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AMA 2008 Interim Meeting

Delegates Adopt Joint Principles of Patient-Centered Medical Home

By Barbara Bein

The AAFP and other primary care specialty groups recently scored a huge win when the AMA House of Delegates threw its support behind the patient-centered medical home, or PCMH.

During the 2008 interim meeting of the AMA House of Delegates in Orlando, Fla., AMA delegates adopted, intact, the "Joint Principles of the Patient-Centered Medical Home," a document that was developed by the AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association.

The seven joint principles describe characteristics of the PCMH, including:

- coordination of care to enhance the patient-physician relationship,
 - a focus on quality and safety,
 - enhanced access to care, and
 - a payment structure that recognizes the value of and pays
- See Patient-Centered Medical Home, page 2*



Jose David, M.D./AAFP

On-screen at the AMA interim meeting in Orlando, AAFP President Ted Epperly, M.D., testifies in a reference committee hearing about the benefits of the patient-centered medical home.

AAFP Challenges Wisdom of Adopting ICD-10

By Sheri Porter

The AAFP came out swinging recently against CMS' proposal for the adoption of the greatly expanded International Classification of Diseases, 10th Revision, Clinical Modification, or ICD-10-CM, for outpatient diagnosis coding.

AAFP Board Chair Jim King, M.D., of Selmer, Tenn., outlined the Academy's objections to

CMS' proposed rule on the ICD-10 diagnosis coding in an Oct. 14 letter to CMS Acting Administrator Kerry Weems.

ICD-10 would replace the current ICD-9 code set that has been used in the United States since 1977. The proposed ICD-10 compliance deadline is Oct. 1, 2011.

King argued that CMS has not done its homework in assess-

ing the impact of "the extreme overhaul of the current outpatient medical system required for the transition."

He said the "purported benefits" of CMS' proposal were "based on assumptions and not supported with any real world trial involving practicing physicians in the United States." King pointed out that U.S. physicians

have been slammed with government mandates since 2000, each promising a simpler or better health care system, but physicians have seen little benefit.

"We fear that change fatigue and financial hardships are becoming chronic conditions common to the health care industry," said King.

See ICD-10, page 2

DECEMBER HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

Payment for Medical Home page 4

FPs who participate in CMS' medical home demonstration project, which will debut in January, may make as much as \$100 extra per patient.

Call to Action page 6

The Senate finance chair has unveiled a blueprint for universal health care coverage to move the health care reform debate forward.

Patient-Centered Medical Home, *continued from page 1*

physicians appropriately for coordinated services and care management.

AAFP President Ted Epperly, M.D., of Boise, Idaho, told *AAFP News Now* that the adoption of the principles is "historic" for the Academy because it "brings on board the AMA's support of the Joint Principles of the PCMH as a health care delivery system that's rooted deeply in primary care for the people of America."

Epperly, testifying in support of the PCMH during a reference committee hearing on Nov. 9, said that the principles exemplify "comprehensive patient-centered health care with deep trusting relationships with a patient's personal physician and his or her practice in which care is integrated, coordinated and

focused on the whole person."

"Multiple state, national and international studies have demonstrated that this care will increase the value of health care by increasing quality and lowering cost," Epperly testified.

Dale Moquist, M.D., of Houston, chair of the Academy's delegation to the AMA, told *AAFP News Now* that the delegates' action indicates "where the house of medicine is going to be" on this issue. "When we're testifying about health system reform and the benefits of the PCMH, the AMA can be right beside us," he said. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/2008112ama-pmch.html>.

ICD-10, *continued from page 1*

If ICD-10 were adopted, the number of diagnosis codes would balloon from the current 13,500 to 68,000.

A cost analysis of the proposed transition to ICD-10 found that the transition to ICD-10 would cost an estimated

- \$83,290 for a small practice with three physicians,
- \$285,195 for a medium practice with 10 physicians, and
- \$2.7 million for a large practice with 100 physicians.

MGMA President and CEO

William Jessee, M.D., said in an interview with *AAFP News Now* that a rapid move to ICD-10 would

"We fear that change fatigue and financial hardships are becoming chronic conditions common to the health care industry."

— AAFP Board Chair Jim King, M.D.

"divert critical human and financial resources and would likely lead to massive and lengthy disruption to the claims payment process."

Jessee pointed to the current environment of financial turmoil,

saying "Physicians are facing an increasing number of challenges related to declining reim-

bursement, increasing operating expenses and reduced capital expenditures. We're concerned that the federal government may move forward with mandating ICD-10

with an overly accelerated time frame, a move that would add additional cost and complexity for physicians." ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20081029icd10.html>.

CMS Delays Ban on Faxed Prescriptions

Physicians who participate in Medicare and depend on computer-generated faxes to transmit prescriptions to pharmacies can breathe a collective sigh of relief. CMS has extended its deadline for banning faxed prescriptions by three years, moving the Jan. 1, 2009, deadline to Jan. 1, 2012.

The deadline change is included in the 2009 Medicare Physician Fee Schedule final rule announced by CMS on Oct. 30. According to CMS' press release, the agency reversed its position "in the interest of patient care and safety and to encourage prescribers and dispensers to adopt e-prescribing."

Steven Waldren, M.D., director of the Academy's Center for Health IT, said the AAFP supports changing the Jan. 1, deadline on faxed prescriptions.

"The Academy's position was that the 2009 deadline would force some physicians to move backward in their efforts to accomplish e-prescribing," said Waldren. He explained that although many physicians initiate prescriptions through their electronic health record systems, their computers actually generate a fax to the pharmacy.

Had the deadline been imposed on Jan. 1 of next year, "those physicians would have reverted back to paper-based prescriptions," said Waldren.

