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# NEWS NOW

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## House Stimulus Package Calls for Strengthening Primary Care Infrastructure

*\$20 Billion Slated for HIT, \$600 Million Provided for Training*

By James Arvantes

The U.S. House of Representatives has passed an \$819 billion economic stimulus package that contains several provisions to support and strengthen the nation's primary care infrastructure, clearly showing that Congress and the incoming Obama administration

view primary care as a critical health care component in the nation's overall economic recovery plan. (See related story on page 7.)

"This is a huge step in the right direction," said AAFP President Ted Epperly, M.D., of Boise, Idaho. "It shows that Congress and the Obama administration truly understand what is wrong with the health care system, and they are willing to do something to fix it."

House Democrats unveiled a draft version of the economic stimulus bill on Jan. 15. The measure provides \$20 billion to help physicians adopt health information technology, or HIT, and \$600 million to train primary care health professionals, such as primary care physicians, dentists and nurses, while also helping medical students who agree to practice in underserved areas after graduation pay their medical school expenses.

*See Stimulus Package, page 2*



The House economic stimulus bill provides funding amounts in many areas to support primary care.

## UnitedHealthcare Sets Feb. 11 as Deadline for Review of Physician Designation Program

By Sheri Porter

A key deadline is rapidly approaching for some physicians who hold contracts with UnitedHealthcare, or UHC. Feb. 11 is the cutoff for requests that UHC re-examine the accuracy of certain physician

performance data the insurer has gathered before going public with it in early March.

Family physicians who practice in markets that use the UnitedHealth Premium physician designation program should already

have received letters from the insurer detailing the process.

The letters, dated Dec. 23, informed physicians that their individual quality and cost-efficiency assessment results had been completed and would be

made available to the public no earlier than March 4, 2009.

Physicians who have concerns about the accuracy of their data, and who can provide documentation that shows that patient

*See UnitedHealthcare, page 2*

### FEBRUARY HIGHLIGHTS



**AAFP**  
STRONG MEDICINE FOR AMERICA

**PQRI Results** ..... page 3

CMS has released results on participation data and outcomes from its 2007 Physicians Quality Report Initiative.

**AAFP President Q&A** ..... page 8

AAFP News Now sits down with AAFP's president to discuss the Academy's priorities for the future.

## Stimulus Package, *continued from page 1*

The bill also includes \$3 billion for a prevention and wellness fund to better manage and treat chronic and infectious diseases. The prevention and wellness fund would include support for hospital infection prevention programs, immunization programs and evidence-based disease prevention programs.

"This is a clear indication that Congress and the new administration recognize that those investments of money are well worth the dollar amount," said Epperly.

In addition, the legislation will provide \$1.1 billion for health care research and quality programs to compare the effectiveness of different medical treatments funded by Medicare, Medicaid and the State Children's Health Insurance program, or SCHIP.

Community health centers and Indian Health Service facilities also fare well under the measure. The draft legislation provides \$1.5 billion in funding for community centers, including \$500 million to increase the number of uninsured Americans who receive health care through the centers and \$1 billion to renovate clinics and to upgrade HIT systems in the centers. At the same time, the legislation allo-

cates \$550 million to the Indian Health Service to modernize older hospitals and health clinics and to upgrade health care technology to improve care for underserved rural populations.

The largest sum of money, \$95.6 billion, would increase the federal government's Medicaid contributions to states, allowing states to maintain their Medicaid and SCHIP coverage programs. Other provisions would help people who lose their jobs keep their employer-provided health insurance longer than the current law allows.

The stimulus package represents a down payment on health care reform, a harbinger of major health care reform initiatives that are sure to follow and likely will place a greater emphasis on primary care and prevention as a way to reform the nation's health care system, said Epperly.

At press time, the Senate was still considering its version of the economic stimulus bill. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090116stimulus.html>.

## UnitedHealthcare, *continued from page 1*

information was incorrectly captured, can request a "reconsideration" of their UHC designation.

Physicians need to act quickly, however. Reconsideration requests, including all the necessary documentation, must be postmarked, faxed or e-mailed to UHC by the February deadline to give the insurer enough time to review and process the requests,

said Marilyn Levi-Baumgarten, UHC's director of the UnitedHealth Premium designation program.

Reconsideration requests can be sent by e-mail; faxed to (414) 721-0770; or mailed to United Healthcare Premium Reconsideration, Mail stop MN012-S117, 5901 Lincoln Drive, Edina, MN 55436.

To be considered, a written request must include the physician's comments on UHC's Designation Detail Report, along with the physician's signature.

UHC will review reconsideration requests received after the deadline, and physician designation ratings will be changed if indicated, "but we can't guarantee that

we'll have that review complete by the time we finish the new designation posting," said Levi-Baumgarten.

Most late reconsideration requests will be

completed about 30 days after they are received, she added, and updated designations will post weekly on UHC's online physician directory.

According to Trevor Stone, an AAFP private sector advocacy specialist, the AAFP has ongoing concerns about short timelines for requests such as this one. Academy members require sufficient time to review their detailed designation reports and respond by the deadline given, said Stone.

**"The AAFP has ongoing concerns about short timelines for requests such as this one."**

— Trevor Stone, AAFP Private Sector Advocacy Specialist

For instance, "a common industry standard for timely filing of claims is, typically, 90 days," said Stone. However, in this instance, physicians were given only 50 days from UHC's letter mailing date to the deadline for making their reconsideration requests.

