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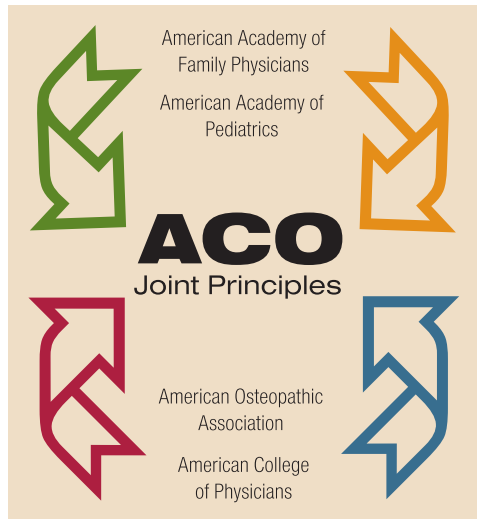
Primary Care Associations Release Joint Principles for Accountable Care Organizations

By Sheri Porter

The country's top primary care medical associations — the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association — have released their Joint Principles for Accountable Care Organizations. The move comes in response to language in the recently enacted Patient Protection and Affordable Care Act that encourages physicians and other health care professionals to organize as accountable care organizations, or ACOs.

According to AAFP Board Chair Lori Heim, M.D., of Vass, N.C., it is important that the four primary care organizations articulate a shared vision of ACOs, much like they did with the Joint Principles of the Patient-Centered Medical Home. "You have all four organizations coming together to develop policy, and that sends

a very strong message to the government and to other payers about what they need to be aware



of as they roll out these accountable care organizations," said Heim.

"ACOs will not be successful if they are not based on primary care and the patient-centered medical home, because that's where we're going to get the care coordination, cost savings and quality of care that we're all interested in."

Indeed, according to the document, an ACO should provide accessible, effective, team-based care based on the Joint Principles of the Patient-Centered Medical Home. In addition, the ACO principles say an ACO should deliver culturally proficient and patient- or family-centered health care.

The four organizations also agree that structurally,

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Changes to PCIP Program Ensure 80 Percent of FPs Will Be Eligible for Incentives

By James Arvantes

After feedback from the AAFP and several other primary care organizations, CMS has changed its implementation rules for the Medicare Primary Care Incentive Program, or PCIP. Those changes will allow approximately 20 percent more family physicians to qualify for the bonus program than previously anticipated.

As of January, the Patient Protection and Affordable Care Act requires Medicare to pay all primary care physicians whose primary care billings comprise at least 60 percent of their total Medicare allowed charges a 10-percent bonus. The bonus program will last until December 2015, and bonuses will be paid quarterly.

However, CMS' original proposed implementation of the *See PCIP Program, page 2*

Breaking News: Medicare Pay Cut Delayed

On Nov. 29, the U.S. House of Representatives approved a one-month delay in the 23 percent reduction in the Medicare physician payment rate scheduled to take effect on Dec. 1. The Senate approved the measure on Nov. 18. Visit *AAFP News Now* online often for further developments regarding changes to the sustainable growth rate formula to which physician payment rates are tied.

DECEMBER HIGHLIGHTS



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New Flu Vaccine Codes..... page 6

CMS has created five new HCPCS codes — reported as "Q" codes — for physicians to use when administering seasonal influenza beginning Jan. 1.

Harvard Invests in Primary Care... page 10

With the help of a \$30 million gift, Harvard Medical School launches a Center for Primary Care 16 months after defunding its primary care division.

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an ACO should, among other things,

- demonstrate strong physician leadership that includes equitable representation from primary care and subspecialist physicians;
- strive for clearly defined and transparent organizational relations – including payment methodologies – between physicians, other health care professionals and consumers;
- include patient and family input in policy development;
- commit to interfacing with programs that improve the health of the public;
- provide incentives for patients and families to pursue personal health and wellness activities;
- encourage patient selection of a primary care physician if the patient is assigned to an ACO or otherwise ensure voluntary ACO participation by all participants;
- use nationally accepted and validated clinical measures to gauge performance and efficiency and to evaluate patient experience;
- implement clinically integrated information systems;
- include monitoring to prevent unintended consequences;
- allow physician participation in multiple ACOs;
- address and eliminate barriers to small practice participation;
- protect physicians and other health care professionals from existing antitrust and similar laws that restrict collaboration on payment models; and
- promote processes that reduce administrative burdens on practices and their patients.

Heim said the Academy wanted to ensure that the ACO design was not driven by other organizations that may not have the same awareness of the primary care and family medicine perspectives. “One of the big fears we have is that the big players in the field – the folks who are really ready to ‘rock and roll’ with this – are the large health systems and the hospitals,” she said.

Heim also noted that CMS is stepping up its efforts to test medical home projects and, as part of that process, the agency also will test ACOs. “It’s critical for our members to be involved with this at the ground level,” said Heim.

The joint principles for ACOs also lay out guidelines on payment models and incentives, which must, among other things,

- align mutual accountability at all levels;
- base rewards for performance on target levels of performance, achievement and improvement that have been developed with significant input from physicians and other health care professionals; and
- protect physicians and other health care professionals from insurance risk unless otherwise stated in the participation agreement.

Heim said that as quality improvement and cost savings to the system are realized, primary care practices that are at the heart of the ACO model must be recognized. “Primary care practices will need to make sure that they are receiving the benefits of the shared savings,” said Heim. ■

For the complete story, visit <http://www.aafp.org/news-now/professional-issues/20101118acojointprinciples.html>.

PCIP Program, *continued from page 1*

program would have precluded a significant number of primary care physicians who are providing comprehensive and longitudinal care from receiving the incentive payment. The AAFP, both on its own and along with several other primary care organizations, repeatedly pointed out the drawbacks of CMS’ implementation proposal.

In response, CMS made eligibility rules for the PCIP more inclusive. The agency excluded labora-

tory charges and other charges from the bonus payment eligibility calculation and subtracted physician hospital visits from the allowed charges, as well. These changes will ease the PCIP’s eligibility requirements and allow as many as 80 percent of the nation’s family physicians to qualify for the bonus payment, according to initial estimates from CMS.

“We have been telling everyone who would listen how wrong the message would be to family

physicians who provide comprehensive family medicine services – often in the most needy areas – if they do not qualify,” said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas. “This is incredibly good news and further confirmation that our issues are being heard and responded to.” ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101103pcipchanges.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between October 27 and November 20, 2010.

Leave CMS Elimination of Consultation Codes Intact, Says AAFP

The AAFP has sent a letter to every House and Senate member expressing the Academy's strong support for the elimination of Medicare consultation codes in the final 2010 physician fee schedule.