Having three additional years to transition to true e-prescribing will benefit many physicians, but Waldren cautioned family physicians to stay focused on implementing e-prescribing technology. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20081105cms-fax-ban.html>.



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New USPSTF Guidelines Highlight Colorectal Cancer Screening, Counseling to Prevent STIs

The U.S. Preventive Services Task Force, or USPSTF, recently issued revised recommendations on screening for colorectal cancer and on behavioral counseling to prevent sexually transmitted infections, or STIs.

The colorectal cancer screening recommendations are especially timely in light of a recent study that found nearly half of all adults don't get the recommended screening for colorectal cancer.

The task force recommends screening adults for colorectal cancer using fecal occult blood testing, sigmoidoscopy or colonoscopy beginning at age 50 and continuing until age 75. Modeling evidence considered by the USPSTF suggests that screening this population using any one of three regimens will be about equally effective in life-years gained. The

three regimens are annual screening with high-sensitivity fecal occult blood testing; screening every five years with sigmoidoscopy, combined with high-sensitivity fecal occult blood testing every three years; and a screening colonoscopy every 10 years.

The task force also recommends against routine colorectal cancer screening in adults ages 76-85. In addition, the USPSTF recommends against screening patients ages 86 and older for colorectal cancer, noting that "competing causes of mortality preclude a mortality benefit that outweighs the harms."

The USPSTF also has issued updated recommendations for behavioral counseling to prevent STIs in adolescents and adults at increased risk for such infections. The task force recommends high-intensity behavioral coun-

seling for all sexually active adolescents and for adults at increased risk for STIs. Furthermore, the group has concluded that the available evidence is insufficient to assess the benefits and harms of behavioral counseling in nonsexually active adolescents and adults not at increased risk.

A key first step, according to the USPSTF recommendations, is to improve methods to identify sexually active adolescents and at-risk adults in primary care settings.

However, the USPSTF found that successful high-intensity

interventions are delivered through multiple sessions, most often in groups, and usually last from three to nine hours. The evidence does not support single-session interventions or those that last less than 30 minutes. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20081112uspstf-recs.html>.



Sheri Porter/AAFP

Family physicians are uniquely positioned to tackle multiple health promotion and disease prevention issues with their adolescent patients, including avoidance of sexually transmitted infections. Here, FP Michael Munger, M.D., of Overland Park, Kan., talks with one of his teenage patients about her health concerns.

AHA Issues 'Science Advisory' on Treating Depression in Patients With Coronary Heart Disease

The American Heart Association, or AHA, recently issued a "science advisory" on screening, referral and treatment of depression in patients with coronary heart disease, or CHD, that was published in the journal *Circulation*.

The AHA advisory recommends routine screening for depression in patients who have CHD. At a minimum, clinicians should ask patients two questions from the Patient Health Questionnaire, or PHQ: how often in the previous two weeks have they been bothered by "little interest or pleasure in doing things" and "feeling down, depressed or hopeless."

A positive response to either or both questions should trigger administration of the full nine-item PHQ screening instrument. For patients who have mild symptoms of depression, follow-up at a subsequent visit is recommended. If a patient has high depression scores, a physician or nurse should promptly review the PHQ results with the patient. Patients who have screening scores that indicate a high probability of depression "should be referred for a more comprehensive clinical evaluation by a professional qualified to evaluate and determine a suitable individualized treatment plan." These individuals also should be evaluated for other mental disorders that are associated with adverse outcomes in patients who have CHD.

The AHA advisory recognizes three types of treatment options: antidepressant drugs, cognitive behavioral therapy and physical activity.

Two selective serotonin reuptake inhibitors, sertraline and citalopram, have been shown to be safe for patients who have CHD. Although these drugs should be considered first-line antidepressants for patients with CHD, says the advisory, if patients have tolerated a different antidepressant in the past, they can continue to take it or resume its use. However, tricyclic antidepressants and monoamine oxidase inhibitors have cardiotoxic side effects, so they are usually contraindicated in these patients.

Cognitive behavioral therapy and physical activity and exercise also can be useful in reducing depression in patients who have CHD. Because patients with depression may be unwilling to participate in cardiac rehabilitation and exercise programs, physicians should encourage them and provide follow-up. Physicians also can enlist the patient's spouse, partner or other family members to provide encouragement.

Finally, the advisory stresses the importance of coordinating care among health care professionals treating patients with combined medical and mental health issues. Patients who experience depression may need additional clinical management to ensure that they comply with cardiac treatment regimens and to promote lifestyle and behavioral changes. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20081105aha-advisory.html>.

CMS Moves to Finalize Payment Levels for Medical Home Demonstration

By James Arvantes

CMS recently announced that, tentatively, it would pay physician practices participating in its upcoming medical home demonstration project a per-member, per-month management fee of \$40 or more. In addition, participating practices would be eligible to receive a share of any cost savings the demonstration project might generate.

Under the plan, CMS would tentatively pay practices an overall per-member, per-month management fee of either \$40.40 or \$51.70, depending on a practice's level of medical home capability. The management fee would be adjusted up or down, depending on a patient's severity of illness. For example, for patients with a hierarchical condition code, or HCC, of less than 1.6, the management fee would be adjusted down to \$27.12 or \$35.48. For patients with an HCC score of 1.6 or greater, management fees would go up to \$80.25 or \$100.35.

"We have announced payment rates, but they are tentative because we are still going through the clearance process for the demonstration," said Sidney Trieger, director of the Division for Health Promotion and Disease Prevention in the Office of Research Development and Information at CMS.

CMS based the payment rates on recommendations made by the

AMA/Specialty Society Relative Value Scale Update Committee. HHS and the Office of Management and Budget still must approve the payment rates and the design of the demonstration project before it moves forward, said Trieger.