The Dec. 23 mailing date UHC chose was unfortunate for a couple of other reasons, he added. The high volume of holiday mail may have caused some delivery delays, and some physicians undoubtedly were away from their practices on holiday vacations.

Stone noted that the AAFP Commission on Quality and Practice will send a proposal to the AAFP Board of Directors that would ask health insurers to provide a minimum of 120 days for physicians to review, validate and appeal their payer's performance report before public reporting. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20090128uhc-physician-desig.html>.

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# Report Assesses Physician Experiences With PQRI

**C**MS has released a report that examines participation data from its 2007 Physicians Quality Reporting Initiative, or PQRI, and also addresses physicians' frustrations with the program.

According to the new CMS report, the agency paid eligible providers slightly more than \$36 million in incentive payments for the 2007 PQRI reporting period. The average bonus paid to individual providers was \$635. The average bonus paid to practice groups was \$4,700.

Of the more than 14 million quality data codes submitted, 51.6 percent were submitted correctly; 48.4 percent of submissions were invalid.

CMS says that nearly 16 percent of all eligible providers and groups submitted at least one quality data code during the 2007 PQRI reporting period. Of those 109,359 providers or groups,

- 92.5 percent submitted at least one quality data code that was valid;
- 64 percent correctly reported quality data on 80 percent of eligible cases for at least one measure;
- 52 percent earned an incentive payment by successfully reporting data on one to three

applicable measures for 80 percent of applicable cases; and

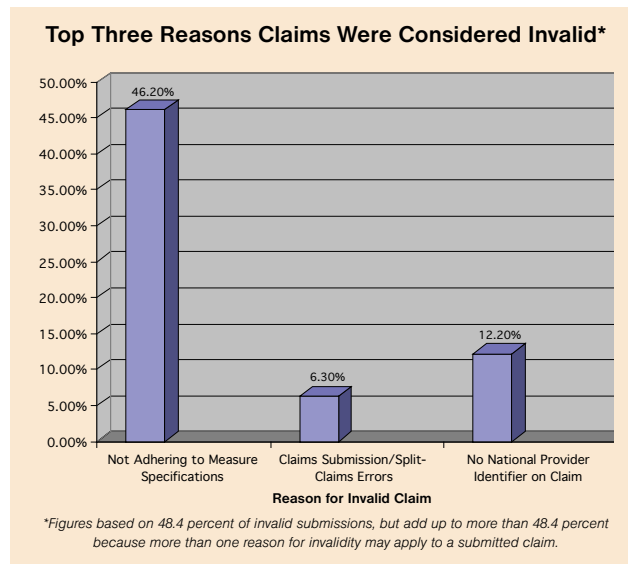
- 1 percent were subject to the PQRI incentive cap.

The CMS report also identifies possible causes for the more than 48 percent of invalid codes submitted. CMS says that based on its review, many physicians didn't adhere to quality measure reporting specifications.

The National Provider Identifier, or NPI, number also created problems for physicians. More than 12 percent of submissions didn't include an NPI number on the appropriate line with the reported quality data. In addition, billing and clearinghouse errors involving NPI numbers invalidated some physicians' reports.

CMS acknowledges that the computerized system designed specifically to allow physicians access to their feedback reports created problems and that registration to the secure accounts was "both cumbersome and time consuming."

In response to complaints that the 2007 feedback reports were difficult to understand, CMS promises that the 2008 feedback reports will be redesigned to provide more helpful information. ■



For more information, visit

<http://www.aafp.org/news-now/practice-management/20081224pqri-report.html>.

## AAFP Board Chair Confers With CMS, Urges Changes in PQRI Program

By James Arvantes

**A**AFP Board Chair Jim King, M.D., of Selmer, Tenn., personally delivered a message to CMS recently: Fix Medicare's Physician Quality Reporting Initiative, known as PQRI, or physicians may not agree to participate in the program.

King and representatives from other physician organizations met with CMS Acting Administrator Kerry Weems and other high-ranking CMS officials in Washington on Dec. 4 to ask why thousands of physicians who participated in the PQRI program did not receive a promised Medicare bonus payment of 1.5 percent. According to King, about 18 percent of the nation's physicians participated in the program, but less than 9 per-

cent actually received payment.

CMS launched the PQRI in 2007, agreeing to pay physicians a 1.5 percent bonus for reporting on a series of quality measures from July 1 through Dec. 31, 2007. However, the program was plagued by coding and technical problems from the outset, resulting in nonpayment for thousands of physicians who made a good faith effort to report the data and participate in the program.

King acknowledged that only a small percentage of the problems occurred at CMS, but he told CMS officials they need to fix every part of the PQRI process that does not work properly.

In addition, King told CMS that they need to "establish a real-time

method for letting physicians know whether their claims went through."

In response to the AAFP's concerns, Weems notified the Academy in January that the agency plans to rerun data for the 2007 reporting period based on a revised analytical process to more accurately determine who successfully submitted a quality code and should be paid a bonus under terms of the program.

In a Dec. 30 letter to King, Weems said the agency has "uncovered certain technical issues related to the business rules for reporting."

"These can be dealt with through modifications to our analytic algorithms for calculating satisfactory reporting that will result in

additional quality data codes being considered valid," said Weems.

