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Agencies Issue Final Rules that Define, Support 'Meaningful Use' of EHRs

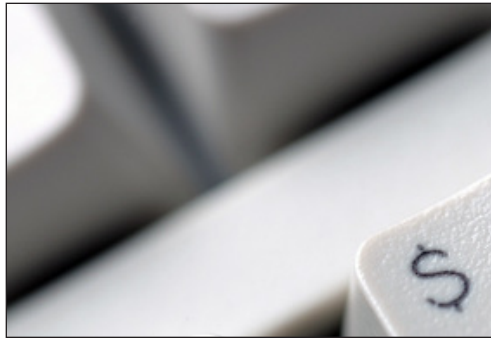
By Sheri Porter

A July 13 press conference hosted by HHS Secretary Kathleen Sebelius set the stage for the release of two final rules that define and support the "meaningful use" of electronic health records, or EHRs.

One rule, issued by the Office of the National Coordinator for Health Information Technology, identifies the standards and certification criteria for the certification of EHR technology so that hospitals and physicians will know that

the EHRs in which they invest can perform the required functions.

A companion rule, issued by



CMS, defines the minimum EHR meaningful use objectives that physicians and other profession-

als must meet to qualify for bonus programs enacted under the American Recovery and Reinvestment Act of 2009.

According to a July 13 HHS news release, CMS estimates that it may pay out \$27 million in incentive payments during the next 10 years. Physicians and other health care professionals can choose to participate in the Medicare bonus program — potentially earning as much as \$44,000 in additional income — or they can choose to earn Medicaid incentives of as much as \$63,750.

In the news release, David Blumenthal, M.D., national coordinator for health information technology, or health IT, called the regulations "a turning point for electronic health records in America and for improved quality and effectiveness in health care."

He said the federal government received extensive input from the health care community, and he added, "We have drawn on their experience and wisdom to produce objectives that are both ambitious and achievable."

CMS received more than 2,000 comments — including

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CMS Fudges on PECOS Enrollment Deadline

Agency Says It Will Not Enforce July 6 Cutoff

CMS has had a change of heart regarding its July 6 deadline for physician enrollment in the agency's Provider Enrollment, Chain and Ownership System, or PECOS. According to a June 30 news release, the federal regulation that requires all ordering and referring physicians to be enrolled in PECOS will still be effective as of July 6, but "CMS will, for the time being, not implement changes that will automatically reject claims based on orders, certifications and referrals made by providers that have not yet had their applications approved by July 6."

The decision to ease up on enforcing the deadline was made as CMS continues to receive feedback and complaints from physicians about PECOS' painful enrollment process.

"While more than 800,000 physicians and other health care professionals have successfully enrolled in PECOS, some Medicare providers have encountered problems," said CMS in the release. "CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days." ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100702pecosdeadline.html>.

AUGUST HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

Certification Changes page 3

The American Board of Family Medicine has announced that it is further enhancing its Maintenance of Certification for Family Physicians program.

Medical Education page 10

A new report from the Carnegie Foundation for the Advancement of Teaching is calling for better integration of clinical experience in medical education.

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comments from the AAFP — on the proposed meaningful use rule that was issued on Jan. 13.

According to Steven Waldren, M.D., director of the AAFP's Center for Health IT, CMS thoughtfully reviewed the comments it received and made significant changes to the regulations.

"CMS has addressed the Academy's biggest concerns, and many of the changes they have made will benefit family physicians," said Waldren.

For example, in its Feb. 26 comment letter to CMS, the AAFP suggested that CMS abandon its "all-or-nothing" approach to achieving meaningful use of EHRs and, instead, increase phy-

sician participation by offering partial incentives.

Waldren pointed out that the final rule grants physicians greater flexibility in meeting and reporting certain objectives for demonstrating meaningful use. The final regulation states that physicians initially must meet 15 core measures but then can choose from a subset of additional objectives to work on in 2011-12.

"CMS also significantly reduced the threshold for some of the measures that the AAFP deemed particularly onerous for physicians," said Waldren. For example, the threshold for an electronic prescribing measure

that originally called for 75 percent of all permissible prescriptions to be transmitted electronically has been reduced to 40 percent.

Another priority issue for the Academy was CMS' measure on computerized provider order entry that called for transmitting at least 80 percent of all orders electronically. That percentage now applies to medication orders only, and the threshold for electronic transmission of other types of orders has been reduced, said Waldren. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100714meaningfuluserule.html>.

AAFP Presents 'Meaningful Use' Webinar

To help family physicians and others sort out what is meant by "meaningful use," the AAFP is presenting a webinar on Aug. 19. The "2010 Understanding the Meaning of Meaningful Use" webinar will be 90 minutes in length and will take place from noon to 1:30 p.m. CDT. The cost to attend the webinar is \$10 for members. Registration can be completed at http://www.centerforhit.org/online/chit/home/project-ctr/meaningful_use.html and is limited to 500 participants. ■

CMS Creates Online Resources to Help Physicians Who Infrequently Use Medicare Services

CMS is aiming to quell confusion in the physician community regarding concerns about provisions found in section 6405 of the Patient Protection and Affordable Health Care Act that deal with Medicare enrollment processes for physicians who do not send claims for services provided directly to a Medicare contractor for payment.

The new four-page resource, titled "Medicare Enrollment Guidance for Physicians That Infrequently Receive Reimbursement from the Medicare Program," refers to a "specific set of physicians" who will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries.

CMS says it has created an "abbreviated" enrollment process for those physicians and health care professionals who are employed by the Department of Veterans Affairs; the U.S. Public Health Service; the Department of Defense's TRICARE program; or federally qualified health centers, rural health clinics or critical-access hospitals.