Congress created the three-year medical home demonstration project as part of the Tax Relief and Health Care Act of 2006. The project will be conducted in eight states and will involve about 400 practices, 2,000 physicians and 400,000 Medicare beneficiaries, according to CMS. The agency plans to announce the project demonstration sites by the end of year, said Trieger.

CMS will accept applications for the demonstration project from January until March 2009 and will require practices chosen for the project to submit to a qualification process conducted by the National Committee on Quality Assurance, or NCQA. The agency will cover the cost of the NCQA review and designation of participating practices as medical homes. CMS will start paying participating practices the management fee in January 2010 and will continue payment through the end of 2012. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20081111pay-home-demo.html>.

2008 Health Confidence Survey

Consumers Voice EHR Privacy Concerns

By Sheri Porter

Even as the federal government and the AAFP focus their resources on ensuring that America's physicians get onboard with electronic health records, or EHRs, some American consumers are wrestling with confidentiality concerns about the technology.

That's according to the recently released 2008 Health Confidence Survey.

According to survey responses, more than 55 percent of the 1,000 people interviewed said it was important for health care providers to use EHRs rather than paper records. In addition, 60 percent of respondents said it was important that



FP Darren Killen, M.D., always has his laptop computer in hand so he can access his patients' electronic health records.

Sheri Porter/AAFP

authorized providers have electronic access to their health information.

However, survey respondents clearly lacked confidence in the security of their online records; 62 percent of people interviewed were concerned that health records stored in an EHR and shared via the Internet would not remain private.

Steven Waldren, M.D., director of the AAFP's Center for Health IT, said consumers' concerns reflect their misunderstand-

ing about how health information is used, exchanged and stored.

"People look outside the health care industry, and they see security breaches and identification theft," said Waldren. That causes a certain level of uncertainty and angst about what might happen to their private health information, he added.

"What consumers may not understand is that a lot of their health data — such as billing information — is already exchanged electronically," he said.

Paul Fronstin, Ph.D., director of the Employee Benefit Research Institute's Health Research and Education Program and co-author of the 2008 study, said some patients are concerned about how their health information might be used against them.

"I think it's going to take time for people to trust the electronic

medical records system because right now we don't have one. So until they're using it and seeing how it works, there's going to be large concerns about privacy," said Fronstin.

Waldren said many consumers haven't experienced the value — in terms of increased patient safety and convenience — that an EHR can offer.

He also pointed out that consumers who demand absolute privacy for their personal health information could pay a steep price in terms of risks to their own health. For instance, a patient's undisclosed and untreated diabetes could pose a much greater personal threat than the confidentiality of the patient's personal health records. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20081112ehr-priv-surv.html>.

CMS Introduces Personal Health Record Pilot

Program Targets Beneficiaries in Utah, Arizona

By Sheri Porter

Beginning in January, Medicare beneficiaries in Arizona and Utah will have the opportunity to make health history by participating in a personal health record, or PHR, pilot program.

HHS Secretary Michael Leavitt introduced the Medicare PHR Choice Pilot during a press conference Nov. 12 in Phoenix, and announced four vendors that were awarded contracts for the one-year pilot. Each company brings something unique to the table, said Leavitt. Specifically,

- Google Health features a publicly available application program and a platform that interfaces with other online information;
- HealthTrio offers a real-time, secure messaging system;
- NoMoreClipboard.com renders patient health records directly into provider-specific forms; and
- PassportMD provides secure physician access to real-time, diagnostic-quality X-rays, CT scans, positron emission tomography scans and MRIs.

Unlike electronic health records, which are owned by physicians and other health care providers, “personal health records are owned by the patient and are under the control of the patient,” said Leavitt.

“PHRs can contain a wealth of information entered by patients, their providers, and in some cases, their health plan,” he added. At the heart of the Medicare PHR pilot is the ability of Medicare — at the patient’s request — to populate a PHR with two years of previous Medicare claims data.

CMS has been working for several years “to build a framework for an interconnected electronic information system that works quickly and seamlessly,” said CMS Acting Administrator Kerry Weems during the press conference. “PHRs are another piece in this puzzle.”

With Internet access, “users



can download their files from secure Web sites and populate them with information about health conditions, allergies, when they’ve last seen a doctor, when they last went to the hospital and what happened to them in those settings,” he said.

Jeff Donnell, VP of marketing for NoMoreClipboard.com, said during the press conference that Americans share a common experience of sitting in doctors’ offices with a clipboard full of medical forms to fill out.

“And we struggle in that doctor’s office waiting room to remember our medications and allergies and procedures,” said Donnell.

According to Donnell, the net

result of having patients manage their own health information is that physicians will get a much clearer picture of a patient’s health status. The PHR will facilitate the flow of communication between physician and patient and also will help “improve the coordination of care, reduce errors and just overall improve health outcomes,” he said.

In a subsequent interview with *AAFP News Now*, Donnell said that his company understands that the proliferation of consumer-created PHRs will put increasing pressure on physicians to be able to accept patient information.

“We don’t want to force the physicians or the practices to have to alter the way they practice medicine ... to accommodate the PHR,” said Donnell. The patient-supplied information should integrate right into the practice workflow, he added. ■

For more information, visit
<http://www.aafp.org/news-now/practice-management/20081119cms-phr-pilot.html>

In Brief *Public Health*

Immunization Coalition Offers Online Videos on Influenza Vaccination

The Childhood Influenza Immunization Coalition has posted new influenza vaccination videos aimed at family physicians and other health care professionals, as well as videos intended for patients and their caregivers, on its Web site. The 10 short videos for health care professionals each feature an immunization expert answering a particular question about influenza immunization. The site also features 16 short videos aimed at families and caregivers.