CMS eliminated the consultation codes as part of the 2010 fee schedule, but some medical subspecialty organizations are actively urging Congress to overrule the CMS decision, according to the AAFP. In the Oct. 21 letter to Congress, AAFP Board Chair Lori Heim, M.D., of Vass, N.C., urged congressional members "not to interfere with this finalized policy."

"As the Medicare agency accurately demonstrated in the proposed 2010 physician fee schedule and as the HHS Office of Inspector General has well documented, the distinction between consultations and other 'evaluation and management' services became drastically blurred over the past several years," Heim wrote. "Prior to CMS' elimination of these codes, Medicare reimbursement for consultation services was at a higher rate than that of corresponding office and inpatient visit services, despite similar work and documentation requirements." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101026consultcodes.html>.

Health Care Reform Calls for Shared Savings Programs, ACO Model

By Sheri Porter

One of the goals of the recently enacted health care reform legislation is to improve the nation's health care system by providing higher quality health care for more individuals at a lower cost. And, according to Section 3302 of the Patient Protection and Affordable Care Act, accountable care organizations, or ACOs, may play a leading role in achieving those goals.

The section of the legislation titled "Medicare Shared Savings Program" requires the secretary of HHS to establish a shared savings program that "promotes accountability for a patient population and coordinates items and services under (Medicare) parts A and B." The program also is tasked with encouraging "investment in infrastructure and redesigned processes for high quality and efficient service delivery."

Although the legislation includes language that defines participation, eligibility and reporting requirements, much of the fine print as to how ACO test programs will function under HHS will be left to the rulemaking discretion of the HHS secretary.

For example, the HHS secretary will determine appropriate measures to assess the quality of care furnished by an ACO, and, in turn, ACOs will submit data in a form and manner specified by the secretary.

Those data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by members of the ACO. The secretary also will determine how Medicare beneficiaries are assigned to ACOs.

According to AAFP President Roland Goertz, M.D., M.B.A., the Academy is pleased that the health care reform law leaves certain elements of ACOs open to interpretation. "At this point, the law allows a broad definition of an ACO, and that allows physicians to play a significant role in how ACOs can be organized," said Goertz.

"There are a considerable number of things that need to be done, including the development of organizational and payment structures," he told *AAFP News Now*. "It's a lot like building a new business. I'm convinced that any successful ACO will have physicians at the top managing the organization and woven into the very fabric of the ACO's operations — unless, of course, physicians are creating ACOs themselves, which certainly should be considered."

Goertz acknowledged that the health care bill gives a lot of power to a single agency in the federal government. "Hopefully, the HHS secretary respects that power and puts deliberate thought into making decisions that are going to affect all of the Medicare population," said Goertz.

He cautioned family physicians to carefully consider any offers to join an ACO. "Be very deliberate in analyzing whatever proposal is brought to the table, and assess the advantages and disadvantages for your practice and your patients," he said.

Harold Miller, executive director of the Center for Healthcare Quality and Payment Reform and a recognized expert on ACOs, wants family physicians to go out and proactively form their own ACOs.

Miller told *AAFP News Now* that if family physicians don't lead the charge, "they're going to be at the mercy" of what some other entity decides — be it a hospital or big health system — and those decisions may not be in the best interest of physicians.

He pointed out that family physicians are perfectly positioned because they know how to manage chronic health care conditions for their patients and already work to keep those patients out of the hospital.

Miller said the success of the ACO model depends a lot on the payment system. "One of the concerns I have about the shared savings payment model — which is the principal method that's in the federal law — is that it creates a strong incentive for hospitals to acquire primary care practices."

That's because the biggest cost savings in the ACO model comes from keeping patients out of hospitals, said Miller, and that reduces the hospitals' revenue.

"Under the shared savings model, hospitals can't recoup any of those revenue losses unless they own physicians' practices, because shared savings don't go to hospitals, they go to doctors. In fact, they go to primary care doctors," he said.

Family physicians "should recognize that under these payment models, they are in control," said Miller. He also noted the reams of HHS rules left to be written and said that rule makers would be influenced by the wants and needs of early ACO implementers. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101027hcreformacos.html>.

DEA Policy on Schedule II Drugs Harmful to Some Patients, Say Medical Organizations

By David Mitchell

The DEA's policies for prescribing Schedule II controlled substances in long-term care practice settings create unnecessary delays in managing patients' pain and conflict with CMS guidance, according to a letter to the DEA signed by the AAFP, six other national health care organizations and more than 30 state medical associations.

The Nov. 5 letter, which was spearheaded by the American Medical Directors Association, or AMDA, responds to a DEA policy statement that was published Oct. 6 in the *Federal Register*.

Federal regulations require prescriptions for Schedule II controlled substances to be made in writing and signed by a clinician registered with the DEA. If the prescribing health professional determines that the situation is an emergency, a pharmacist may dispense a Schedule II drug after receiving verbal authorization directly from the prescriber. The prescribing clinician is required to follow up with a written prescription within seven days of a verbal order.

According to the AMDA, the DEA has been aggressively enforcing regulations for Schedule II controlled substances, forcing health care professionals in long-term care settings to modify long-standing procedures and delaying dispensing of controlled substances to patients who urgently need them.



In August, the AAFP signed on to a tip sheet developed by the AMDA to help physicians in their efforts to ensure proper prescribing of controlled substances.

The tip sheet — which also is supported by the American Academy of Hospice and Palliative Medicine, the American Geriatrics Society, and the AMA — makes recommendations for prescribers to expedite the filling of controlled substance prescriptions.

The DEA clarified in its new policy statement that the agent of a practitioner in a long-term care facility may fax a prescriber-signed prescription to a pharmacy. The DEA also said that agents may telephone pharmacies and convey prescription information from the prescriber for controlled substances in Schedules III-V.

However, agency officials held firm on the position that agents can not call in an oral prescription for a Schedule II controlled substance on behalf of a practitioner “even in an emergency circumstance.”

The letter to the DEA says that the agency's policy on Schedule II drugs conflicts with CMS guidance for long-term care, which calls for residents to be given rapid relief of “excruciating pain.”

According to the letter, the conflicting regulations could cause nursing facility staff to inadequately treat pain by not prescribing needed medication or risk failing to comply with DEA policy.

“Pain that is not promptly treated due to avoidable delays in receiving Schedule II analgesic medications can lead to difficulty with self-care, behavioral difficulties, anxiety, depression, difficulty sleeping, and poor appetite, in addition to the signs and symptoms of drug withdrawal, including diarrhea and abdominal cramping, bone pain, and severe malaise and myalgias, as well as extreme dysphoria,” the letter says. ■

For the complete story, visit <http://www.aafp.org/news-now/professional-issues/20101110schedule2ltr.html>.