The CMS document also answers questions about how to verify current enrollment in CMS' Provider Enrollment, Chain and Ownership System, or PECOS. Physicians who are not already enrolled in PECOS and who are included in the above list are advised to forgo electronic enrollment because CMS' system cannot accommodate the abbreviated enrollment form; instead, those physicians should use the paper enrollment application. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100720cmsmedicarehelp.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between June 22 and July 21, 2010.

ABFM Announces Further Enhancements to MC-FP *Changes Affect Part II, Part IV Requirements, Period of Certificate Validity*

By Cindy Borgmeyer

The American Board of Family Medicine, or ABFM, has announced it will introduce some major changes to its Maintenance of Certification for Family Physicians, or MC-FP, program beginning next year.

According to a message from ABFM President and CEO James Puffer, M.D., in the summer 2010 issue of the organization's newsletter, *The Phoenix*, giving ABFM diplomates the option to move from a seven-year to a 10-year MC-FP cycle has resulted in nearly all diplomates who were offered this opportunity choosing the 10-year pathway.

"When we provided diplo-

mates the opportunity to choose between either a seven-year or a 10-year MC-FP cycle, we suspected that the 10-year option would be appealing," Puffer told *AAFP News Now*. "However, we have been gratified that more diplomates are willing to meet the more rigorous 10-year pathway requirements in trade-off for extending the time that they would be required to take the examination by three years."

Currently, either option culminates with the administration of the cognitive examination (Part III), but now the ABFM is unlinking the examination temporarily from the MC-FP cycle, beginning with those who certify or recertify in summer 2011. Diplo-

mates will now be able to take the examination at any point in the cycle they choose, and the results will be valid for 10 years.

In addition, diplomates will be free to choose how they wish to complete their MC-FP Part II self-assessment module requirements and their Part IV (e.g., the ABFM's performance-in-practice modules; methods in medicine modules; and approved alternatives, such as the AAFP's Measuring, Evaluating and Translating Research Into Care modules) requirements during each three-year stage of the MC-FP cycle.

Each module will be assigned a point value, and diplomates will be required to accu-

mulate a sufficient number of points every three years. The precise total of points needed to satisfy the requirement has yet to be determined.

Diplomates can decide how they wish to accrue the required point total as long as the activity combination completed during the three-year stage includes at least one Part II module and one Part IV module.

According to *The Phoenix* article, the coming changes to the MC-FP should permit the ABFM to begin issuing certificates without end dates next summer. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20100721mcfpchanges.html>.

AAFP Recruiting Practices for Smoking Cessation Pilot

'Office Champions' Program Aims to Ramp Up Anti-Tobacco Activities

The AAFP is recruiting 50 family medicine practices for a pilot project that will train "office champions" to implement system changes that encourage the integration of tobacco cessation activities in daily office routines.

The program will educate these office champions through an online training module, live teleconferences and a practice manual. The office champions will be required to submit an implementation plan to the AAFP and track and report results.

"I can say from experience that changing the system in which you practice can help improve care on a consistent basis," said Saria Carter Saccocio, M.D., of Rome, Ga., a member of the Academy's Tobacco Cessation Advisory Committee.

Carter Saccocio, who is associate director of the Floyd Family Medicine Residency in Rome, said that implementing a similar tobacco cessation program improved her residency's quality of care by putting a bigger emphasis on the issue.

Office champions in the pilot project can be physicians, but they

more likely will be practice administrators, nurses, physician assistants or other staff members.

The deadline for applications is Aug. 16. Additional information and applications are available online. Members with questions may contact AAFP tobacco control manager and project director Pamela Rodriguez at prodriguez@aafp.org or by calling (800) 274-2237, Ext. 3135.

Practices chosen to participate will be announced in September, with implementation and evaluation scheduled to take place from October through May 2011. Practices that complete the program will be reimbursed for administrative costs associated with the project.

Participating practices also will receive a recognition kit that includes

- certificates;
- a news release to send to local newspapers;
- an article for patient newsletters;
- electronic "Tobacco Treatment Excellence" logos to use on letterhead, business cards, advertisements, etc.;
- tips on having a recognition ceremony for staff;
- tips on publicizing the practice's office champion status; and
- posters for the office.

The project is supported by a \$400,000 grant from Pfizer Inc. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100622officechamps.html>.



ACIP Ponders Changing Its Recommendation Process

AAFP Voices Support for Evidence-based, Graded System

By David Mitchell

The CDC's Advisory Committee on Immunization Practices, or ACIP, is considering adopting an evidence-based recommendation process similar to that used by the U.S. Preventive Services Task Force, or USPSTF.

The AAFP, the American Academy of Pediatrics and the American College of Physicians voiced support for such a change June 23 during an ACIP meeting in Atlanta.

Doug Campos-Outcalt, M.D., M.P.A., the AAFP's liaison to the ACIP, spoke on behalf of the Academy at the meeting. Campos-Outcalt, who also serves as the AAFP staff liaison to the USPSTF, said in an interview with *AAFP News Now* that the ACIP lacks a step-by-step process for evaluating and grading evidence, making recommendations, and stating the level of evidence on which recommendations are based.

"It's hard for us to endorse recommendations that don't come from an evidence-based process," Campos-Outcalt said. "It's not that ACIP doesn't use an evidence-based process, it's just that it's not formalized and transparent."

According to Campos-Outcalt, who is associate head of the department of family and community medicine at the University of Arizona College of Medicine, Phoenix, participants at the ACIP meeting discussed how graded recommendations might affect parental acceptance of vaccines. The ACIP will vote during its October meeting on whether to move forward with a process that would result in graded recommendations and stated grades for the levels of evidence supporting those recommendations.

Campos-Outcalt said the ACIP would not immediately apply the process to vaccines already on the market with established recommendations. Instead it would be applied to new recommendations and revised recommendations.

The advisory committee periodically revises its recommendations, so all vaccines evaluated by the ACIP eventually would be subjected to the new process, if it is adopted.