In these videos, coalition experts answer basic questions about influenza, its impact and how to prevent it. Another video on the site offers an overview of essential information, including the seriousness of influenza and the importance of annual vaccination against the disease. <http://www.aafp.org/news-now/health-of-the-public/20081105cicc-videos.html>

FDA Provides Single Source for Drug Safety Information

The FDA recently created a Web page for health care professionals and their patients that provides a single source for postmarket safety information on prescription drugs, according to an Oct. 15 news release from the agency. The new Web page includes information on drug labeling; risk evaluation and mitigation strategies; searchable databases of postmarket studies and clinical trials; drug-specific safety information; information on drugs being evaluated for safety issues; warning letters, import alerts, recalls, market withdrawals, and safety alerts; regulation and guidance documents; and instructions on how to use the FDA’s MedWatch alert program.

<http://www.aafp.org/news-now/health-of-the-public/20081022fda-safety-page.html> ■

House Legislation Lays Groundwork for Primary Care Base

By James Arvantes

The House is considering a bill that would reform the nation's Medicare system by financially encouraging students to enter primary care while also bolstering payments for current primary care physicians and the patient-centered medical home, or PCMH.

Rep. Allyson Schwartz, D-Pa., a member of the House Ways and Means Committee, introduced H.R. 7192 on Sept. 27. The bill, known as the Preserving Patient Access to Primary Care Act, would establish grants, scholarships and loan forgiveness programs to encourage medical students to choose careers in primary care.

It also would provide enhanced monthly fees for physician practices that operate as qualified PCMHs. At the same time, the bill would establish higher payments for primary care providers and provide payment for services, such as telephone and e-mail consultations. In addition, the bill would require a study to recommend the designation of primary care as a shortage profession if certain criteria are met.

"A lot of young medical students are not necessarily feeling the incentive to go into primary care," said Kate Gross, legislative aide to Schwartz. "They are not paid well, their hours are not ideal and they have a harder time repaying their loans."

Gross described Schwartz as a strong proponent of primary care, explaining that the congresswoman believes in "providing the right care, at the right time, with the right provider."

"That starts with having a home base," Gross said. "That is where her support of the medical home comes in. Rep. Schwartz sees the medical home as an opportunity to help patients get a better understanding of what is going on with their health, to understand what their next steps might be and also having someone who is there helping to coordinate their care," said Gross. "Otherwise, they get left out in the cold." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20081029hr7192bill.html>

Senate Finance Chair Issues Call for Greater Primary Care, Prevention Efforts

Plan Would Promote Primary Care, Medical Homes

By James Arvantes • Washington

The chair of the Senate Finance Committee has unveiled a call to action for health care reform that relies heavily on primary care and preventive services to improve quality, enhance access and reduce the overall cost of health care in the United States.

Sen. Max Baucus, D-Mont., unveiled the plan during a Capitol Hill press briefing on Nov. 12. He told the gathering of reporters that primary care and prevention are ways of focusing on America's overall health.

"My plan would put more primary care doctors in practice," said Baucus. "Watching over a patient's full medical history and keeping them healthier all of their lives ... that is a quality measure and a cost-control measure."

Baucus has not formally introduced his plan as a bill, choosing instead to issue a 98-page blueprint that lays out a proposal for universal coverage as a way to move the debate about health care reform forward in the next Congress.

AAFP President Ted Epperly, M.D., of Boise, Idaho, said the Baucus proposal recognizes that a strong and robust primary care system must be an essential part of any successful health care reform effort. "Family physicians and the patient-centered medical home are the basic building blocks of this health care foundation," Epperly said.

The blueprint urges increases in Medicare payments for services furnished by primary care health professionals. "Payments for primary care physician visits are undervalued, particularly compared to procedures and services furnished by (sub)specialists," the document says. "In fact, the overvaluation of procedures in the Medicare physician fee schedule has both created financial incentives to provide unnecessary services and served as a disincentive for physicians to become primary care physicians."

Baucus said increased payments for primary care physicians may require a shift in resources, resulting in reduced payments to subspecialists. "There might have to be a bit of a readjustment," he said. "Some of these (sub)specialists might have to take a bit of a nick, but the (sub)specialists know the system is not working well. They know primary care doctors need more help individually. They also know, more fundamentally, that by giving more emphasis to primary care doctors, it is going to help the whole system."

"Family physicians greatly appreciate Sen. Baucus' support and his long-standing recognition that primary care physicians and the patient-centered medical home are central to an effective and efficient health care system," said Epperly.

However, he added, Congress needs to look beyond Medicare Part B (i.e., Medicare payments made to physicians) to find savings to support primary care and the patient-centered medical home. These savings should come from every part of Medicare, said Epperly. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20081118baucus-plan.html>



"There must be a greater role for primary care in America," says Sen. Max Baucus, D-Mont., as he unveils his blueprint for health care reform during a Nov. 12 Capitol Hill press conference.

James Arvantes/AAFP

Health Care Leaders Endorse Payment Reform, Higher Payments for Primary Care

According to a recently released study, many health care leaders support a revision in the Medicare payment system to provide more money for primary care and the patient-centered medical home. That's among the findings of a survey conducted on behalf of the Commonwealth Fund and in partnership with *Modern Healthcare*.

The online Health Care Opinion Leaders Survey was based on a sample of 222 leaders in the health care delivery, policy and financing fields. The survey found that 85 percent of respondents supported revising the Medicare payment system to increase payments for primary care. Seventy-four percent of respondents favored paying physician practices a monthly per-patient fee for serving as a medical home, and 77 percent supported realigning the system to pay for transitional care services.