Because of the time required to implement the new algorithms, payment for the 2008 PQRI program is anticipated to be pushed out to late October or early November 2009, according to Weems, who added, "The additional 2007 PQRI payments will be made at the same time."

In addition, Weems noted that CMS expects "to publish, in early 2009, detailed, aggregate-level measures data information for claims-based reporting that occurred for the 2008 PQRI reporting year." ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20081216pqri-mtg.html>.

## ICD-10 Implementation Deadline Extended to 2013

**W**ith the stroke of a pen, HHS Secretary Michael Leavitt gave the U.S. health care industry two additional years to comply with a rule that many experts said would be far more difficult to implement than the government had acknowledged.

In a Jan. 15 news release, HHS announced that it would extend the implementation deadline for the International Classification of Diseases, 10th Revision, Clinical Modification, or ICD-10-CM, for outpatient diagnosis coding, to Oct. 1, 2013.

The new deadline gives physicians, health insurers, software vendors and other stakeholders two additional years to prepare for a change that will increase the number of outpatient diagnosis codes from 13,500 to 68,000.

In the HHS press release, CMS Acting Administrator Kerry Weems said the agency received more than 3,000 comments on the proposed rule, including a good number of requests for a delay in the initially proposed deadline of 2011.

The AAFP voiced strong opposition to the adoption of ICD-10 and AAFP Board Chair Jim King, M.D., of Selmer, Tenn., argued last fall that CMS should delay transition to the new code set indefinitely. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20090121icd-10-delay.html>.

## 2009 Immunization Schedules Debut

### *Schedules Call for More Pneumococcal and Influenza Vaccinations*

By David Mitchell

**S**mokers and people with asthma should be vaccinated against pneumococcal disease, and 30 million more children should receive an annual influenza vaccination. That's according to the 2009 immunization schedule for adults and the 2009 immunization schedule for children and adolescents released by the CDC.

The new schedules were developed by the AAFP in conjunction with the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the CDC's Advisory Committee on Immunization Practices, or ACIP.

#### Adult Immunization Schedule

The AAFP already had adopted provisional recommendations from ACIP that added smoking and asthma as indications for administration of the 23-valent pneumococcal polysaccharide vaccine in adults ages 19-64.

"Asthma and use of cigarettes are both independent risk factors for invasive pneumococcal disease," said Jonathan Temte, M.D., Ph.D., an associate professor in the department of family medicine at the University of Wisconsin, Madison, and a member of the ACIP. "Accordingly, use of the pneumococcal vaccine can offer protection for these individuals."

This year's adult immunization schedule includes several other changes, as well:

- the recommendation for human papillomavirus vaccine clarifies that health care workers are not at increased risk because of any potential occupational exposure, but they should be vaccinated consistent with age-based recommendations;
- the varicella vaccine recommendation clarifies that adults who previously received only one dose of vaccine should receive a second dose; and
- the meningococcal vaccine recommendation clarifies that people who previously received meningococcal polysaccharide vaccine may be revaccinated after five years with quadrivalent polysaccharide vaccine if they remain at increased risk for meningococcal disease.

#### Kids, Teens Immunization Schedules

The 2009 immunization schedules for children and adolescents call for children ages 6 months to 18 years to receive an annual influenza immunization. The previous recommendation was to vaccinate children ages 6-59 months against the flu.

Temte said about 70 children die each year in the



Sheri Porter/AAFP

United States from influenza infection. "Most of these deaths occur in unvaccinated children," he said.

Last February, ACIP recommended that all children ages 6 months to 18 years be vaccinated each year against seasonal influenza beginning no later than the 2009-10 flu season.

Although the expanded ACIP recommendation isn't scheduled to be fully implemented until the 2009-10 flu season, physicians should continue immunizing children, other at-risk groups and all people interested in reducing their risk for influenza, said Temte.

Delaying full implementation of the recommendation until fall 2009 is intended to allow physicians and other vaccine providers time to plan for vaccination of this expanded patient group, the CDC said on its Web site.

The 2009 adolescent immunization schedule includes an additional clarification related to influenza vaccine: that children younger than age 9 years who are receiving the vaccine for the first time — or who were vaccinated for the first time during the previous season but only received one dose — should receive two doses at least four weeks apart.

Meanwhile, the recommendations pertaining to vaccination against rotavirus infection changed the maximum ages for vaccination. The maximum age at which the first dose should be given is 14 weeks and six days, and the oldest age at which any dose may be given is 8 months. If GlaxoSmithKline's liquid rotavirus vaccine, Rotarix, is administered at ages 2 and 4 months, a dose at 6 months is not needed.

Finally, human papillomavirus vaccination recommendations are clarified in the child and adolescent immunization catch-up schedule. There should be an interval of no less than six months between the first and last dose. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090112adult-sked.html> and <http://www.aafp.org/news-now/clinical-care-research/20090106-kids-teens-skeds.html>.

# Influenza Survey Shows ‘Sobering’ Results

By David Mitchell

**F**ewer than one-third of U.S. adults surveyed in a nationwide poll had been vaccinated against seasonal influenza as of mid-November, and more than half of those remaining said they had no intention of getting the vaccine.

“There are opportunities for improvement here,” said William Schaffner, M.D., president-elect of the National Foundation for Infectious Diseases, which hosted a Dec. 10 teleconference on results of the study conducted by the Rand Corp.