In other news, the ACIP voted June 24 in favor of new influenza vaccination recommendations for children ages 6 months through 8 years during the 2010-11 flu season. The recommendations have since been officially approved by HHS and the CDC and were published July 29 in *Morbidity and Mortality Weekly Report*.

The provisional recommendations say children in the above age group should receive two doses of seasonal flu vaccine if they meet any of the following conditions:

- they have never received seasonal flu vaccine;
- they have received only one dose of seasonal vaccine previously; or
- they did not receive novel influenza A (H1N1) vaccine last season.

The 2010-11 trivalent flu vaccine will include the 2009 influenza A (H1N1) virus as one of its three strains. During the 2009-2010 flu season, separate vaccinations were required for seasonal and H1N1 flu. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20100630acipevidence.html>.

FDA Issues Recommendations for Parents, Industry on Infant Vitamin D Supplements

Products Pose Potential Overdose Risk

The FDA is warning consumers about the risk of overdosing infants with liquid vitamin D supplements. In 2008, the American Academy of Pediatrics doubled the recommended daily intake of vitamin D for infants and children from 200 international units, or IU, a day to 400 IU.

But Linda Katz, M.D., M.P.H., interim chief medical officer in the agency's Center for Food Safety and Applied Nutrition, said in a June 15 teleconference that some liquid vitamin D products come with droppers that can hold significantly more than the recommended amount of liquid vitamin D.



The FDA is warning consumers about the potential for overdosing infants with vitamin D liquid drops.

David Mitchell/AAFP News Now

In a June 15 letter to manufacturers, the FDA recommended that 400 units be clearly and accurately marked on droppers packaged with vitamin D supplements. It also recommended that products intended specifically for infants have droppers that hold no more than 400 units.

Vitamin D promotes calcium absorption and plays a key role in the development of strong bones. However, Katz said excessive vitamin D can cause nausea, vomiting, loss of appetite, excessive thirst, frequent urination, constipation, abdominal pain, muscle weakness, muscle and joint aches, confusion, fatigue, and kidney damage.

The agency said other potential serious consequences of overdose may include cardiac arrhythmias, osteomalacia and hypercalcemia, which can lead to soft-tissue deposition of calcium, resulting in other associated problems, such as hypertension.

The agency's recommendations, which are aimed at parents and other caregivers, include

- ensuring that an infant does not receive more than 400 IU of vitamin D a day;
- keeping vitamin D supplement products with the original packaging so caregivers can follow the dosing instructions;
- using only the dropper that comes with the product because it is manufactured specifically for that product;
- ensuring the dropper is marked so units of measure are clear and easy to understand, and making sure units of measure correspond to those mentioned in the instructions;
- talking to a health care professional before giving the supplement to an infant if a caregiver cannot clearly determine the dose of vitamin D delivered by the dropper; and
- checking with a physician before giving the child vitamin D supplements if an infant is being fully or partially fed with infant formula. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100622vitamin-d.html>.

Pertussis Activity Spiking in Several States

Vaccination Critical in Preventing Illness

An outbreak of pertussis has been declared an epidemic by the California Department of Public Health. The agency said that as of June 15, the state had 910 reported cases — four times more than at the same time last year — and 600 potential cases were being investigated.

As of the same date, five infants had died of the disease, commonly known as whooping cough, in California this year, according to the state's health department.

The CDC said June 19 that 5,120 cases of pertussis had been reported nationwide. Although that number was less than the 6,326 reported at the same time last year, several states reported significant increases in pertussis activity, including Texas (1,154 cases), Ohio (523 cases),

Michigan (380 cases) and Arizona (163 cases).

In addition, the South Carolina Department of Health and Environmental Council issued a public health advisory June 8, saying reported pertussis cases were above an epidemic threshold. The state agency said that in the first 20 weeks of 2010, there were 81 confirmed or probable cases of pertussis, which doubles the number of cases reported during the same period during each of the previous three years. The department said the case total was above an epidemic threshold because it was two standard deviations above the annual mean.

South Carolina had 134 cases of pertussis as of June 25, according to the CDC. The CDC's Advisory Committee on Immu-

nization Practices, or ACIP, and the AAFP recommend that children receive five doses of diphtheria, tetanus, and pertussis, or DTaP, vaccine, including a primary series at 2 months, 4 months and 6 months. Additional doses should be given at 15-18 months and 4-6 years.

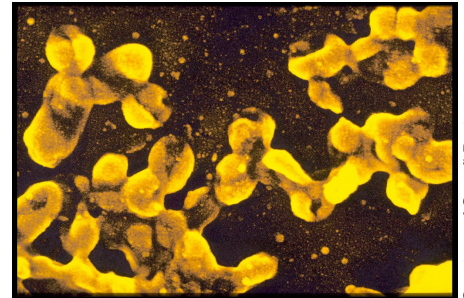
The CDC issued the following recommendations for physicians June 30.

- Make sure patients of all ages are up-to-date on pertussis-containing vaccines.
- Consider the diagnosis of pertussis in patients and close contacts. Atypical presentation is common in infants. Their cough may be minimal or absent, and the

primary symptom can be apnea.

- Use the correct tests.
- Treat suspected and confirmed cases promptly because pertussis may progress rapidly in infants.
- Quickly report cases to local public health departments. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100706pertussis-spikes.html>.



Pertussis bacteria, shown here, have caused more than 5,000 reported cases of the disease as of June 25, according to the CDC.