AAFP Asks CMS Administrator Berwick to Consider Changes to RUC

In an Oct. 8 letter to CMS Administrator Donald Berwick, M.D., AAFP Board Chair Lori Heim, M.D., of Vass, N.C., pushed for changes in the AMA/Specialty Society Relative Value Scale Update Committee, commonly referred to as the RUC.

“The role and influence of the RUC is well-documented, as is CMS' acceptance of the RUC's recommendations,” said Heim, noting that the Academy is concerned that CMS relies “too heavily” on the sole committee that examines the valuation of codes in the Medicare

physician fee schedule.

Heim reminded Berwick of the Medicare Payment Advisory Commission's 2006 recommendation that CMS establish a group of experts separate from the RUC to help the agency review relative value units, or RVUs.

The Academy has long supported that recommendation, said Heim.

“Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and validating

RVUs,” said Heim.

An expert panel that included consumers and employers could analyze supporting evidence without bias because they would be less invested financially in the outcome, she said. Such a panel should augment, not replace, the RUC.

Heim also pointed out that CMS and the RUC rely on physician specialty societies to identify misvalued services that merit review. However, in the current system, when changes in RVUs are budget-neutral across the fee

schedule, “specialty societies have no vested interest in identifying potentially overvalued services,” said Heim.

The Academy also asked Berwick to encourage more transparency in the RUC process, as well as a “fundamental change in the composition of the RUC that more equitably recognizes the value of primary care.” ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101022rucletter.html>.

South Carolina Insurer Embraces PCMH Model of Care

By James Arvantes

BlueCross BlueShield of South Carolina has started rolling out patient-centered medical home, or PCMH, initiatives across the state after a medical home pilot project led to dramatic improvements in the care and treatment of patients with diabetes in the Charleston area during the past year.

The initial medical home pilot project that inspired the move was a joint venture between BlueCross BlueShield of South Carolina, or S.C. BlueCross; its subsidiary, Blue Choice HealthPlan of South Carolina; and Palmetto Primary Care Physicians, a large primary care practice in the Charleston area that includes 24 clinic sites and 50 physicians. The pilot project targeted 1,200 patients with diabetes.

Based on data from the 809 patients who were continuously enrolled in the project for 12 months, officials found that patients experienced 10.4 percent fewer inpatient hospital days and 12.4 percent fewer emergency room, or ER, visits when compared with figures from the previous year. Moreover, patients in the medical home had

better control of their cholesterol and glucose levels and were able to improve their body mass index and their measures of potential kidney damage. These patients also had higher rates of completing recommended eye exams.

In analyzing the data, the organizations also compared outcomes for patients in the medical home pilot with a control group of patients with diabetes who were treated by other primary care practices in the Charleston area. Age and gender mix were similar for both groups.

The patients in the medical home group experienced 10.7 percent fewer hospital admissions than the control group, as well as 36.3 percent fewer inpatient hospital days and 32.2 fewer ER visits than the control group.

S.C. BlueCross said it intended to move aggressively to roll out the PCMH approach around the state. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101109scpcmhpiilot.html>.

In Brief *Clinical Care and Research*

FDA Adds Cardiac Warning to HIV Drug's Label

The FDA is notifying the public and health care professionals about potentially life-threatening side effects when the HIV antiviral drug saquinavir, which is marketed as Invirase, is used in combination with another antiviral agent, ritonavir, which is marketed as Norvir. The medications are given together to treat HIV infection. Low-dose ritonavir is given to boost the level of saquinavir in the body, lowering the number of saquinavir capsules or tablets that a patient needs to take each day. When used together, the two drugs could cause prolongation of the QT and/or PR intervals. Each of these changes in the heart's normal electrical activity can be detected readily on an electrocardiogram. Prolongation of the QT interval can precipitate torsades de pointes, a type of ventricular tachyarrhythmia that may be self-limited or progress to ventricular fibrillation. Prolongation of the PR interval can lead to heart block of varying degree (first, second or third). <http://www.aafp.org/news-now/clinical-care-research/20101026saquinavir.html>

ACIP Expands Recommendations for Pertussis Vaccination

With the pertussis outbreak in California nearing a 60-year high in the number of cases reported, the CDC's Advisory Committee on Immunization Practices, or ACIP, has voted to recommend the off-label use of tetanus, diphtheria and acellular pertussis, or Tdap, vaccine in two specific patient groups. Children ages 7-9 years who did not complete the recommended childhood series of diphtheria and tetanus toxoids and acellular pertussis, or DTaP, vaccine should receive a catch-up dose of Tdap. Adults ages 65 and older who have close contact with infants should receive a dose of Tdap.

A dose also may be given to people in this age group who have not previously received Tdap. The purpose of the recommendation is to protect infants from the dangers of pertussis. The California Department of Public Health reported that as of Oct. 19, the state had received reports of 6,257 confirmed, probable and suspected cases of pertussis. <http://www.aafp.org/news-now/clinical-care-research/20101103aciprecs.html>

AAFP NRN Recruiting Practices for Pilot With YMCA

Starting in January, a 24-month pilot funded by the Agency for Healthcare Research and Quality, or AHRQ, will examine a quality improvement project that links seven primary care practices to existing community resources at the YMCA in Providence, R.I. Each participating practice will be introduced to concepts of the AAFP's Americans In Motion-Healthy Interventions, or AIM-HI, program. Each practice then will be asked to recruit 12-20 adult patients to participate in one of two of the YMCA's existing programs: a diabetes prevention program designed for individuals with prediabetes or a healthy lifestyle program designed for people interested in making behavior changes. Researchers will track the number of patients referred to the YMCA programs and the number who actually enroll, as well as patient outcomes, such as body mass index and blood pressure changes. Researchers also will collect data related to the project's effect on practices, such as workflow modifications, infrastructure requirements for maintaining the link to the YMCA, and changes in office culture or practices. <http://www.aafp.org/news-now/clinical-care-research/20101103nrnymcapilot.html> ■

Mission-driven Physicians More Likely to Practice Among Urban Underserved

By Barbara Bein

Physicians with mission-based values (i.e., a sense of responsibility or moral obligation to a particular community or a defined patient population) as well as those who self-identify with a certain community and its patient population, are more likely to practice in urban underserved areas. Recognizing this, medical schools interested in identifying physicians motivated to practice in underserved areas can examine such humanistic- and intrinsic-level factors in greater detail to identify and recruit mission-driven students.

