars National Poster Contest Winner Offers Idea to Chew On

By David Mitchell

Tar Wars isn't just about teaching kids not to smoke. It's about teaching them to stay away from all forms of tobacco. And, at this time of year, it's about taking that critical message to federal lawmakers.

Alexa Barrett, an 11-year-old from American Falls, Idaho, was named the AAFP initiative's national poster contest winner on July 13 during the Tar Wars National Conference in Washington, D.C. Barrett's poster featured a drawing of a cow accompanied by the slogan, "Cows are smart, they don't chew, they moo."

"That's pretty unique," said Pam Rodriguez, AAFP's tobacco control manager. "I don't think we've had a poster focused on chewing tobacco. The posters' messages are usually about smoking, but Tar Wars is about preventing all kinds of tobacco use."

Family physicians and other health care workers across the country present Tar Wars tobacco-free education programs to fourth- and fifth-graders in their local schools each year, discussing the toll tobacco takes on health, as well as the financial costs of tobacco use. More than 8 million children have heard the tobacco-free message since the program's inception in 1988.

The program, which is supported by the AAFP Foundation and the Campaign for Tobacco-Free Kids, culminates each year with a national poster contest made up of submissions from state-level poster contest winners. As the 2009 national contest winner, Barrett will receive a family trip to Disney World in Orlando, Fla., worth as much as \$3,000. ■

For more information, visit <http://www.aaFP.org/news-now/inside-aaFP/20090715tar-wars-conf.html>.



Hilary Schwab/AAFP

Tar Wars national poster contest winner Alexa Barrett, an 11-year-old from American Falls, Idaho.

Tobacco Cessation Counseling Effective

By Sheri Porter

America's health insurance companies should include tobacco cessation counseling and associated pharmacotherapy in their standard benefit plan packages, and they should pay physicians fairly to provide those services.

That's the central message of a July 21 letter sent to dozens of health plans and signed by the presidents of the AAFP; the AMA; the American Academy of Pediatrics, or AAP; the American College of Obstetricians and Gynecologists; and the American College of Physicians.

According to the letter, primary care physicians are in a unique position to help patients with their tobacco addictions because nearly six of every 10 office visits in this country are made to primary care physicians.

The letter notes that that smoking and exposure to secondhand smoke causes nearly 440,000 deaths annually and says tobacco use is the country's leading preventable cause of death. In addition tobacco use and nicotine addiction costs the coun-

try \$193 billion each year in health-related costs and lost productivity. Quit rates increase when patients have insurance coverage for smoking cessation treatment, say the organizations.

Jonathan Klein, M.D., M.P.H., is director of the AAP's Julius B. Richmond Center of Excellence, an initiative dedicated to the elimination of children's exposure to tobacco and secondhand smoke. He told *AAFP News Now* that there's a gap between good prevention strategies and the availability of insurance to pay for them.

"There is no routine coverage by most health plans for smoking cessation services; it's considered an add-on service," said Klein. Insurance companies will add the coverage but for an extra charge. Klein added that employers should reject any benefit proposals that don't include all preventive services. ■

For more information, visit <http://www.aaFP.org/news-now/practice-management/20090729tobacco-ltr.html>.

AS WE SEE IT

Voices From the AAFP

From the President

Qualified Public Plan Option Can Be Component of Health Care Transformation

By Ted Epperly, M.D.

We all know the health care system is a mess and must be reformed, and I'm gratified that Congress finally is making a concerted effort to bring that reform into reality. It's an exciting and sometimes frustrating process to watch.

One of the most hotly debated potential ingredients of health care reform is a public health insurance plan option, which would serve as an alternative to plans offered by private insurance companies. Earlier this year, the AAFP Board decided to support inclusion of a public plan option in health reform legislation, but only if the public plan meets certain conditions for fair competition with private insurers.

Some Academy members have questioned the AAFP's support for a public plan option. They are concerned that such a plan could serve as the proverbial camel's nose under the tent. They fear that the plan could eventually lead to a single-payer, government-run health care system.

Members of the AAFP Board thought long and hard about supporting the public plan option, but, in the end, we unanimously decided to support it because we wanted to continue to be proactive in our thinking about health care reform. The Academy has a long history of advocating health care coverage for all, and a public plan option would provide another option for both individuals and employers.

Moreover, a public plan option would serve as a driver for insurance reform, which is long overdue. Like me, you've probably had to fight with insurance companies to get your patients the care they need. That happens because private insurers don't answer to the people they cover — they answer to their stockholders and to Wall Street. Without a public plan option, patients who are denied coverage under private insurance have nowhere to go. They likely would continue to delay health care and end up in an emergency room with no follow-up care or continuity of care.

However, there's an excellent chance that a public health insurance plan would advance a system based on primary care and family medicine. Washington policymakers increasingly are acknowledging the importance of primary care and the need to boost the supply of primary care physicians. For example, health care reform legislation currently under consideration in the House includes a new public plan option with a primary care base. Committees in both the House and Senate have introduced reform bills that call for better primary care payment and include provisions for the patient-centered medical home.

Will a public plan option eventually lead to a single-payer system under government control? The answer is no, if the AAFP-supported conditions for fair competition are in place. These conditions were set forth by the



Ted Epperly, M.D.

New America Foundation in "A Modest Proposal for a Competing Public Health Plan," by Len Nichols, director of the foundation's health policy program, and John Bertko, an actuarial consultant to the program.

"The key to achieving fair competition is to set and enforce the rules of the insurance marketplace (or exchange) in such a way that they apply to all participants, public and private alike. All rules must apply to all plans," Nichols and Bertko wrote.

The AAFP Board agrees with the New America Foundation that the public plan option shouldn't be "Medicare for All." The proposed legislation in the House would link payment rates in the public plan to Medicare payment rates for three years. The AAFP has expressed concern about this provision in the House bill, but the Board decided to accept this linkage because it is time-limited and because the payment system would include a 5 percent incentive payment for primary care physicians.

The Board also agrees that physicians participating in Medicare shouldn't be forced to participate in the new public plan. Moreover, we've told Congress that opting out of the new plan must be easy — not a bureaucratic nightmare.

Finally, the Board considers it critical that the rules governing a public plan be the same as those for private insurers to create a level playing field. Otherwise, private insurers conceivably could be driven out of business, which eventually could result in the single-payer system many of our members fear. ■

Conditions for Fair Competition

The AAFP supports a public plan only if administrators of the plan are accountable to an entity other than the one identified to govern the marketplace. Furthermore, the plan

- cannot be Medicare,
- must be actuarially sound,
- should not leverage Medicare or any other public program to force physician participation,
- cannot require use of Medicare payment rates,
- must operate under the same insurance market rules and regulations as private health plans,
- should not have an unfair advantage in enrolling uninsured or low-income people, and
- must contribute to value-based initiatives that benefit all payers.

Finally, public and private insurers should adhere to the same rules regarding reserve funds. ■

For more information, visit <http://www.aafp.org/news-now/opinion/20090729pres-msg-option.mem.html>.