"This report is saying that, overwhelmingly, people think we should be paying differently for health care," said Stuart Guterman, M.A.,

assistant vice president at the Commonwealth Fund and one of the authors of the report.

The current fee-for-service system pays for individual services, creating incentives to provide more expensive and more technical services rather than encouraging more effective, higher-quality care, according to the survey.

"There is nothing in that (fee-for-service) payment system that encourages a broader perspective on what appropriate health care is for a given patient or that encourages coordination of care across different providers and different settings," said Guterman.

"Fee-for-service tends to pay more for complicated care, more for technical care, more for subspecialty care and less for primary care," said Guterman, who noted that the survey results seem to indicate respondents want to move in the direction of bundling. However, "that doesn't mean we are paying (physicians) less," said Guterman. "We are just not paying (physicians) for things that don't help ... patients." ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20081112commonwlth-surv.html>.

"Fee-for-service tends to pay more for complicated care, more for technical care, more for subspecialty care and less for primary care."

— Stuart Guterman, M.A.
Assistant VP, Commonwealth Fund

MedPAC Finalizes Recommendations on Disclosing Financial Ties Between Physicians, Manufacturers

By James Arvantes • *Washington*

Congress should require drug and device manufacturers to reveal their financial ties with physicians and other health care providers as a way of discouraging inappropriate financial arrangements between the entities, according to a series of recommendations recently adopted by the Medicare Payment Advisory Commission, or MedPAC.

MedPAC adopted five recommendations relating to financial disclosure during a two-day meeting here on Nov. 6 and will submit them to Congress as part of its annual report in March.

MedPAC is recommending that Congress

- require all manufacturers, distributors and their subsidiaries

to report financial relationships with physicians, pharmacists, pharmaceutical benefits managers, hospitals, medical schools, and medical or health organizations;

- direct HHS to post information on financial relationships in a searchable format on a public Web site;
- require manufacturers and distributors to report information on who receives drug samples;
- require all privately owned hospitals and other entities that bill Medicare for services to reveal the names of physicians who directly or indirectly own an interest in that hospital or entity and to post the information on a Web site; and
- ask HHS to submit a

report on the types and prevalence of financial relationships between hospitals and physicians.

"All we are asking is that companies disclose their relationships and their ownership in various facilities," said FP Thomas Dean, M.D., of Wessington Springs, S.D., in an interview with *AAFP News Now*.

"I don't think (these recommendations) should hurt anyone who is comfortable with their (financial) relationships," added Dean, who is the only family physician on MedPAC.

Dean said the recommendations are a way to address perceived conflicts of interest between physicians and other entities. It's a way of "proving we

are patient advocates and not just in this for our own benefit," he said.

However, Dean said he voted against the recommendation that companies report on the free drug samples they distribute to physicians. Although Dean said he supports the intent of the recommendation, drug samples are distributed in such a way that it is virtually impossible to track sample use by individual physicians. Without that information, the MedPAC recommendation would have little effect on physician prescribing patterns, resulting in an inefficient use of time and resources, said Dean. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20081112-medpac-ties.html>.

Medicaid Spending Up, Growth of Economy Down

New Report Looks Ahead a Decade

By Sheri Porter

According to a new report released by CMS, Medicaid spending will significantly outpace the growth of the U.S. economy during the next 10 years. Medicaid benefit expenditures are projected to reach \$339 billion in 2008 and more than \$673 billion by 2017.

The report, 2008 Actuarial Report on the Financial Outlook for Medicaid, predicts that Medicaid costs will grow by about 7.9 percent each year, compared with an annual average gross domestic product growth of 4.8 percent.

The report raises the issue of sustainability for both Medicaid and

the entire U.S. health care system, said Actuary Christopher Truffer, F.S.A., who led the team that produced the report. "How much can we as a society afford to spend on health care? How much should we spend on health care? How much should public programs, such as Medicare and Medicaid, spend?" are among questions that should be explored, he said.

The answers, he said, will come from policymakers and the American public.

Actuaries calculated average Medicaid enrollment in 2007 at 49.1 million people. However, they noted that at some point

during that year, 61.9 million people — or about one out of five individuals in the United States — were enrolled in Medicaid.

The report estimates that Medicaid enrollment will increase at an average annual rate of about 1.2 percent per year for the next decade and will reach 55.1 million enrollees by 2017.

There are numerous reasons for the surge in Medicaid costs — as well as the cost for all health insurance, public and private — according to the report. Reasons include the number of people insured; an increase in wages and price inflation in the medical sec-

tor; the provision of a wider array of health care services; and the development of more complex and expensive medical services.

In a statement attached to the report, CMS Chief Actuary Richard Foster said, "Determining how to optimally balance our collective demand for the best health care possible with our not-unlimited ability to fund such care through private and public efforts represents one of the most challenging policy dilemmas facing the nation." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20081030medicaid-rpt.html>.

Expert Panel Calls for Medicare Payment Reform

Current Payment System Undermines Primary Care, Panelists Say

By James Arvantes • Washington

Medicare's fee-for-service payment structure has created a disjointed and fragmented payment system that discourages care coordination and the provision of primary care services. That was one of the main messages delivered by an expert panel during a forum on health care quality and the health delivery system held here on Oct. 31.

Paul Ginsburg, M.D., president of the Center for Studying Health System Change, decried the "toxic effects" of the current payment system, saying it is dramatically undermining primary care.

"I just got back from doing site visits in California, and I was really struck by the shortages of community-based primary care physicians," said Ginsburg, one of seven panelists who participated in the forum, which was sponsored by the Center for American Progress.