Moreover, clinical practices in physician-shortage areas can retain these mission-driven physicians through modifications in work hours and other lifestyle factors.

These are among the findings of a study led by family physician Kara Odom Walker, M.D., M.P.H., M.S.H.S., that involved primary care physicians in Los Angeles County. The study, "Recruiting and Retaining Primary Care Physicians in Urban Underserved Communities: The

Importance of Having a Mission to Serve," was published in the November *American Journal of Public Health*.

"Many studies have shown that those from underserved, rural and minority backgrounds are more likely to return and remain in underserved areas," Walker said in an interview with *AAFP News Now*. "We need to continue to encourage students throughout the pipeline to consider opportunities in underserved communities."

"We need to identify motivated and mission-driven premedical students prior to entering medical school and support their interests through training and mentorship opportunities in medical school."

Study researchers conducted in-depth interviews with 42 physicians, including African-American, Latino and non-Latino white individuals, who practiced in underserved and nonunderserved areas of Los Angeles County. Most of those interviewed practiced internal medicine (48 percent), followed by family medicine (31 percent)

and pediatrics (17 percent). The remainder identified themselves as practicing in some other primary care field.

Researchers examined the physicians' childhood backgrounds, residency training locations and practice locations to date, starting their queries with the basic question, "How did you decide to work here?" They then segmented responses into three domains of factors that affected the physicians' current choice of practice location: personal motivators, career motivators and clinic support.

Personal motivators included opportunities for personal growth; self-identity, as influenced by language and personal, family, cultural, socioeconomic or geographic backgrounds; and mission-based values, such as a sense of responsibility to a particular community or patient population.

According to the study, physicians who worked in underserved areas were more likely to emphasize mission-based values and self-identity as reasons for

choosing their practice location.

Additionally, researchers found that more than 80 percent of physicians who trained in or who were from an underserved area worked in an underserved setting; no physicians who trained in a nonunderserved setting went to work with the underserved.

Indeed, the study reported, physicians gave ringing personal endorsements for deciding to practice in urban underserved communities. One told the researchers, "I grew up in the East Los Angeles community ... I grew up uninsured ... so that was a big motivation to come back and practice in the community here."

Another said, "I feel like I have a moral obligation to be here."

"Regardless of their race and ethnicity, the majority of physicians who practiced in underserved areas reported feeling a unique connection to the particular community in which they practiced," the study said. ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101110mission-driven.html>.

CMS Creates New Influenza Vaccine Product Codes Effective Jan. 1

CMS has created five new Healthcare Common Procedure Coding System, or HCPCS, codes for physicians to consider when reporting seasonal influenza immunizations they give their patients. Beginning Jan. 1, physicians should use these "Q" codes when administering products previously reported with CPT code 90658.

The new HCPCS codes and the specific products for which they should be used are:

- Q2035 for Afluria,
- Q2036 for Flulaval,
- Q2037 for Fluvirin,
- Q2038 for Fluzone, and
- Q2039 for influenza virus



Sheri Porter/AAFP News Now

vaccine, split-virus, when administered to individuals 3 years of age and older — for intramuscular use (not otherwise specified).

Certain other vaccine codes still are valid 2010-2011 flu vaccine codes, so physicians should use CPT codes 90655-90657, 90660 and 90662 when they use vaccine products represented by those codes.

According to Cynthia Hughes, C.P.C., an AAFP coding specialist, CMS has deemed CPT code 90658 a "nonpayable" code.

"Any physician who uses CPT code 90658 for dates of service after Dec. 31 will see that portion of the claim denied," said Hughes. "If practices start right away, they'll have the rest of this month to make changes to their billing forms and programs," she added.

Hughes attributed the coding changes to wording in the final 2011 Medicare Physician Fee Schedule. The rule allows Medicare to base vaccine payments on the average wholesale

price of each vaccine.

"Medicare has assigned 'Q' codes to each individual product this year to account for variances in manufacturers' pricing of their influenza vaccine product," said Hughes, adding that this step should help ensure physicians are paid fairly for products that may have significant cost differences.

Hughes noted that private insurers may make independent decisions about whether or not to adopt CMS' coding changes. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101109qcodes.html>.

Health Care Reform Law Provides Grants for Workplace Wellness Programs

A provision in the newly enacted health care reform legislation could provide primary care physicians in small communities with a unique opportunity.

Section 10408 of the Patient Protection and Affordable Care Act allows HHS to provide grants to small businesses — those with fewer than 100 employees — to create comprehensive workplace wellness programs based on evidence-based research and best practices.

The provision authorizes the appropriation of \$200 million for fiscal years 2011 through 2015.

HHS has not released specific criteria for the grants or details of the application process, but the legislation outlines the following requirements for workplace wellness programs:

- health awareness initiatives, including health education, preventive screenings and health risk assessments;
- efforts to maximize employee engagement, including mechanisms to encourage employee participation;
- initiatives to change unhealthy behaviors and lifestyle choices, including counseling, seminars, online programs and self-help materials; and
- supportive environment efforts, including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity and improved mental health.

Companies that established wellness programs before the health care reform bill was signed into law are not eligible for the grants.

The Wellness Council of America estimates that wellness programs save employers \$1.50 to \$3 for every dollar spent on such programs. That return on investment, which typically begins after three years, has dipped somewhat in recent years as employers have invested more money in such programs.

Martin Sepulveda, M.D., vice president of integrated health services for IBM Corp., said the grants could offer primary care physicians in rural areas and small communities a chance to partner with local businesses.

"If you're in New York City, those 100 employees are probably going to 100 different places to get care," he said. "On the other hand, if you're in a community with a small number of primary care practices and you know you have a significant proportion of an employers' 100-person workforce in your practice, then you really have an opportunity ... to try to collaborate with the employer to pursue funds to enable things to be done in the workplace or the practice or delivered by practice team members."

IBM knows about operating wellness programs on a large scale. The technology giant has been offering standard screenings and risk assessments since before Sepulveda arrived in the mid-1980s.

Sepulveda said as many as 80 percent of IBM's U.S. employees participate in health risk assessments. The company focuses on helping employees change the risk factors they can control, such as diet, exercise, resilience and smoking. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20101110wellnessprogs.html>.

NFID Urges Docs to Help Boost Adult Immunization Rates

By David Mitchell

Although nearly 90 percent of U.S. adults would agree to immunizations if their physician recommended a vaccine, only 41 percent would agree to receive a vaccine if their doctor did not prompt them. That is according to recent surveys by the National Foundation for Infectious Diseases, or NFID.