Courtesy of Sanofi Pasteur

In Brief *Public Health Digest*

FDA Warns Against Off-label Use of Malaria Drug

Off-label use of the malaria drug Quaaliquin has resulted in reports of two dozen serious adverse events, including two deaths. The FDA has responded by approving a Risk Evaluation and Mitigation Strategy, or REMS, for the medication. The majority of patients who reported adverse events took the drug to prevent or treat leg cramps or restless leg syndrome, the FDA said. There were serious and life-threatening reactions in 24 cases, including thrombocytopenia, and hemolytic uremic syndrome/thrombotic thrombocytopenic purpura. Some patients suffered permanent kidney impairment and required hospitalization. The REMS requires that patients be given a medication guide explaining what a drug is and is not approved for, as well as potential side effects. <http://www.aafp.org/news-now/health-of-the-public/20100712fdamalaria.html>

HHS Launches National Action Plan to Improve Health Literacy

HHS has issued a national action plan designed to make health information and services easier to understand and use. An HHS news release said the plan seeks to banish the jargon-filled language and complex explanations that often fill patient handouts, medical forms, health websites and recommendations to the public. HHS Secretary Kathleen Sebelius said in a news release that pay-

ers and physicians need to communicate clearly and make necessary changes to improve their interaction with consumers, patients and beneficiaries. <http://www.aafp.org/news-now/health-of-the-public/20100701healthliteracy.html>

Shortage of Prefilled Epinephrine Syringes Raises Dosing Error Risk

The American Society of Health-System Pharmacists, or ASHP, and the Institute for Safe Medication Practices, or ISMP, issued a joint alert on June 16 about a shortage of prefilled epinephrine syringes that creates the potential for serious, even fatal, medication errors due to inappropriate dosing. Injectable epinephrine is available as 1 mg/mL in 1-mL vials and as 1 mg/mL in 30-mL vials, as well as in emergency syringes with intracardiac needles, but the organizations said in their alert that those products may not be safe alternatives for code carts, emergency vehicles or other emergency needs. The ASHP and the ISMP recommended in their alert that current supplies of epinephrine emergency syringes that health care professionals and facilities have on hand should be reserved for code boxes, emergency response vehicles and other settings where pharmacists would not be present to dilute epinephrine during a code situation. <http://www.aafp.org/news-now/clinical-care-research/20100702epinephrineshortage.html> ■

Higher Percentage of American Adults With Hypertension Are Controlling Their Condition, Says Study

The United States has achieved the Healthy People 2010 objective of adequately controlling blood pressure in 50 percent of Americans with hypertension. That figure represents an improvement from 10 percent in 1980 and 31 percent just 10 years ago.

The figures were published in a study in the May 26 issue of *JAMA: The Journal of the American Medical Association*. The study suggests that the increased proportion of patients with well-controlled hypertension (i.e., systolic blood pressure less than 140 mm Hg and diastolic blood pressure less than 90 mm Hg) likely did not stem from more patients adopting healthier lifestyles.

Rather, the increased percentage of patients with hypertension who are adequately controlling their blood pressure probably reflects improvements in awareness levels and treatment protocols, as well as growth in the proportion of patients who are receiving appropriate treatment, according to the study.

Researchers say the fact that obesity increased during the period covered by the study (1988-2008) indicates that it is unlikely overall increases in ade-



The United States has reached the Healthy People 2010 goal of controlling blood pressure in 50 percent of Americans with hypertension.

quate control of hypertension can be attributed to positive lifestyle modifications.

The study's authors point out that obesity is a characteristic of individuals with treatment-resistant hypertension. Yet, despite challenges involved in controlling blood pressure in patients who are obese, they note, from 1999-2004, control improved in all obese patients but not in all non-obese patients with hypertension.

Therefore, they suggest that more patients — especially patients who are obese — are receiving more medications to control their blood pressure.

Healthy People 2010 called for reducing the prevalence of hypertension from 28 percent in 1994 to 16 percent by 2010. According to the study, however, the prevalence of hypertension actually increased between the National Health and Nutrition Examination Survey conducted in 1988-94 and the survey conducted in 1999-2000. Although the prevalence did not change between the 1999-2000 survey and that conducted in 2007-08, it “remains much higher than the national goal,” says the study. ■

Healthy People 2010 called for reducing the prevalence of hypertension from 28 percent in 1994 to 16 percent by 2010. According to the study, however, the prevalence of hypertension actually increased between the National Health and Nutrition Examination Survey conducted in 1988-94 and the survey conducted in 1999-2000. Although the prevalence did not change between the 1999-2000 survey and that conducted in 2007-08, it “remains much higher than the national goal,” says the study. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100621hypertensioncontrol.html>.

Hypertension by the Numbers

32 — percentage of noninstitutionalized American adults with hypertension in 2003-06, or 74.5 million people

53 — percentage of U.S. nursing home residents with hypertension in 2004, or about 790,000 people

326,000 — number of people for whom hypertension was a primary or contributing cause of death in 2006

40.5 million — number of ambulatory care visits in 2006 with hypertension as the primary diagnosis

\$76.6 billion — estimated direct and indirect costs of high blood pressure this year in the United States

Sources: CDC FastStats and CDC
Feature: High Blood Pressure

AAFP Among Organizations Calling on CMS to Allow Medicaid Coverage for Tobacco Quitlines

The AAFP is one of three dozen organizations that recently signed a letter to CMS, urging the agency to allow states to obtain federal Medicaid matching funds for the cost of tobacco cessation services provided by quitlines.

According to the June 14 letter, which was drafted by the Campaign for Tobacco Free Kids, Medicaid beneficiaries use tobacco at rates 50 percent higher than the general population and account for up to 40 percent of calls to quitlines.

The letter also says that tobacco-related illnesses account

for 10 percent to 15 percent of all Medicaid expenditures.

Every state and two U.S. territories have tobacco cessation quitlines, which provide phone-based counseling on how to quit smoking. Some provide medications to help smokers quit, as well as links to health information and resources, the letter says.

However, some states do not have CMS approval for Medicaid coverage, which is required to receive federal matching funds to pay for quitline programs.