"The incentives resulting from our payment system are so discouraging for people choosing primary care. If we are going to be able to deliver good care for chronic disease, we have to turn that around quickly," said Ginsburg.

He warned that the nation is in danger of losing primary care as a specialty altogether without significant payment reform. And he called on the next administration and Congress to enact reforms that would



David Blumenthal, M.D., director of the Institute for Health Policy, calls on the federal government to reinvigorate primary care, as Karen Davenport, M.P.A., left, director of health policy for the Center for American Progress, and Judith Hibbard, Ph.D., M.P.H., professor of health policy at the University of Oregon in Eugene, look on.

better align payments with the relative cost of providing services.

Payment reform should entail "better mechanisms for payment," which could include multi-provider, per-episode payments for acute care and major illnesses and capitated payments for managing chronic disease.

Robert Berenson, M.D., a senior fellow at the Urban Institute, also called for major payment reform, saying that certain subspecialists earn two to three times more than family physicians or internists. This, in turn, has put primary care in peril.

"We are facing a crisis of an absence of primary care physicians," Berenson said.

"Physicians of my generation are about to retire if the stock market goes up a little bit. In Medicare, we are going to have a real problem of access to care."

Berenson cited data underscoring the need for care coordination and primary care services. For example, 20 percent of Medicare patients suffer from five or more chronic conditions, see 14 different physicians, and take 60 prescriptions a year, according to Berenson. This creates the potential for different physicians ordering different prescriptions that might be incompatible, Berenson said. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20081105american-prog.html>.

News From 2008 AMA Interim Meeting

AAFP, AAP Call for AMA to Support Tobacco Control Content in EHRs

By Barbara Bein

The AAFP has long-standing policy on tobacco use, including a recommendation that urges family physicians to collaborate with other health professionals to counsel patients who smoke or use smokeless tobacco to quit. Now, that recommendation could become easier to follow, thanks to a measure introduced at the recent interim meeting of the AMA House of Delegates that calls for inclusion of prompts to ask about tobacco use in electronic health records, or EHRs.

The AAFP and the American Academy of Pediatrics co-sponsored a resolution that asks the AMA to advocate that all EHR systems include a template that prompts clinicians to collect data about patients' tobacco use, exposure to secondhand smoke, interest in quitting and past attempts to quit. The resolution proposes that the template be automated to appear when patients present with a cough, upper respiratory problems, diabetes, ear infections, hypertension, depression, anxiety and asthma, as well as during well-patient exams.

According to the resolution, automatic prompts in these systems also should remind clinicians to

- encourage patients who use tobacco to quit,

- advise them about the importance of maintaining smoke-free environments, and
- connect patients and their families to tobacco cessation resources.

"In a busy family medicine practice, any way that a doctor can take a few minutes to talk to patients about their smoking gets the best results in getting them to stop," said AAFP Board Chair Jim King, M.D., of Selmer, Tenn., in an interview with *AAFP News Now*. King testified in support of the tobacco control EHR templates during a Nov. 9 reference committee hearing at the AMA interim meeting in Orlando, Fla.

According to that committee's report, testimony on the measure was mixed, with a number of speakers addressing "both the value and deterrents associated with multiple prompts that may be embedded in electronic medical record templates." In the end, delegates referred the resolution to the AMA Board of Trustees for its decision on what action to take. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20081119ama-tobacco.html>.

AMA Backs Measures That Benefit Primary Care Physicians

The AMA House of Delegates voted to support several measures that would encourage physicians and physicians-in-training to choose careers in primary care during its 2008 interim meeting, Nov. 8-11, in Orlando, Fla. The measures included calls to enhance payment for primary care physician services and decrease debt loads.

The AMA Council on Medical Education report on barriers to primary care directs the AMA, in collaboration with primary care specialty organizations, to advocate the adoption of recommendations from the AMA/Specialty Society Relative Value Scale Update Committee that address payment for evaluation and management, or E/M, services and coverage of services related to care coordination. The report also directs the AMA to work to ensure that private payers recognize the value of E/M services.

Included in the council report

were recommendations specifically addressing medical education issues, including calls to develop programs to recruit medical students interested in primary care, train primary care physicians, and enhance the image of primary care practice. The report also recommends urging medical schools to develop policies and programs that encourage students to select primary care specialties.

Furthermore, said the delegates, the AMA should support existing programs and advocate the establishment of new programs that decrease the debt load of physicians who choose primary care.

A second CME council report, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," called on the AMA to advocate the continuation of scholarship and loan

repayment programs, including the National Health Service Corps; permanent reauthorization and expansion of the Conrad State 30 J-1 visa program; and adequate funding for federal legislation that supports educational experiences for medical students and resident physicians in underserved areas. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20081125ama-prim-care.html>.

AMA Wants to Set Limits on 'Dr. Nurse' Tests

Noting that state-based licensure of physicians is a "hallmark of American medicine," delegates at the 2008 interim meeting of the AMA House of Delegates called on the AMA to develop model state legislation designed to avoid any perception that doctors of nursing practice, or DNPs, are equivalent in training to doctors of medicine or doctors of osteopathy.

Delegates directed the AMA Council on Legislation to develop and circulate to all state medical and national medical specialty societies legislation that would prohibit the National Board of Medical Examiners, or NBME, from using past, present or future content of the U.S. Medical Licensing Exam Step 3 in the certification processes for nonphysician providers.

The model legislation also would prohibit the National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX Exam Step 3 in those certification processes. ■

2008 Medical School Enrollment at All-time High

Data released recently by the Association of American Medical Colleges, or AAMC, show that first-year enrollment at U.S. medical schools in 2008 totaled more than 18,000 students, the highest enrollment in history. However, although this development might mean the country gets more physicians, it doesn't necessarily translate into a big boost for family medicine or primary care, says one physician workforce expert.