"Patients need to hear these recommendations from their providers, and it needs to be clear," said NFID medical director Susan Rehm, M.D., during a Nov. 17 news conference to announce a campaign that calls for adult vaccinations to be integrated into routine health care.

The initiative is supported by more than a dozen national health organizations, including the AAFP.

"Practices need to institute formal procedures to make sure vaccines are discussed and the value of vaccines is reinforced at every visit," said Rehm, who also is vice chair of the Department of Infectious Diseases at the Cleveland Clinic. "Each visit needs to be an immunization visit because we don't get adults in for routine care as often as we'd like."



Fifty thousand Americans die each year from vaccine-preventable illnesses, and 95 percent of those are adults, according to HHS. Hundreds of thousands of individuals are hospitalized with preventable illnesses, while millions of others get sick and suffer lost productivity.

Rehm said separate NFID surveys of consumers and primary care physicians showed a "communication breakdown" between doctors and their patients.

For example, 87 percent of physicians surveyed said they discuss vaccines with all their patients, and 12 percent said they discuss vaccines with all patients who have risk factors or indications for particular immunizations.

However, nearly half of the consumers surveyed said they didn't recall discussing immunizations, other than the seasonal flu vaccine, with their physician, and 21 percent said they had not discussed any vaccines with their physician. Furthermore, 99 percent of physicians indicated that they initiate vaccine conversations with their patients, but 45 percent of patients said they had to ask their physicians about vaccines.

Melinda Wharton, M.D., M.P.H., deputy director of the CDC's National Center for Immunization and Respiratory Diseases, said the role of health care providers in improving adult immunization rates could not be overstated. "That's who people want to get advice from," Wharton said during the news conference. "They want to hear from their doctor about what's in their best interest for their health."

It also is important that health care providers are up-to-date with the adult immunization schedule developed by the CDC's Advisory Committee on Immunization Practices, the AAFP, the American College of Obstetricians and Gynecologists, and the American College of Physicians, said Wharton. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20101118nfidadultvaccines.html>.

FDA to Require Graphic Warnings on Cigarette Packages, Tobacco Ads

Smokers will be starkly confronted with the potential consequences of their habit every time they buy a pack of cigarettes under the terms of an FDA proposed rule published Nov. 12 in the *Federal Register*.

"Every pack will become a mini-billboard that tells the truth about smoking," FDA Commissioner Margaret Hamburg, M.D., said during a Nov. 10 news conference.

The Family Smoking Prevention and Tobacco Control Act signed into law by President Obama last year gave the FDA the authority to regulate tobacco products, while also requiring that cigarette packages and advertisements have larger and more visible graphic health warnings.

Hamburg said that when the new rule is finalized, manufacturers will be required to devote half of the front and back panels of

cigarette packages to the warnings, which are getting a significant update for the first time in 25 years.

For the first time, the warnings will include a statement reflecting the fact that tobacco products are addictive. Another warning — one of nine new cautionary messages — says that tobacco products can kill people.

Hamburg said the facts are being presented "directly and bluntly" to raise public awareness about the dangers of smoking, encourage adult smokers to quit and discourage youth from starting.

Tobacco use is the leading cause of premature and preventable death in the United States,



according to HHS, accounting for more than 400,000 deaths each year. Thirty percent of all cancer deaths are related to tobacco.

Unlike the tiny warnings that currently reside on the side panels of cigarette packages, the new larger warnings will be accompanied by graphic images.

The grim photos released by HHS include one image of a dead body in a coffin and another showing a cadaver bearing a toe tag and lying on a morgue table. A third depicts an emaciated, deathly ill young woman lying in a hospital bed.

"Some of the images are very powerful," Hamburg said. "That is the point."

HHS will issue its final rule in June 2011.

Tobacco companies will have until September 2012 to begin using the warnings in their packaging and print advertisements. Marketers will be required to devote 20 percent of print advertisement space — specifically, at the top of all ads — to the warnings.

The FDA has taken several steps since it was given authority to regulate the tobacco industry last year. The agency already has prohibited the use of the terms "light," "low" and "mild" in cigarette marketing and packaging; banned cigarettes with fruit, candy, and spice flavors; and restricted the sale and marketing of tobacco products so that young people are less likely to be exposed to tobacco ads.

"It's been a very busy first year," Hamburg said. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20101112fda-cigwarnings.html>.

In Brief *Health of the Public*

Actavis Inc. Recalls Fentanyl Patches as Safety Precaution

Actavis Inc. is recalling 18 lots of its Fentanyl Transdermal System 25-mcg/hour C-II patches because the opioid-containing products may release their active ingredient faster than approved specifications permit. The FDA said in an Oct. 22 safety alert that accelerated release of fentanyl can lead to adverse events for at-risk patients, including excessive sedation, respiratory depression, hypoventilation and apnea. Fentanyl patches are indicated for the management of moderate to severe chronic pain that requires around-the-clock opioid administration for an extended period of time and cannot be managed by other means, the agency said. <http://www.aafp.org/news-now/health-of-the-public/20101025fentanylrecall.html>

FDA Requires New Safety Warnings for Some Prostate Cancer Drugs

The FDA is requiring manufacturers of gonadotropin-releasing hormone, or GnRH, agonists to update their products' labeling with new safety information because the medications, which are used primarily to treat advanced prostate cancer, have been linked to an increased risk of developing diabetes and cardiovascular disease. The following medications are affected by the label changes: leuprolide acetate, which is marketed as Eligard, Lupron, Lupron Depot and Viadur; goserelin acetate, which is marketed as Zoladex; triptorelin pamoate, which is marketed as Trelstar; and histrelin acetate, which is marketed as Vantas. <http://www.aafp.org/news-now/health-of-the-public/20101021gnrhlabelchanges.html>

NIH Alerts Caregivers to Increased Risk of SIDS in Cold Weather

With winter approaching, the NIH is alerting parents and caregivers that babies are at higher risk for sudden infant death syndrome, or SIDS, during the winter months. Parents often place extra blankets or clothes on infants during cold weather. However, infants are sensitive to extremes in temperature and cannot regulate their body temperatures well. Studies have shown that multiple layers, heavy clothing, heavy blankets and warm room temperatures increase the risk for SIDS. According to the National Center for Health Statistics, more than 2,300 children died of SIDS in 2006. <http://www.aafp.org/news-now/health-of-the-public/20101108sidsalert.html> ■

Unprofessional Conduct Among U.S. Medical Students Linked to Burnout

By Barbara Bein

Like many residents and practicing physicians, U.S. medical students are prone to burnout. When they feel this distress, they're more likely to engage in unprofessional conduct. They rarely engage in academic dishonesty, such as cheating, but they may short-cut aspects of patient care, such as reporting a test result as normal when they actually omitted the test. These are among the findings presented in a Mayo Clinic study published in the Sept. 15 *JAMA: Journal of the American Medical Association*.