“Ensuring Medicaid coverage of tobacco cessation quitlines

will improve access to these services, help more tobacco users to quit, help protect children and adults from secondhand smoke, and reduce the disease and premature death attributable to tobacco use,” the letter says.

The letter points out that the CDC’s guide “Best Practices for Comprehensive Tobacco Control Programs” calls for promoting and expanding quitline services. Specifically, the guide says quitlines are “a resource for busy health care providers, who can ask patients about their tobacco use status and then link them to quitline cessation

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www.smokefree.gov

services for counseling. Optimally, quitline counseling should be made available to all tobacco users willing to access the service.”

The letter also points out that CMS itself has recognized the importance of cessation counseling because the agency recently proposed expanding coverage for Medicare beneficiaries. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100706medicaidquitlines.html>.

Health Centers Will Save Billions Under Health Care Reform Act, Says Study

By James Arvantes • Washington

The recently enacted health care reform legislation provides an additional \$11 billion in funding for community health centers, or CHCs, during the next five years, and, according to a new research brief, this will enable CHCs to double the number of people they serve by 2015. The cumulative effect should produce at least \$180 billion in system-wide health care savings by 2019, say the brief's authors.

Findings from the policy research brief, "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform," which was conducted by the Geiger Gibson/RCHN Community Health Foundation Research Collaborative at the George Washington University School of Public Health and Health Services in Washington, were released during a press conference here on June 30.

"Health centers reduce hospitalizations, emergency department use, (sub)specialty use and provide quality care, thereby saving money," said Leighton Ku, Ph.D., M.P.H., the lead author of the brief



Sen. Bernard Sanders, I-Vt., says during a June 30 Capitol Hill press conference that health care reform investments in community health centers represent a "revolution in primary care."

James Arvantes/AAFP News Now

and a professor of health policy at the George Washington University School of Public Health and Health Services. "We are not alone in asserting that health centers are an efficient way to provide care. There is certainly a lot of research that consistently shows this."

The health care reform measure, known as the Patient Protection and Affordable Care Act, will bring a projected 32 million more people into the health care system by 2014, creating an even greater demand for primary care services and raising a number of questions in the process.

"Are we going to have doctors and places for (patients) to go where they can get that care?" asked Ku, framing the issue during the press conference. "And will we be able to reduce health care costs over time?"

The research brief addresses these questions by calculating the effect of the expansion of CHCs on patient health care access and health care costs. In the final analysis, the brief concludes that the investment in CHCs will greatly expand access to high-quality care while saving billions in health care costs, thus accomplishing two goals established by the health care reform legislation.

As amended by the Health Care and Education Reconciliation Act, the Patient Protection and Affordable Care Act provides \$11 billion in dedicated funding for CHCs from 2011 through 2015 in addition to the current annual funding level of \$2.2 billion. This investment is likely to increase the number of patients served by CHCs each year from 18.8 million today to 33.8 million by 2015 and to 36.3 million by 2019, according to the brief. ■

For more information, visit <http://www.aaafp.org/news-now/government-medicine/20100708chcbrief.html>.

Study Finds Consumers Need Help Understanding Evidence-based Care

Many Consumers Confused by Terminology, Distrustful of Process

A study in the July issue of *Health Affairs* indicates that many consumers may be skeptical about the benefits of health care that uses an evidence-based approach. That very approach is expected to play a big role in future efforts to reform the U.S. health care system.

The study, "Evidence That Consumers Are Skeptical About Evidence-Based Health Care," indicates that few consumers understand terms such as "medical evidence" and "clinical guidelines." According to the study, participants described such guidelines as representing a "minimum standard of care."

"Consumers' current knowl-

edge, beliefs, attitudes and experiences related to health care are often incompatible with evidence-based approaches," wrote the authors of the study. Study participants believed that "any new treatment is improved treatment," and only 47 percent of survey respondents said it was reasonable to pay less out-of-pocket for the most effective treatments and drugs.

"Linking cost sharing to clinical effectiveness may be perceived as restricting treatment options, particularly for unproven therapies," wrote the authors.

Many respondents also equated high-quality care with higher-cost care. One-third of survey respondents agreed or

strongly agreed with the statement "medical treatments that work the best usually cost more than treatments that don't work as well." Another 27 percent disagreed or strongly disagreed with that statement, and 40 percent said they were unsure.

"The consistent finding that consumers prefer subjective information from friends and family about selecting doctors and hospitals to objective information about performance and outcomes shows how difficult it is to shift toward an evidence-based approach to making health care choices," said the authors.

The researchers concluded that such "gaps in knowledge

and misconceptions point to serious challenges in engaging consumers in evidence-based decision making."

"Clearly, consumers will revolt if evidence-based efforts are perceived as rationing or as a way to deny them needed treatment," said the authors. "Policymakers, employers, health plans, providers and researchers will thus need to translate evidence-based health care into accessible concepts and concrete activities that support and motivate consumers." ■

For more information, visit <http://www.aaafp.org/news-now/clinical-care-research/20100721evidbasedconsumers.html>.

FDA Committees Critical of Avandia

Plurality of Agency's Expert Panel Members Votes to Pull Product From Market

A plurality of members of two committees that advise the FDA on medications has voted to recommend that the agency remove rosiglitazone, which is marketed as Avandia, from the market because the diabetes drug has been linked to an increased risk for cardiovascular events.

The medication, which is manufactured by GlaxoSmith-Kline, or GSK, has been under FDA scrutiny since 2007, and recent studies in *JAMA: The Journal of the American Medical Association* and the *Archives of Internal Medicine* concluded that use of the drug significantly increases patients' heart attack risk.

During a July 13-14 joint meeting of the FDA's Endocrinologic and Metabolic Drugs Advisory

Committee and the agency's Drug Safety and Risk Management Advisory Committee, 18 of 33 committee members indicated that available data on rosiglitazone, which is a member of the thiazolidinedione class of drugs, are sufficient to raise significant safety concerns for ischemic cardiovascular events in patients with type 2 diabetes in relation to nonthiazolidinediones, such as metformin and the sulfonylureas. Six committee members disagreed.