According to an AAMC press release, enrollment of first-year students at the nation's medical schools this year increased nearly 2 percent, compared with 2007, to an all-time high of 18,036. The release attributed the increase primarily to the establishment (or planned establishment) of new branch campuses of existing facilities.

"It would be a stretch to say the enrollment high will be 'good news' for family medicine, except that it expands our pool of potentially interested students by a small percentage," said Perry Pugno, M.D., M.P.H.,

director of the AAFP Division of Medical Education.

"I think the impact of the numbers on family medicine will be minimal," he added. "But at the same time, I think interest in primary care careers — especially family medicine — will be increasing on its own for other reasons."

The AAMC data may illustrate one such reason: students' increased involvement in community service. That involvement, said Pugno, often has been shown to correlate with students' choice of specialty.

AAMC President and CEO Darrell Kirch, M.D., said in a national press teleconference that 63 percent of this year's applicants had nonmedical volunteer experience and 77 percent had medical volunteer experience.

"They have a real sense of service, commitment and discovery that I know we all want in a future doctor at our bedside," Kirch said. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20081119med-school-enroll.html>.

FamMedPAC Reaches New Funding-raising Heights

The AAFP's federal political action committee, FamMedPAC, emerged as a powerful force during the recent election cycle. It raised and contributed nearly \$800,000 on behalf of congressional candidates who support primary care and family medicine issues.

Via FamMedPAC contributions, the AAFP has been able to build relationships with lawmakers on Capitol Hill, giving the Academy a voice in every major health care decision made by Congress.

"This gives us 'face time' with our elected officials," said FamMedPAC Board Chair and AAFP Past President Michael Fleming, M.D., of Shreveport, La. "By supporting candidates, we make it easier for them to get elected, and we have become resources for them. We have lawmakers and candidates calling us now, asking, 'What do you think about this issue or that issue?'"

FamMedPAC contributes to congressional candidates — Republicans and Democrats — who support the ideals and aspirations of primary care and family medicine, making it a bipartisan political action committee. According to Fleming, it is the only political action committee in the country dedicated to primary care and family medicine. In this role, FamMedPAC puts a human face on the issues of family medicine, elevating the presence and prestige of the specialty on Capitol Hill, said Fleming. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20081104fammedpac.html>.



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Justice Group Underscores Need for Primary Care Infrastructure

By James Arvantes • *Washington*

The nation's inability to build and sustain a primary care infrastructure has led to a disjointed and fragmented health care system that is incapable of addressing the nation's growing health care needs. That's according to former Surgeon General and family physician David Satcher, M.D., Ph.D., and other speakers who addressed a press briefing convened by the National Summit of Clinicians for Healthcare Justice here on Oct. 23.

Satcher described primary care as a "critical part of the health care system." But, he noted, primary care has been "so underfunded, under-supported and abused in so many ways, it cannot play the role in making this health care system work in terms of bringing together treatment, prevention and health promotion."

"There is no excuse for not having a primary care infrastructure in this country that serves all the people," said Satcher, the current director for excellence on health disparities and head of the Satcher Health Leadership Institute at the Morehouse School of Medicine in Atlanta.

U.S. medical schools continue to produce subspecialists at the expense of primary care physicians, despite the shortage of primary care physicians, Satcher said. And that situation will never change as long as health care is treated as a commodity available only to the highest bidder.

"In medicine, you have this dichotomy," said Satcher. "You have the highly-paid specialists and the lowly-paid primary care providers – so where do you think students are going to go, especially when many of them are loaded with debt when they get out (of school)."

"We have to find a way to provide incentives for people to go into primary care," he added. "And we have to see health care as a right in this country and make sure it is available to everybody."

This will entail some changes in physician payment systems, acknowledged Satcher. But as he explained, "what is wrong with paying for what we need? When we go to the store, we pay for what we need; we don't pay money for something we don't need. I don't see anything wrong with those who are spending tax dollars saying, 'We are going to put America's dollars where America's health needs are.'"

The two other speakers on the panel, Mary Carol Jennings, a Jack Rutledge legislative director for the American Medical Student Association and George Rust, M.D., M.P.H., a professor of family medicine and director of the Center for Primary Care at the Morehouse School of Medicine, also decried the lack of primary care physicians while touting the benefits of a primary care-based health care system.

"Primary care doctors are the ones who keep America healthy, and they are the ones who keep other nations healthy," said Jennings. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20081029hcjustice.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, 2008	May 31, 2007
Assets		
Cash and cash equivalents	\$3,497,308	\$6,550,787
Accounts receivable, net of allowance for doubtful accounts of \$916,195 in 2008 and \$881,892 in 2007	8,431,908	7,450,905
Inventories	35,887	58,500
Prepaid expenses and other assets	3,259,966	2,924,459
Deferred income taxes	456,052	491,128
Marketable securities	49,952,055	59,942,801
Property and equipment, at cost		
Land	5,781,848	5,781,848
Office buildings	30,990,158	30,889,342
Office equipment, furniture and fixtures	13,862,653	12,916,802
Assets not placed in service	3,166,492	1,596,042
	<u>53,801,151</u>	<u>51,184,034</u>
Less accumulated depreciation	<u>20,059,823</u>	<u>17,890,791</u>
	33,741,328	33,293,243
Investments in deferred compensation plan, at fair value	2,226,446	2,610,175
	<u>\$101,600,950</u>	<u>113,321,998</u>
Liabilities and net assets		
Liabilities		
Accounts payable	3,527,505	2,861,960
Accrued expenses	6,170,068	5,805,569
Unearned revenue	25,789,453	24,911,615
Income taxes payable	2,043,227	1,643,178
Mortgage note payable	13,607,570	15,193,538
Pension obligation	2,192,088	2,209,063
Liability for deferred compensation plan	2,226,446	2,610,175
	<u>55,556,357</u>	<u>55,235,098</u>
Net assets		
Unrestricted	46,044,593	58,086,900
	<u>\$101,600,950</u>	<u>\$113,321,998</u>