According to the CDC, 70 percent of American adults are covered by one or more of the agency’s indications for receiving influenza vaccination, meaning they are age 50 or older, a health care worker, a caregiver to children or the elderly, or have a

high-risk health condition. However, among survey respondents, only 37 percent of adults in these categories had been vaccinated as of mid-November. Among respondents age 50 and older, fewer than half had been vaccinated, and 34 percent said they did not intend to get vaccinated.

In addition, although 52 percent of respondents with heart disease, chronic lung disease or diabetes had been vaccinated, more than 20 percent of respondents in each of these three groups said they would not get vaccinated. Only one-third of respondents with asthma had been vaccinated, and more than one-half said they had no intention of getting vaccinated.

“That is still significant morbidity, and potentially mortality, that could be avoided if we reach

those (people),” said Litjen Tan, Ph.D., co-chair of the National Influenza Vaccine Summit and director of infectious diseases, immunology and molecular medicine for the AMA. “It points again to the fact that we have some outreach we need to do with people who have high-risk conditions.”

The study found that 41 percent of respondents who had not yet gotten vaccinated cited inadequate free time as a reason for not being vaccinated. Respondents also said they

- had forgotten (15 percent),
- didn’t know where to receive the vaccine (4 percent) or
- didn’t know it was flu season (5 percent).



Sheri Porter/AAFP

Among respondents who had no intention of receiving the vaccine, reasons included

- belief that they didn’t need it (25 percent),
- belief that the vaccine doesn’t work (20 percent) and
- fear of side effects (19 percent). ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20081224flusurvey.html>.

## In Brief *Clinical Care & Research*

### **Merck Stops Sales of Monovalents for Measles, Mumps, Rubella**

Merck & Co. Inc. has stopped production and sales of its monovalent vaccines for measles, mumps and rubella. The manufacturer instead plans to focus on its combination vaccine, MMRII. Merck spokeswoman Amy Rose said MMRII accounts for 98 percent of the company’s volume for measles, mumps and rubella vaccines, compared to just 2 percent from monovalent vaccines Attenuvax (measles), MumpsVax (mumps) and Meruvax (rubella). Rose said Merck had not decided when, or if, it might make the monovalent vaccines available for sale in the future. <http://www.aafp.org/news-now/clinical-care-research/20081224merckcombo.html>

### **CDC Study Shows Vaccination Rates for Kids, Teens Are Up**

Two studies published late last year by the CDC indicate that vaccination rates for children and teenagers are rising. The CDC’s 2007 National Immunization Survey of children found that 90 percent or more of children surveyed had received all vaccines in the 4:3:1:3:3:1 series except for the fourth dose of diphtheria-tetanus toxoid-acellular pertussis, or DTaP. In addition, coverage with one or more doses of varicella reached 90 percent for the first time in this age group. The 2007 National Immunization Survey of adolescents found administration rates for the tetanus-diphtheria-acellular pertus-

sis vaccine increased from 10.8 percent in 2006 to 30.4 percent in 2007. In addition, rates for administering the quadrivalent meningococcal conjugate vaccine rose from 11.7 percent in 2006 to 32.4 percent in 2007. <http://www.aafp.org/news-now/clinical-care-research/20090114kids-teens-vacc-rates.html>

### **CDC Interim Guidance Responds to Growing Oseltamivir Resistance**

The AAFP has adopted CDC interim guidance for physicians on the use of influenza antiviral medications during the 2008-09 influenza season. The CDC issued the recommendations because a high proportion of influenza A (H1N1) viruses have been resistant to the antiviral medication oseltamivir. According to the CDC, since Oct. 1, 2008, 103 H1N1 viruses collected from 25 states have been tested for resistance to the neuraminidase inhibitors oseltamivir and zanamivir. None of the viruses tested was resistant to zanamivir, but 101 (98 percent) were resistant to oseltamivir, which is marketed under the brand name Tamiflu. The agency recommends that when H1N1 virus infection or exposure is suspected, zanamivir or a combination of oseltamivir and rimantadine “are more appropriate options than oseltamivir alone.” <http://www.aafp.org/news-now/clinical-care-research/20090122oseltamivir-recs.html> ■

*Report to Congress*

## IOM Proposes Additional Changes to Residents' Duty Hours, Workloads

**A** recently released report from the Institute of Medicine, or IOM, recommends new restrictions on medical residents' duty hours and workloads, with the goals of minimizing fatigue and maximizing patient safety while maintaining "the rich educational experience necessary to achieve professional competence in the complexities of diagnosis and treatment of patients."

The recommendations in the IOM report, "Resident Duty Hours: Enhancing Sleep, Supervision and Safety," keep residents' work hours at the maximum of 80 hours per week — averaged during a four-week period — set by the Accreditation Council for Graduate Medical Education, or ACGME, in 2003. However, the report focuses on "increasing opportunities for sleep during residency training to prevent acute and chronic sleep deprivation and to minimize fatigue-related errors, rather than on simply reducing total duty hours."

One major change the IOM calls for is that shifts should not exceed 16 hours of continuous work. The current maximum shift length of 30 hours must be broken up after 16 hours by an uninterrupted five-hour sleep period between 10 p.m. and 8 a.m. The remainder of the shift should be spent only in transitional and educational activities, says the report.