Twenty-one of the members of the two committees, however, indicated that data are sufficient to raise significant safety concerns about ischemic cardiovascular events in patients with type 2 diabetes who take rosiglitazone compared with use of a second thiazolidinedione, pioglitazone,



which is marketed as Actos.

Nine panelists said they were not able to make a finding regarding either question.

When asked what regulatory action the FDA should pursue in regard to rosiglitazone, 12 committee members recommended that the drug be removed from

the market. Ten members, however, recommended allowing continued marketing of the medication on the condition that the current package label is revised to include additional warnings and additional restrictions are put in place. According to the FDA, such restrictions could include limiting prescribing to physicians who have enrolled in a program and completed required training.

In addition, seven members of the committees recommended allowing continued marketing of rosiglitazone with only the addition of further label warnings, three voted for continued marketing with no label changes, and one member abstained. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100720avandiarec.html>.

AAFP Applauds Appointment of Donald Berwick as New CMS Administrator

Administration Declares Recess Appointment Necessary

The AAFP has praised the appointment of Donald Berwick, M.D., as the new administrator of CMS, saying in a prepared statement that Berwick's medical expertise and commitment to ensuring high quality care for all will serve America well as CMS implements the reforms in the Patient Protection and Affordable Care Act.

"As a research professional, a clinician and a policy analyst, he brings an extensive background that's crucial to ensuring that health care policy improves patient care and the practice of medicine," said AAFP President Lori Heim, M.D., of Vass, N.C., in the statement. "His leadership has helped ensure that best practices in medical care and groundbreaking medical research are brought to the physicians' offices, and his support for strengthening primary care in the Medicare and Medicaid systems will help set the path for building up the foundation of all high quality health care."

As CMS administrator, Berwick will serve as a key player in overhauling the nation's health care system by overseeing a variety of major tasks associated with the new health care reform law. Those tasks include expanding Medicaid coverage, writing new rules and regulations, and establishing pilot projects to test different models

of care and payment policies. Heim said the AAFP "looks forward to working with Dr. Berwick as the nation moves forward in ensuring that Americans have access to high quality, affordable health care."

President Obama used a recess appointment to make Berwick the new administrator of CMS on July 7, thereby circumventing a contentious confirmation process for the nomination in the Senate. Although Obama nominated Berwick for CMS administrator in April, Republicans were critical of the choice because they were concerned that Berwick could be a proponent of health care rationing. Republican opposition could have delayed the nomination indefinitely, prompting Obama to make a recess appointment while Congress was out of session.

The AAFP supported the Berwick nomination from the outset, saying in a prepared statement in April that Berwick has "demonstrated a long-standing commitment to building a patient-centered, quality focused and efficient health care system." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100707berwickappointed.html>.

ACGME Task Force Airs Latest Proposal on Residents' Duty Hours

The Accreditation Council for Graduate Medical Education, or ACGME, task force on resident physician training standards has released a draft of proposals that, among other things, provide more supervision of first-year residents, reduce first-year residents' duty periods to no more than 16 hours a day and set stricter requirements for duty hour exceptions.



The ACGME said in a June 23 press release that the proposals build on recommendations made by the Institute of Medicine in 2008. The proposals maintain work hours at a maximum of 80 per week, averaged over a four-week period, but call for significant changes in training, especially for first-year residents.

The proposed 2010 ACGME requirements include the following:

- Three classifications of supervision — direct supervision, indirect supervision and oversight — would be set. First-year residents, for example, must have direct supervision, in which the supervising physician is physically present and overseeing the resident's activities, or indirect supervision, in which the supervising physician is on-site.

- Workloads for each resident are to be set based on level of training, patient safety, resident education, severity and complexity of patient illness, and available support services.

- Duty periods for first-year residents are to be no longer than 16 hours a day. Residents in postgraduate year two or greater may continue to be scheduled for a maximum of 24 hours of continuous duty.

- Residents would be allowed to remain on-site for no longer than an additional four hours to provide for the transfer of care. They may not, however, attend continuity clinics after 24 hours of duty.

- Inhospital on-call frequency would be set for every third night, with no averaging, for residents in postgraduate year two or greater.

- First-year residents would be required to have a minimum of eight hours free of duty between scheduled duty periods. Similar provisions are included for residents in postgraduate year two or greater and for residents in their final year of training. Residency review committees, however, may permit certain exceptions.

- Residents would not be scheduled for more than six consecutive nights of "night float."

- Internal and external moonlighting would be included in the 80-hour work week limit. First-year residents, however, would not be permitted to moonlight at all. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100707dutyhours.html>.

AAMC Report Offers Guidelines for Managing Conflicts of Interest in Clinical Care

The Association of American Medical Colleges, or AAMC, is urging U.S. teaching hospitals to establish policies to manage financial relationships between physicians and industry to avoid any potential influence on patient care.

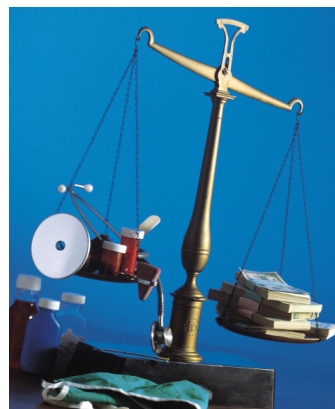
The AAMC's position is spelled out in the report, "In the Interest of Patients: Recommendations for Physician Financial Relationships and Clinical Decision-Making." According to an AAMC press release, the report provides guidance on how academic medical centers can identify, evaluate and disclose conflicts of interest in clinical care.