CONSOLIDATED STATEMENTS OF ACTIVITIES

Revenues		
Membership dues and fees	\$19,694,623	\$18,520,592
Publishing activities	19,687,601	20,547,159
Programs and miscellaneous	34,853,846	30,712,770
	<u>74,236,070</u>	<u>69,780,521</u>
Expenses		
Membership services and programs	54,547,197	47,658,576
Publishing activities	14,263,257	14,683,993
Organizational business services	13,231,294	12,491,646
Income taxes	32,172	83,434
	<u>82,073,920</u>	<u>74,917,649</u>
Other income (expense)		
Investment income	2,738,119	3,465,586
Unrealized gains (losses) on marketable securities	(4,674,026)	4,627,339
Political action committee revenue	413,588	260,048
Political action committee expenses	(413,588)	(260,048)
TransferMED expenses	(2,268,550)	(811,955)
	<u>(4,204,457)</u>	<u>7,280,970</u>
Change in net assets	(12,042,307)	2,143,842
Net assets, beginning of year	<u>58,086,900</u>	<u>55,943,058</u>
Net assets, end of year	<u>46,044,593</u>	<u>\$58,086,900</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

It's Flu Shot Time – for You As Well As Your Patients

By "Voices" Staff

As your practice gears up for the influenza season, are you forgetting something important? In addition to vaccinating as many patients as possible, it's imperative that your office staff and you be vaccinated against the disease. Without vaccination, those working in your practice are more likely to stay home sick with the flu or – even worse – come in and spread their sickness to others, including vulnerable patients. That's a significant patient safety issue.

The CDC first called for annual influenza vaccinations for all health care workers in 1981. Although the percentage of health care workers who actually get vaccinated has increased since then, the sad truth is that less than half – only 42 percent – were vaccinated during the 2005-06 flu season, the most recent season for which statistics are available.

The AAFP is actively involved in the CDC's Advisory Committee on Immunization Practices, or ACIP, and has approved its 2008 recommendations for influenza prevention and control, which emphasize the critical importance of vaccinating health care workers. In that document, ACIP calls on all health care facilities to

- offer free, convenient influenza vaccinations at the workplace for health care workers;
- educate workers about the benefits of vaccination and the potential health consequences of influenza;
- consider obtaining signed declinations from workers who choose not to be vaccinated for reasons other than medical contraindications; and
- use the level of worker vaccination coverage as a patient safety quality measure.

Several health care groups have spoken out about this vaccination issue as well. For example, in 2007 the Infectious Diseases Society of America recommended mandatory vaccination for health workers unless they opt out in writing for religious, philosophical or medical reasons.

Also in 2007, The Joint Commission began requiring organizations that it accredits to offer influenza vaccinations to staff members. In September, The Joint Commission's publishing and educational affiliate, Joint Commission Resources, kicked off a "flu vaccination challenge" to recognize hospitals that exceed the 42 percent vaccination rate for health care workers.

Last month, the Association for Professionals in Infection Control and Epidemiology, or APIC, added its voice to the call for mandatory vaccination. "Evidence ... demonstrates that the current policy of voluntary vaccination has not been effective in achieving acceptable vaccination rates," APIC asserted. "As health care providers, we have an obligation to ensure that all (health care personnel) are vaccinated against influenza."

This flu season's plentiful vaccine supply makes 2008 the perfect

year to drive the health care worker vaccination rate closer to where it needs to be. As you begin vaccinating your patients, make sure you reach out to your staff members as well. And don't underestimate your impact as a role model. According to the ACIP, vaccination of senior medical staff or opinion leaders has been associated with higher vaccination acceptance among staff members. When you get in line for a flu shot, you make it that much more likely others in your practice will do the same. ■

For more information, visit <http://www.aafp.org/news-now/opinion/20081112flu-vacc-ed.mem.html> (members only).

Letter to the Editor

ICD-10 Has Unintended Consequences for EHR Users

To the Editor:

Your Oct. 29 posting "AAFP Challenges Wisdom of Adopting ICD-10" is the best article I've seen in ages describing the downside of ICD-10. Thank you for the realistic plea to spare primary care physicians.

What is never mentioned in the conversation about ICD-10 is the potentially even greater impact on physicians who are using electronic health records, or EHRs.

EHRs have evolved using ICD-9 as the common language of the patient's problem list. So not only are they used for the back office coding/billing processes, but they are used to identify a patient's diagnosis and then track that condition. The EHR triggers treatment alerts, launches protocols and more.

Typically, an ICD-9 diagnosis, such as hypertension, is identified and remains unchanged on the patient's list of diagnoses for years, allowing the physician to track the condition throughout the patient's life. This is a nonfinancial function of EHRs that is critical to patient care.

ICD-10, which requires a modification of the code at every visit to articulate the patient's current condition, could potentially turn that embedded clinical function of the diagnosis code on its head.

Perhaps in five or 10 years, EHRs could evolve to help providers manage the ICD-10 coding discipline in a constructive and informative way. However, current EHRs would need to be redesigned, perhaps from the ground up, to accommodate the change. This will be incredibly costly for the vendors and disruptive to physician practices. Physicians would have to retrain everyone in the practice who uses the EHR on new and different methods of documenting and tracking health conditions.

Susan Thomas, M.D.
Augusta, Maine