The survey of 2,682 medical students from seven U.S. medical schools also found that students experiencing burnout had less altruistic views about physicians' responsibility to society, including less desire to provide care for the medically underserved.

"Although students recognize cheating and dishonest clinical

behaviors as unprofessional, feel guilty about engaging in these behaviors and believe that the behaviors make them a less trustworthy physician, a relatively high prevalence of unprofessional conduct related to patient care was reported by students in this study," said the authors, who include FP David Power, M.D., M.P.H., director of medical student education at the University of Minnesota Medical School in Minneapolis.

The students who responded to the electronic survey came from a wide-ranging cross-section of medical schools including Mayo Medical School College of Medicine, Rochester, Minn.; University of Washington School of Medicine, Seattle; and University of California-San Diego School of Medicine, La Jolla.

According to the study, more than half of the surveyed students were experiencing burn-

out, based on their measures of emotional exhaustion, depersonalization and sense of personal accomplishment as assessed by the Maslach Burnout Inventory.

Very few students reported academic dishonesty, such as copying from a "crib sheet" or taking credit for another person's work, the authors said. But many students reported dishonest clinical behaviors; for example, they reported a physical examination finding as normal when they had skipped it entirely.

As a group, students with burnout were more likely to have engaged in one or more unprofessional behaviors than those without burnout, the study said.

"It was rare for any students to engage in clearly unprofessional activities like cheating or blatantly lying – and, of course, this is reassuring for us all," Power told *AAFP News Now*. "Some of the more

subtle behaviors, like documenting something that did not actually occur, are certainly of concern.

"However, as an educator and physician myself, I've had to check myself when, in the electronic health record, a preprinted template has all the elements that would be performed in a complete physical. It actually takes more diligence and time to go through this already-constructed template and cut and edit the template to reflect what actually occurred."

Indeed, now that the association between burnout and unprofessional conduct has been recognized, the study authors recommend that future research investigate whether interventions designed to reduce burnout help students cultivate professional values and behavior. ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101026studentburnout.html>.

Robert Graham Center Unveils Medical School Mapper

The AAFP's Robert Graham Center has unveiled a medical school mapping program that allows users to gauge the role of medical schools in promoting and sustaining primary care access within states, regions and localities.

The free Med School Mapper tool can be used to identify counties in which a school's graduates currently practice, the number of physicians in each county who have graduated from a particular school, medical schools that provide the most graduates to each county, and the percentage of graduates who are practicing in rural or underserved areas.

"We designed this program to help people understand the role of medical schools in their state in making sure they have access to the doctors they need, in the places they need them the most," said Andrew Bazemore, M.D., M.P.H., assistant director of the Graham Center, in a prepared statement.

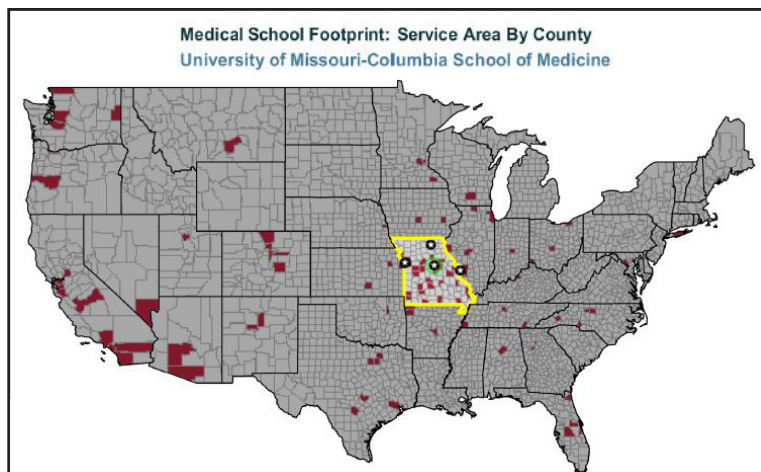
"In short, this application was built to help state policymakers, legislators, and education and health care workforce planners better understand

how each school currently contributes to their local area, to communities in greatest need and to the specialties at the greatest risk of shortage."

Although multiple studies demonstrate that patients with access to primary care show improved health outcomes and decreased costs, 30 percent of Americans report having trouble gaining access to primary care physicians. Meanwhile, physician workforce studies predict a shortage of at least 35,000 primary care physicians by 2020.

"One of the ideas behind the Med School Mapper is to identify medical schools that are particularly prone to producing graduates in areas of high societal need," said Bazemore. "Primary care is one of those areas of high need." ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20101110medschoolmapper.html>.



Harvard Medical School Launches \$30 Million Center for Primary Care

By Barbara Bein

Almost 16 months after Harvard Medical School, or HMS, defunded its primary care division and sparked an outcry from students, faculty and primary care clinicians, the AAFP and other primary care leaders are applauding the school's recent launch of a new \$30 million Center for Primary Care.

AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, told *AAFP News Now* that it is significant that one of the nation's leading medical schools has taken steps to revitalize and expand its focus on primary care education and training.

"I applaud Harvard for recognizing that their decision over a year ago was not the right decision. To have Harvard appreciate and value primary care is very important," Goertz said.

Thomas Bodenheimer, M.D., M.P.H., adjunct professor of family and community medicine at the University of California-San Francisco and co-director of its Center for Excellence in Primary Care, said Harvard's new center is a step in the right direction.

"We still need to narrow the primary care-specialty income gap and make primary care less stressful for primary care physicians. But changing the culture in

medical schools to be less toxic to primary care is something that the Harvard center could begin to address," said Bodenheimer, who received his medical degree from Harvard.

In an Oct. 28 news release, the medical school described the new Center for Primary Care — the result of a \$30 million anonymous gift — as "a center of excellence geared toward transforming primary care education, research and delivery systems." In addition, the school said the center will be a "physical and intellectual docking point" for students, residents, fellows and faculty.

"This new center will more

effectively position HMS to develop programs and train leaders in primary care and health systems research, education and policy," said HMS Dean Jeffrey Flier, M.D, in the news release.

"The center will also contribute to innovation in primary care delivery, which we expect to have a transformative, global impact," he added.