The report made a number of recommendations aimed at helping academic medical centers manage industry relationships.

- Compensation mechanisms

at academic medical centers should be aligned with the best interests of patients. The centers should carefully evaluate their compensation systems to determine whether the bases for compensation and reward amounts adversely influence physician behavior.

- Academic medical centers should address their physicians' financial relationships with industry in the context of the clinical care they deliver. For example, they could establish mechanisms to identify physician-industry financial relationships and evaluate the potential of those relationships to bias physicians' clinical practice. Such relationships should include the receipt of royalties by physicians and consulting or other services physicians perform for industry,



as well as physicians' ownership in related companies.

- These medical centers should set thresholds for physician reporting of industry interests to their institutions and for those institutions' evaluation of such interests. The centers should determine when an individual physician's financial inter-

est relating to drugs prescribed or devices used on patients should be disclosed to these patients.

- The centers also should disclose the industry ties of their physicians to their respective patient communities as a way of managing actual and perceived conflicts of interest in clinical care. Various disclosure mechanisms, including websites and brochures, can be used to communicate the realities of physician-industry relationships.

- Finally, academic medical centers should take responsibility for helping patients understand the benefits, risks and management of bias resulting from physicians' financial relationships with industry. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100721aamcconflictrpt.html>.

Carnegie Report Calls for Key Innovations in Medical Education

Better Integration of Formal Knowledge, Clinical Experience Needed

By Barbara Bein

A recently released study on medical school and residency education from the Carnegie Foundation for the Advancement of Teaching includes recommendations that emphasize standardized learning outcomes and competencies, individualized training, professionalism, and more supportive learning environments.

Family medicine educators say those recommendations, if implemented, would make physician training more patient-centered and safety-oriented and would promote quality improvement.

"We have ample evidence that professionalism training is badly needed," said Perry Pugno, M.D., M.P.H., director of the AAFP Division of Medical Education.

The study, "Educating Physicians: A Call for Reform of Medical School and Residency," was conducted by researchers at the University of California, San Francisco.

According to a summary of the study, present-day medical education is "inflexible, excessively long and not learner-centered." Formalized knowledge and experiential learning are

poorly integrated, and inadequate attention is paid to patient populations, systems of health care delivery and effectiveness.

The authors propose four broad goals for medical education:

- Medical education should standardize learning outcomes and general competencies and then individualize the learning process for students and residents to allow "fast-tracking" in areas of particular interest or opportunities for experiences in research, policy and education.

- Medical education should unite formal knowledge and clinical skills. Students' and residents'

learning in the basic, clinical and social sciences should be integrated with their hands-on clinical experiences.

- Medical schools and teaching hospitals should support the engagement of all physicians-in-training in inquiry, discovery and systems innovation.

- Professional identity formation — the development of professional values, actions and aspirations — should be the "backbone of medical education." It should build on a foundation of clinical competence, communication and interpersonal skills, and ethical and legal understanding and extend "to aspirational goals in performance excellence, accountability, humanism and altruism."

William Hueston, M.D., Ph.D., a member of the AAFP Commission on Education and chair of the department of family medicine at the Medical University of South Carolina in Charleston, says that ensuring competency while still customizing medical education is key to turning out top-notch physicians.

"The truth is that each person comes into medical school and residency with different levels of pre-existing skills and knowledge bases. Those who are more advanced (in particular areas) should devote their time to areas where they are less skilled," said Hueston.

"The cookie cutter-based current system that only measures the time students spend on each topic will not result in excellence in all required areas. It sometimes results in mediocre cookies." ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100629carnegiereport.html>.



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U.S. Medical Schools Vary Widely in Satisfying Medical Education's 'Social Mission'

When it comes to producing primary care physicians, encouraging them to practice in underserved areas, and recruiting and educating minority physicians, U.S. medical schools vary greatly in fulfilling the "social mission" of medical education. That's the message of a first-ever study from George Washington University, or GWU, in Washington, D.C., that ranks the nation's medical schools according to how well they perform that mission.

The study was published in the June 15 *Annals of Internal Medicine*. According to a June 14 press release from GWU's School of Public Health and Health Services, key findings from the study of 141 medical schools include

- historically black medical schools — Morehouse College in Atlanta, Meharry Medical College in Nashville and Howard University in Washington, D.C. — had the highest social mission rankings;
- public and community-based medical schools graduated higher proportions of primary care physicians than did private and noncommunity-based schools;
- schools in progressively smaller cities produced more primary care physicians and physicians who practiced in underserved communities, but they graduated fewer minorities;
- osteopathic schools produced more primary care physicians than did allopathic schools, but also trained fewer minorities;
- for the most part, schools with substantial NIH research funding produced fewer primary care physicians and physicians who went on to practice in underserved areas and had lower overall social mission scores; and
- schools in the Northeast performed poorly on all three goals and had the lowest social mission scores of any region in the country.

"Where doctors choose to work, and what specialty they select, are heavily influenced by medical school," said lead author Fitzhugh Mullan, M.D., a GWU professor of health policy, in the press release. "By recruiting minority students and prioritizing the training of primary care physicians and promoting practice in underserved areas, medical schools will help deliver the health care that Americans desperately need."

The researchers examined data from more than 60,000 physicians who graduated from U.S. allopathic and osteopathic medical schools between 1999 and 2001. The data came from the AMA Physician Masterfile, the Association of American Medical Colleges and the Association of American Colleges of Osteopathic Medicine.

According to the press release, the research team studied physicians in practice after they had completed all training and subsequent obligations, such as serving in the National Health Service Corps or the armed forces, to pinpoint their actual career selections. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100625socialmission.html>.

'July Effect'

Study Identifies Spike in Fatal Medication Errors When New Residents Arrive

By Barbara Bein

Fatal medication errors inside medical institutions spike in July, and the increase is at least partly associated with the arrival of new medical residents who are starting their responsibilities in patient care. That's the conclusion of researchers from the University of California, San Diego, who recommend increasing resident education about medications.