In addition to the five-hour "protected sleep period," the recommendations propose

- modifying the minimum time off between scheduled shifts from 10 hours after any shift to 10 hours after the day shift, 12 hours after the night shift, and 14 hours after any extended duty period of 30 hours;
- setting a four-night maximum on in-hospital night shifts, with 48 hours off after three or four nights of consecutive duty;
- increasing the number of days residents must have off each month from four to five, with one 48-hour period off per month; and
- restricting moonlighting during residents' off hours, such that both internal and external moonlighting is counted against the 80-hour weekly limit. Currently, only internal moonlighting is factored into the 80-hour limit.

In addition to the changes in working hours, the recommendations call for greater supervision of residents by experienced physicians, limits on residents' patient caseloads and overlaps in residents' schedules during shift changes.

The report estimates that if the recommendations were implemented, the cost of shifting resident work to other clinicians, increased numbers of residents and support staff would be about \$1.7 billion a year. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20081217iom-duty-hrs.html>

## Annual Cancer Report: Overall Incidence, Death Rates Decline for Men, Women

### *Rates for Several Types of Cancer Stagnant or Decreasing*

**F**or the first time since the inaugural annual report on cancer was published in 1998, both incidence and death rates for all cancers combined are decreasing for both American men and women. That's according to the most recent annual report from the American Cancer Society, or ACS; the CDC; the National Cancer Institute, or NCI; and the North American Association of Central Cancer Registries.

"The drop in incidence seen in this year's annual report is something we've been waiting to see for a long time," said Otis Brawley, M.D., chief medical officer for ACS, in a recent news release about the report.

Brawley said he was cautious about interpreting the study's results because changes in incidence can be caused not only by reductions in risk factors for cancer, but also by changes in screening practices. For example, a decline in breast cancer incidence might be



**Declines in both incidence and death rates for all cancers are due, in part, to declines in the two most common cancers among women — breast and colorectal.**

related to diminishing use of some hormone replacement therapies that are known to increase breast cancer risk, but it also could be a result of fewer women getting regular screening mammograms.

"Regardless, the continuing drop in mortality is evidence once again of real progress made against cancer, reflecting real gains in prevention, early detection and treatment," Brawley said.

The report said the decline in both incidence and death rates for all cancers is due, in large part, to declines in incidence and death rates for the three most common cancers among men (lung, colorectal and prostate) and the two most common cancers among women (breast and colorectal).

Incidence rates among men also dropped for cancers of the oral cavity and stomach, and incidence rates for women dropped for cancers of the uterus, ovary, cervix and oral cavity.

Although incidence and death rates declined overall for both men and women, rates for American Indian/Alaska Native men and women were stable. Overall cancer death rates were highest among black patients. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20081117cancer-rpt.html>

## Redesigned FamilyDoctor.org Puts AAFP on Cutting Edge of Patient Education

**C**ollaboration between the AAFP and multi-platform video distributor AnswersMedia Inc., has resulted in an extreme makeover for the Academy's award-winning consumer Web site, FamilyDoctor.org.

The redesigned site integrates FamilyDoctor.org's existing peer-reviewed health information with interactive, high-definition video-on-demand. Co-produced by the Academy and Chicago-based AnswersMedia under the name Primetime HealthNet, FamilyDoctor.org now becomes the only medical association-sponsored Web site offering vetted health care information in text-based, video and combined formats.

According to AAFP President Ted Epperly, M.D., of Boise, Idaho, "FamilyDoctor.org is taking health information to a whole new level."



"Visitors will not only be able to read about their own health issues, they'll be able to see and hear the latest clinical information on the same site," he says in an introductory video posted on the site. "Health videos, news and perspectives, interactive tools and quizzes will soon all be found on FamilyDoctor.org."

The redesigned site now features nearly 100 videos, including many in Spanish, on common medical conditions, treatments and preventive health services. The videos are drawn from health programming created by AnswersTV, a division of AnswersMedia. More videos and a variety of other resources are scheduled to be added in the coming months. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20090105new-famdoc.html>.

## AAFP Engages Incoming Administration On Economic Stimulus Package, Health Care Issues

**T**he AAFP has asked President Barack Obama to offer an economic stimulus package that would strengthen the nation's health care system and, in turn, its economy by recognizing and rewarding the provision of primary care services.

AAFP Board Chair Jim King, M.D. of Selmer, Tenn., sent three letters in December to then President-elect Obama on several key health care issues essential to a sustained economic recovery. These issues, King said, should be considered essential components of any economic stimulus package put forward. (See related story on page 1.) They are

- greater access to primary care services,
- the need for better federal payments to primary care physicians, and
- the ability of physician practices to afford health information technology, or HIT.

In a Dec. 23 letter, King commended Obama for his "long-standing interest in improving everyone's access to appropriate

**"There is substantial evidence ... that the 200 percent payment disparity between primary care and subspecialty medicine is a predominant reason that fewer medical students are going into primary care."**

— Jim King, M.D., AAFP Board Chair

health care." He added, however, "without an adequate supply of primary care physician practices, beneficiaries will not be able to find the health care they need."

He pointed out that the Medicare Payment Advisory Commission, or MedPAC, which advises Congress on Medicare payment and other issues, has recommended a 10 percent bonus for all primary care services offered to beneficiaries by qualified primary care practices. The AAFP's stance surpasses the MedPAC recommendation by calling for a 25 percent payment premium.