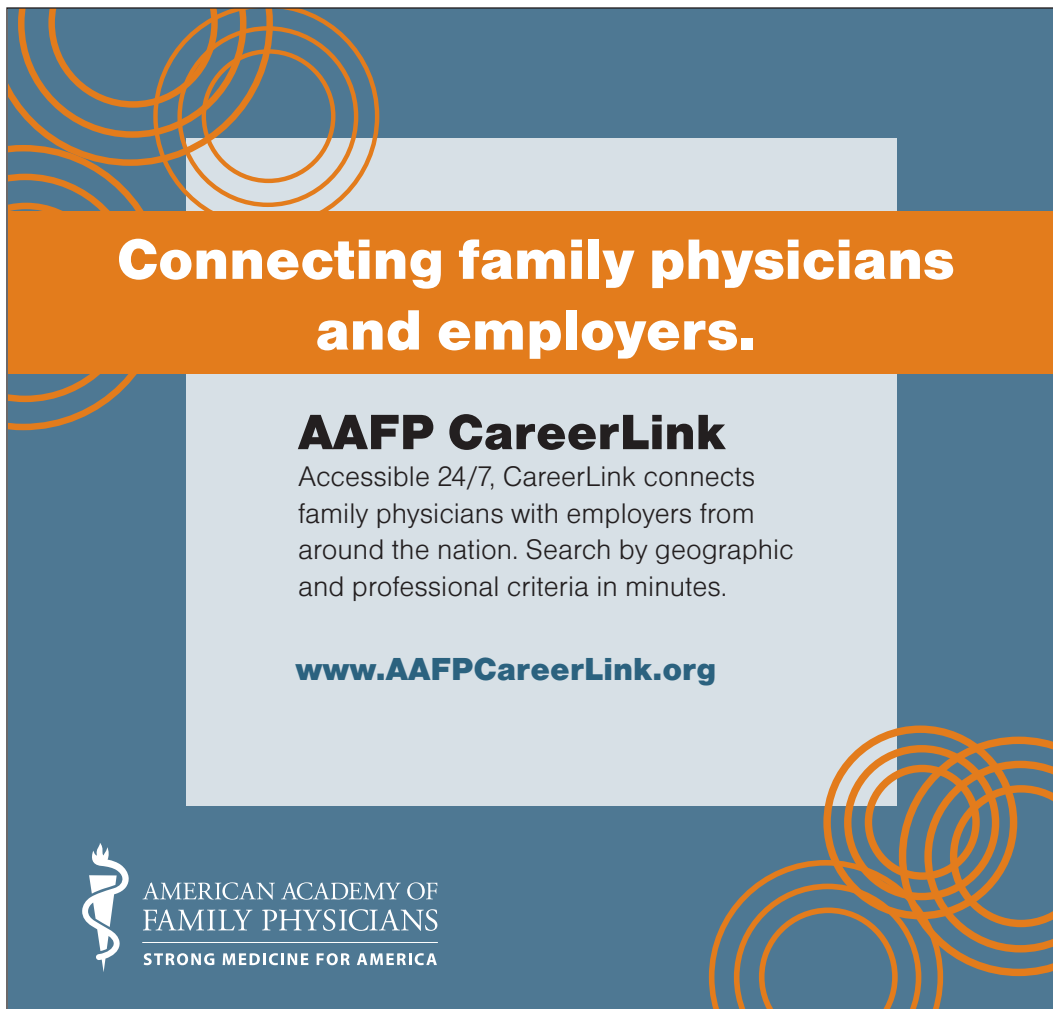
According to the news release, the new center will focus on three broad areas: medical education; local, national and international leadership; and primary care delivery and innovation research.

In August 2009, the AAFP asked Harvard to reaffirm its support for primary care at a time when severe shortages of primary care physicians were anticipated. In a joint letter to HMS, the AAFP and the Massachusetts AFP expressed their "concern and dismay" about the school's elimination of funding for its primary care division.

The letter followed HMS' July 16 statement that the school's department of ambulatory care and prevention, which administered the primary care division, had undergone an academic and organizational review. HMS subsequently suspended funding for the division, which amounted to about \$200,000 a year.

The suspension sparked an outcry among medical students, residents, faculty and others. They sent a petition to the HMS dean that questioned the budget cut in the midst of a primary care crisis and asked the school's administration for an action plan to expand institutional support for primary care. ■


For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101103hmsprimcarectr.html>.



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 **AMERICAN ACADEMY OF FAMILY PHYSICIANS**
STRONG MEDICINE FOR AMERICA

Survey Finds Many U.S. Medical Schools, Residencies Teach Medicare, Medicaid Compliance

Although U.S. medical schools and specialty training programs are not required to provide instruction on Medicare and Medicaid laws aimed at preventing fraud and abuse, almost half of schools and more than two-thirds of institutions offering postgraduate training do so, according to a survey from the HHS Office of Inspector General, or OIG.



“We recognize that medical schools and institutions offering residency and fellowship programs face enormous challenges in providing a comprehensive medical education to their students and physicians-in-training,” the OIG said in an executive summary of the survey. “Despite these challenges, many reported providing fraud and abuse training in 2010.”

To facilitate those efforts, the OIG plans to develop and distribute more training materials on Medicare and Medicaid compliance issues, which should be good news to family medicine educators and family physicians with patients insured through the two government programs.

The materials “could provide medical schools and hospitals with a consistent starting point on which to build their training programs and would support OIG’s efforts to promote voluntary compliance,” the agency said in the executive summary.

The survey was completed by 131 medical school deans and 387 designated institution officials, or DIOs. According to the results, 44 percent of accredited allopathic and osteopathic medical schools and 68 percent of institutions offering residency and fellowship programs reported instructing students and trainees on Medicare and Medicaid fraud and abuse laws in 2010.

In medical schools, most instruction took place in the classroom and covered federal laws, such as the civil False Claims Act, which addresses fraudulent billing of the federal government; the anti-kickback statute, which involves influencing the referral of federal health care program business; and the physician self-referral statute, which prohibits physicians from referring patients to facilities in which they have a financial interest.

In the residency and fellowship programs, instruction most often was provided in conferences and lectures.

Greater percentages – 92 percent of the medical school deans and 90 percent of the DIOs surveyed – said they would be interested in OIG-provided instructional materials relating to Medicare and Medicaid fraud and abuse laws. ■

For the complete story, visit <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/20101027hsoigsurvey.html>.