According to the study, which was published online May 29 by the *Journal of General Internal Medicine*, fatal medication errors spiked as much as 10 percent in July inside medical institutions in U.S. counties that contain teaching hospitals. This spike is informally known as the "July Effect" or the "New Resident Hypothesis."

"We found a significant July spike in fatal medication errors inside medical institutions," said researchers. "After assessing competing explanations, we concluded that the July mortality spike results at least partly from changes associated with the arrival of new medical residents."

The researchers examined computerized death certificates from 1979-2006. They focused on inpatients, outpatients and those who died in the emergency department. Fatal medication errors were defined as those recorded as the primary cause of death.

According to the researchers, computerized death certificates do not record whether the patient died in a teaching hospital, but they do record the county of death. So they looked at the proportion of major teaching hospitals in each county.

The results were clear: "The greater the concentration of teaching hospitals in a region, the greater the July Effect for intra-institutional medication errors in that region," they found.

According to the study, researchers entertained hypotheses other than that new residents contributed to the increase in fatal medication errors, including that the July Effect may result from patient behavioral changes during the summer, that it results from the July 4 holiday or that it results from coding changes in July.

They quickly discounted each of these alternatives, however.

For example, if the July Effect came from greater alcohol consumption in the summer that was associated with harmful alcohol-medication interactions, then the spike also would be seen in August. But no such August spike was found.

In addition, said the researchers, the July Effect does not result from the July 4 holiday because the holiday is celebrated across the country, and the effect is evident only in counties with teaching hospitals.

The researchers could not attribute the July Effect to coding changes, either, because no evidence shows that there are more misclassifications of causes of death in July than in any other month. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100622julyspike.html>.

AS WE SEE IT

Voices From the AAFP

Guest Opinion

Family Medicine and Wonca on World Stage

By Rich Roberts, M.D., J.D., President, World Organization of Family Doctors

On May 22, with family doctors from around the world bearing witness, I pledged to lead the World Organization of Family Doctors, or Wonca, to the utmost of my ability during my three-year term as Wonca president.

My installation, which took place at the 19th World Conference of Family Doctors in Cancun, Mexico, was a significant event in my life and also had larger significance because I'm the third American — and the third AAFP past president — to serve as Wonca president. To date, no other country has provided three presidents to lead Wonca.

My term as Wonca president comes at a time when family medicine stands front and center in health care reform discussions around the globe. I'm proud to say that Wonca has played an important role in making this happen.

Growing Influence

Wonca began 38 years ago, when 18 national academies and colleges of family/general practice (including the AAFP) established the association as a venue for sharing ideas about training family doctors. From that modest beginning, Wonca has burgeoned to include 120 member organizations that represent some 250,000 family doctors and 100 countries, covering 90 percent of the world's population.

In recent years, Wonca's influence and the influence of family medicine have grown enormously. For example, in 2002, Wonca and the World Health Organization, or WHO, published *Improving Health Systems: The Contribution of Family Medicine — A Guidebook*, which positioned Wonca as the go-to organization for countries that want to organize their health care systems around primary care.

Also in 2008, the WHO's leading publication, the *World Health Report*, focused international attention on the importance of primary care. Wonca worked with the WHO on that report, titled "Primary Health Care (Now More Than Ever)."

These days, Wonca representatives participate in almost all major WHO initiatives, a further testament to Wonca's growing visibility.

Finally, two breakthroughs occurred at the WHO's 2009 World Health Assembly. Wonca's president addressed the assembly for the first time ever. The assembly also voted unanimously to commit to the idea that primary care should be the basis of all health care systems — and that countries should be urged to train enough primary care workers, including



Former AAFP President Rich Roberts, M.D., J.D., (far right) poses with Wonca President-elect Michael Kidd, A.M., of Adelaide, Australia, (far left) and Wonca Past President Chris van Weel, Ph.D., of Nijmegen, The Netherlands. Roberts is the new president of the international organization of family physicians.

Courtesy of Wonca

family physicians, for their needs. The commitment to family physicians was new.

Great Expectations

Although Wonca has never been more influential than it is today, it also has never been more vulnerable. Why? Because great influence brings great expectations.

More and more, Wonca is called upon to help and to collaborate. For example, the health ministries of developing nations increasingly turn to Wonca, asking its leaders to consult on their health care systems. This opens up tremendous opportunities in areas where family medicine hasn't been well established.

But Wonca's ability to respond is hampered by its current structure and by its limited resources (made even worse by the economic downturn and reduced support from the pharmaceutical industry), leaving Wonca vulnerable to criticism if it can't help those who ask for assistance. Wonca's greatest challenge right now is to develop the capacity to meet those expectations.

To meet the challenge, Wonca has committed to transforming from an academic club focused on family physician training into an outward-looking professional association with the capacity to nurture family medicine worldwide.

An Invitation

If you're still reading this guest opinion, it's clear that international family medicine interests you. Because AAFP members are indirectly Wonca members by virtue of their AAFP membership, I'd like to close by inviting Academy members to get involved with Wonca. Consider becoming a direct member, which is one way to support Wonca.

To get involved with Wonca, go to www.globalfamilydoctor.com and click on the "Groups" tab on the right to learn more about Wonca's special interest groups, working parties and e-mail discussion groups. You'll enjoy communicating with your international colleagues, and you'll probably glean ideas you can use every day in your practice. I know I have.

Wonca embodies all of the collective aspirations and talents of the world's family doctors and their organizations, and I am enthusiastic and optimistic as I begin my term as Wonca president. I hope you'll join me in Wonca involvement. I know you'll find it fascinating and productive. ■

For more information, visit <http://www.aafp.org/news-now/opinion/20100707woncagsop.html>.