"There is substantial evidence, consistent over 20 years, that the 200 percent payment disparity between primary care and subspecialty medicine is a predominant reason that fewer

medical students are going into primary care," said King.

In a subsequent letter to Obama, King focused on funding for education and training. He pointed out that annual appropriations for Section 747 of the Title VII Health Professions Grants Program have eroded steadily since 2003, despite the growing shortage of primary care physicians. This grant program is the only federal support aimed directly at training primary care physicians.

"Recognizing your steadfast commitment to increased funding for Title VII throughout your tenure in the Senate, the AAFP urges you to include in the economic stimulus legislation a robust investment in the Title VII, Section 747 grant program," said King.

He added that the program should be funded at a minimum level of \$215 million a year. "Including that level of funding for primary care training in the stimulus bill would reinvigorate medical education and residency programs, as well as academic and faculty development in primary care, to prepare physicians to support the patient-centered medical home (PCMH) medical practice model," he said.

In another letter to the administration, King said six changes to HIT should be made as part of the economic stimulus package:

- give every practice committed to providing a PCMH funds to invest in HIT;
- provide grants to organizations to establish clinical data repositories for quality and performance improvement data;
- ensure that no patient can be transferred from one provider to another unless the relevant electronic personal health data accompanies that patient;
- improve communication with patients by using secure electronic messaging and other conveniences;
- use HIT to remove the complexity and costs associated with multipayer claims administration, eligibility and copay verification, and proprietary or dissimilar pay-for-performance systems; and
- build and maintain the Internet infrastructure across the country so everyone has access to it. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090108obama-ltrs.html>.

*Q&A With the AAFP President*

# Epperly Spells Out Academy Priorities

**T**he United States needs to transform its health care system by using the patient-centered medical home, or PCMH, as a key building block in a system built around primary care. That is according to AAFP President Ted Epperly, M.D., a practicing family physician and CEO and program director of the Family Medicine Residency of Idaho in Boise, who recently sat down to talk to *AAFP News Now*.

**Q. You have talked to a lot of members during the past year. What do you think they're feeling, and what are their concerns or expectations?**

**A.** I think that as a specialty group we've been devalued by the system, but we're realizing that recognition, relief and respect for the specialty is just around the corner. Even though a lot of the members feel beat down, they also have this sense that change is afoot and better days are coming. In regard to their major concerns and why they feel beat down and somewhat demoralized — it's around payment. It's around not being valued for everything that they do in a health care system that values procedures and diagnostic imaging to the exclusion of health care. The system is focused more on sick care than on health care. That's the major concern.

**Q. What kind of progress is being made on the PCMH?**

**A.** First, excellent progress is being made on the PCMH. I'm very impressed. It's gained major traction all across the United States in multiple groups, from large employers to legislators — both at the state and federal levels — to insurance companies to consumer organizations and to unions. I can't possibly tell you how big a deal it was when the AMA adopted the Joint Principles of the Patient-Centered Medical Home on Nov. 10 in Orlando.

**Q. What would you say are the Academy's top priorities?**

**A.** The biggest one by far is advocacy around health care transformation, the PCMH, payment reform and workforce reform.

If we were to give health care insurance to everybody — universal coverage — without workforce reform to increase the number of primary care doctors, especially family physicians, out there, we wouldn't have a functional system in which everyone could then have access to care. We just don't have enough people to provide access points. It's kind of like giving out free bus passes to people, but you only have one bus in town. It just doesn't cut it.

**Q. Can you tell us more about what you think should be the future of the U.S. health care system and how family physicians and the Academy can help make it happen?**

**A.** The future of the U.S. health care system should be a transformed system based on primary care. That's what every single country in the industrialized world has already discovered. When you look at those countries, you see very robust, well-designed and well-paid primary care workforce teams. What we have in America is just the opposite.

The big future change of our system is a primary-care-based system with the PCMH as the basic building block in that system.

How family physicians can help that future become a reality is to transform their practices to a PCMH. They must see where this movement is going so they can get on board and become part of the solution. If you were to ask me what my biggest nightmare is, it's that we're



Sheri Porter/AAFP

**Ted Epperly, M.D., of Boise, Idaho, is a practicing family physician, program director of the Family Medicine Residency of Idaho in Boise, and the president of the AAFP.**

out there advocating for this stuff, and we look behind us, and there's nobody there; our own troops haven't followed, and they're not transforming their practices to meet the PCMH concept. Then, suddenly, there's this big disconnect between what we're promising America and what we're delivering.

**Q. Where do you stand on pay-for-performance?**

**A.** I think it's absolutely imperative that our members buy into this big time. It's the right thing to do for patient care, and it's the right thing to do for quality of care. We might as well get paid to do it. What it means is you have to invest in some system that will track the data for you, mostly electronic health records, or EHRs. But you can still do it as long as you have a stubby pencil and someone in the office — a nurse, medical assistant or even yourself — to keep track of the data.