Academy’s Annual Financial Summary

This financial summary has been prepared to present an overall picture of the financial condition and operations of AAFP and its subsidiaries.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

	May 31, 2010	May 31, 2009
Assets		
Cash and cash equivalents	\$10,621,418	\$3,908,827
Accounts receivable, net of allowance for doubtful accounts of \$54,347 in 2010 and \$497,894 in 2009	4,857,012	5,025,450
Inventories	50,859	52,631
Prepaid expenses and other assets	1,928,100	1,610,765
Deferred income taxes	385,900	420,976
Marketable securities	36,479,860	33,022,451
Property and equipment, at cost		
Land	5,781,848	5,781,848
Office buildings	31,112,450	31,054,550
Office equipment, furniture and fixtures	19,993,927	19,356,520
Assets not placed in service	31,415	3,653
	56,919,640	56,196,571
Less accumulated depreciation	24,813,219	22,185,010
	32,106,421	34,011,561
Investments in deferred compensation plan, at fair value	2,298,492	1,921,729
	<u>\$88,728,062</u>	<u>\$79,974,390</u>
Liabilities and net assets		
Liabilities		
Accounts payable	2,227,173	2,483,446
Accrued expenses	5,489,371	5,309,804
Unearned revenue	23,948,202	21,591,846
Income taxes payable	2,171,277	2,043,227
Mortgage note payable	10,051,343	11,896,780
Pension obligation	13,052,215	7,056,036
Liability for deferred compensation plan	2,298,492	1,921,729
	59,238,073	52,302,868
Net assets		
Unrestricted	29,489,989	27,671,522
	<u>\$88,728,062</u>	<u>\$79,974,390</u>

CONSOLIDATED STATEMENTS OF ACTIVITIES

Revenues		
Membership dues and fees	\$21,917,237	\$20,735,661
Publishing activities	19,408,954	17,002,763
Programs and miscellaneous	31,105,100	33,221,717
	72,431,291	70,960,141
Expenses		
Membership services and programs	43,979,484	45,900,522
Publishing activities	12,952,052	12,517,696
Organizational business services	13,194,101	13,604,614
Income taxes	35,076	35,076
	70,160,713	72,057,908
Other income (expense)		
Investment income (expense)	600,668	(1,710,350)
Unrealized gains (losses) on marketable securities	4,868,025	(8,176,562)
Political action committee revenue	295,341	379,730
Political action committee expenses	(294,553)	(379,730)
TransforMED revenue	2,785,912	1,469,444
TransforMED expenses	(2,924,077)	(3,855,913)
	5,331,316	(12,273,381)
Net revenues, expenses and other income (expense)	7,601,894	(13,371,148)
Change in Pension Liability not Included in Pension Expense	(5,783,427)	(5,001,923)
Change in net assets	1,818,467	(18,373,071)
Net assets, beginning of year	27,671,522	46,044,593
Net assets, end of year	<u>\$29,489,989</u>	<u>\$27,671,522</u>

The above data are only a part of the complete financial statements examined by Grant Thornton LLP, certified public accountants.

AS WE SEE IT

Voices From the AAFP

Editorial

Nurse Practitioners Are Team Members, Not Leaders, in the PCMH

By "Voices" Staff

This year, the U.S. Congress passed landmark health care reform legislation that has been, and continues to be, hotly debated. Whatever happens with the health care reform legislation, however, there is no doubt that health care in the United States needs to be rebuilt. And that requires that all health care providers, including family physicians, think about the future of their individual professions.

Some health care professions, however — particularly nurse practitioners, or NPs — seem to see the current broken health care system as an opportunity to expand their scope of practice, and they are seeking to legislate that expansion at both the national and local levels.

Everyone involved with health care — from health care workers to policymakers to physicians — needs to recommit to increasing quality and lowering costs. That is a commitment that the AAFP both embraces and applauds, which is why the Academy has worked so hard to advance the patient-centered medical home, or PCMH, model of care. We believe it has the potential to both increase quality and lower costs.

Notably, health care provided by a team of health care professionals and other providers — a team that includes physicians, nurses, nurse practitioners, physician assistants, and, as necessary, therapists, subspecialists, and hospitals and other facilities — is at the heart of the PCMH.

This team-based approach will lead to the most comprehensive, patient-centered care for patients. But the Academy also believes strongly that medical homes need to be physician-led and that primary care should be at the base of the health care pyramid.

Education Levels

The AAFP believes just as strongly that NPs can be a vital part of the health care team in the PCMH. Many family physician practices have embraced nurse practitioners and physician assistants as physician extenders in their offices. These personnel are an essential component in ensuring patients receive timely and quality health care, but they are not qualified to lead the medical home as independent practitioners.

What it comes down to is education. Nurse practitioners receive only two to three years of post-graduate training and 5,350 hours of clinical training compared with primary care physicians' training, which includes medical school, residency and 21,700 hours of clinical experience. The training and certification NPs receive may be appropriate for dealing with patients who need basic preventive care or treatment of straightforward acute illnesses and previously diagnosed uncomplicated chronic conditions. But patients with complex problems, multiple diagnoses or difficult management challenges require the expertise of primary care physicians working with a team of health care professionals.

An NP's training, education and clinical expertise cannot replace that of a primary care physician. Both professions have plenty of demand for their skills. And when they join together to provide care for patients in a team setting, those skills are put to the best use. The team approach gives the patient access to the full range of health care services without sacrificing the medical expertise that ensures the most accurate diagnoses and the most appropriate treatments in the most timely manner.

Nursing Shortages

As they advocate for an expanded scope of practice that would put them on par with primary care physicians, NPs have pointed out that the shortage of primary care physicians in the United States can be fixed more rapidly and cost-effectively by allowing them to practice independently. Yes, there is a physician shortage in the United States, and, with the rollout of the health care reform legislation, an additional 32 million patients will be seeking health care. But what nursing organizations often fail to mention is that there is an even more severe shortage of nurses at the bedside and in hospital settings. According to the American Association of Colleges of Nursing, or AACN, "the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025."

Although some organizations argue that it is easier and

faster to train nurses than it is to train physicians, the shortage of nurses extends to a shortage of nursing educators. According to the AACN, "U.S. nursing schools turned away 54,991 qualified applicants from baccalaureate and graduate nursing programs in 2009 due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints." In addition, almost two-thirds of nursing schools say faculty shortages are the reason they cannot accept more entrants into their programs.

Jumping on the Bandwagon

NPs want an expanded role in the medical home, and they definitely can be an integral part of the PCMH, along with other types of physician extenders, such as physician assistants. Working with their physician colleagues, NPs can help enhance quality and control costs, while also helping absorb increased patient demand. But, the jury is still out on NPs independently leading the medical home. Can they provide the necessary skills? Do they enhance the quality of care? Can they truly reduce costs for the health care system overall?

NPs have a place on the team, but that team needs to be led by a physician to ensure patients are receiving the care to which they are entitled and that our health care system has promised them. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20101112editorial-nps.html>.