**Q. How can we attract more students into the specialty and retain them?**

**A.** If we get our vision right of what we're trying to create for America — and that's a transformed system with the PCMH as the building block — and they see the vision, they will be inspired because many of them go to medical school to be just this kind of doctor — to give of themselves to a community, to be of service to others and to make differences. Most of them don't see family medicine as being lucrative enough to pay back their medical school debt or their loans. If they see the vision of what we're creating and the payment reform that comes with it, I think we're going to see an explosion of interest of students into the discipline of family medicine. ■

# New Study Expounds on Four Key Elements of PCMH

*Report Focuses on Payment Reform, Need for IT*

By James Arvantes

**T**he ability of insurers and payers to promote and sustain the patient-centered medical home, or PCMH, model depends on four core elements that can make or break the medical home process, according to a new report issued jointly by the Center for Studying Health System Change and Mathematica Policy Research Inc., or MPR.

The report identified the four core elements as follows:

- What capabilities and services will insurers and payers require physician practices to demonstrate to qualify as medical homes?

- How will insurers and payers match patients to medical homes?

- How will they promote the engagement of patients and other health care professionals in working with medical homes to coordinate care?

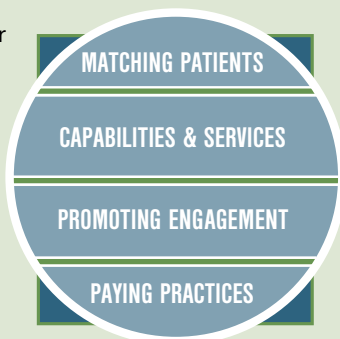
- How will they pay practices for serving as medical homes?

“The goal of the medical home is simple: Improve the quality and reduce the cost of health care by reducing uncoordinated and fragmented care, the redundancy of tests and treatments, and by eliminating the provision of treatments that do not follow clinical guidelines,” says Deborah Peikes, Ph.D., a co-author of the study and a senior researcher at MPR. “Getting these four operational issues right will ensure that insurers reward patient-centered care, not simply the use of more services, more technology, and more tests and procedures.”

The report lays out the benefits of each of the core elements, explaining the processes and procedures currently in place to support them and how each can be improved. For example, the study notes that “payers recognize that medical home services, such as care coordination, are difficult to itemize, may occur outside face-to-face patient visits, and can legitimately vary in type and intensity across different patients over time.”

“Payment approaches for medical homes under current fee-for-service payment systems essentially focus on additional payment for currently uncovered services,” the report says. However, paying for medical home services requires some sort of fixed per-patient fee.

“Extra payment is going to help a lot, particularly as practices begin to provide more care through e-mail and telephone calls, which they cannot bill for in most fee-for-service arrangements,” said Peikes. ■



For more information, visit <http://www.aafp.org/news-now/practice-management/20090107pcmh-rpt.html>.

# NCQA Medical Home Recognition New Guide Helps FPs Navigate Documentation Process

By Sheri Porter

**A**s the patient-centered medical home, or PCMH, concept gathers steam and grabs the interest of public and private payers, family medicine finds itself in the spotlight. As a service to members, the AAFP has produced a guide to help FPs who are interested in achieving PCMH recognition from the National Committee for Quality Assurance, or NCQA.

“Road to Recognition – Your Guide to NCQA Medical Home” is available free to members and can be downloaded from <http://www.aafp.org/online/en/home/membership/initiatives/pcmh/ncqaguide.html>. Members need their AAFP ID number to access the guide.

The guide was supported in part by grants from the United Health Foundation and Pfizer Inc.

NCQA, a not-for-profit organization dedicated to improving health care quality, introduced its Physician Practice Connections – Patient-Centered Medical Home program in January 2008. The NCQA program uses standards that are aligned with the Joint Principles of the Patient-Centered Medical Home to designate family medicine practices as medical homes.

For a fee, practices can achieve one of three levels of recognition as they implement and document program requirements.

Bruce Bagley, M.D., the AAFP’s medical director of quality improvement, said the Academy acted to produce the guide after hearing member feedback that the NCQA medical home documentation process was complex and nearly unmanageable.

“We’ve provided tools, examples and templates to make that process as painless and as easy as possible,” said Bagley. “We’ve tried to break it down into manageable steps.” The first step in using the multi-faceted guide is to read through the NCQA standards to understand how they are constructed and scored, he said.

Bagley added that NCQA medical home recognition would do more than give FPs in some markets an opportunity to earn bonus payments. “The process also benefits physicians in terms of improved practice efficiency and practice organization,” he said.

NCQA’s \$450-per-physician fee for review and recognition is a barrier, particularly for physicians who live in areas devoid of payers who are offering bonus money to participate, said Bagley. Physicians may not want to go the whole nine yards to get the recognition if they don’t see any financial advantage, he acknowledged.

But those physicians can download the standards from the NCQA Web site for no charge “and use them as a checklist for projects and processes that probably should be done anyway,” said Bagley. ■

**“The process also benefits physicians in terms of improved practice efficiency and practice organization.”**

– Bruce Bagley, M.D., AAFP Medical Director of Quality Improvement

For more information, visit <http://www.aafp.org/news-now/practice-management/20090109med-home-guide.html>.

*Need Help With Practice Change?*

## Explore TransforMED's New Line of Products and Services

By Sheri Porter

**F**amily physicians now have a resource on their side when it comes to tweaking — or retooling — their practices to make them more efficient, quality-minded, patient-centered and profitable.

"Doctors know what they're supposed to do and when they're supposed to do it, but they can't necessarily figure out how to do it within their busy day," said Terry McGeeney, M.D., M.B.A., president and CEO of TransforMED LLC, a wholly owned subsidiary of the AAFP.

With that in mind, the company has stepped into the main-

stream marketplace with a host of products and services — dubbed "TransforMED is HOW" — that are designed to help America's primary care physicians incorporate the patient-centered medical home model of care into their practices.

TransforMED has designed several layers of services for practices to explore, including

- practice assessments to show practices where they sit on the medical home continuum;
- medical home facilitation — both virtual and hands-on — with direct assistance from practice enhancement experts;



- medical home retreats designed to help physicians and their office staff members brainstorm as a team in an off-site setting; and the

- medical home marketplace, a free service that offers prenegotiated savings on vendor's products and services ranging from payroll and legal services to software solutions and bulk purchasing opportunities.

Another option soon to be available is a medical home network, an online community of physicians, clinicians and practice managers offering peer-to-peer knowledge and sharing of experiences. The network will appeal to practices "that don't think they'll need much help, or just want to 'tip their toe in the water' to learn about the medical home and start the journey," said McGeeney.


TransforMED also will offer support for practices that want to work on individual practice projects, such as implementation of electronic health records, advance patient access or enhanced chronic disease management.

On the other hand, some practices will want to "dive in and become complete patient-centered medical homes and work toward NCQA (National Committee for Quality Assurance) recognition," said McGeeney.

With the experiences garnered from TransforMED's two-year demonstration project under his belt, McGeeney is convinced that any primary care practice in the country, regardless of size or makeup, can become a medical home. "It takes a focus, it takes commitment, but the resources are there," he says.

Specific pricing information for TransforMED's products and services is available from the company; cost will vary according to the practice size and scope of work. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20081218tmed-tools.html>.




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## Health Experts Clash Over ‘Cost Savings’ From Prevention Measures

Two health care experts provided starkly different perspectives on whether prevention measures actually save costs during a Jan. 6 forum sponsored by the journal *Health Affairs*.

Louise Russell, Ph.D., a professor of health economics at Rutgers University in New Brunswick, N.J., said most prevention efforts do not result in cost savings. Her viewpoint was countered by Ron Goetzel, Ph.D., director of the Institute for Health and Productivity Studies at Emory University in Atlanta, who argued that prevention “offers a very good return on investment.” Russell and Goetzel published their respective views in the January/February issue of *Health Affairs*.

According to Russell, prevention efforts can result in savings

to the health care system, but in most cases, the savings are “outweighed by the cost of the prevention/intervention itself.”

Prevention usually does not result in cost savings, said Russell. Although the “additional medical costs are sometimes minor ... they can be very, very substantial as well. There are many, many medical interventions that we do routinely that cost hundreds of thousands of dollars for a life that is saved, some of them millions of dollars for a life that is saved.”

Russell said there have been thousands of carefully designed cost-analysis studies conducted in the area of prevention during the past 40 years that consistently point to one conclusion: The vast majority of preventive interventions add more to medi-

cal spending than they save.

Prevention efforts are aimed at the probability of a condition — something that might happen, not something that has happened, she said.

Goetzel responded to Russell’s comments, saying that prevention and health promotion can provide high value by improving lives at a relatively low cost when compared with the expense of treatments.

“The issue relative to this debate is not whether any given prevention or treatment service saves money, but rather how much value is gained from that service,” he said.

The discussion should focus on ways to achieve enhanced health care for the population and to allocate resources most effectively to “get the biggest bang for the buck,” said Goetzel.

He acknowledged that certain clinical preventive services do not save money. “But then again, neither do most medical treatments,” Goetzel said. ■

For more information, visit <http://www.aaafp.org/news-now/health-of-the-public/20090114hth-aff-prev.html>.



**Ron Goetzel, Ph.D., tells attendees at a Health Affairs forum that the nation’s health care delivery system favors paying for the treatment of chronic diseases rather than preventing them in the first place.**

## Health Care CEOs Push for Systematic Reform of Health Care

### *New Coalition Recognizes Importance of Primary Care, Medical Home*

The New America Foundation has formed a coalition of health care leaders to accelerate the pace of national health care reform efforts and to create a system of care that improves quality, enhances access and reduces costs.

“Health reform is so important we have to have a profound sense of urgency — we cannot wait,” said Len Nichols, Ph.D., director of the health policy program for New America Foundation during a Dec. 11 press briefing announcing formation of the coalition. “We cannot reform our health care system unless we change business as usual.”

The coalition, known as Health CEOs for Health Reform, comprises the heads of six major health providers from across the country, including Blue Shield of California, Catholic Healthcare West in San Francisco, Virginia Mason Medical Center in Seattle, Denver Health, the Billings (Mont.) Clinic, and Global Human Health, a division of Merck & Co. Inc.

Each of the coalition members supports health care transformation through fundamental reform of the nation’s health care delivery and payment systems. Members also recognize the importance of primary care and the patient-centered medical home in any national health care reform effort.



**“We have a crisis in coverage, affordability and quality,” says Gary Kaplan, M.D., chair and CEO of the Virginia Mason Medical Center, during the launch of Health CEOs for Health Reform.**

“It is time for hospitals and physicians to address the reality that health care costs too much and our current ways of financing and delivering health care are outdated,” said Lloyd Dean, president and CEO of Catholic Healthcare West, the eighth largest hospital system in the nation and the largest nonprofit hospital provider in California.

Patricia Gabow, M.D., CEO of Denver Health, called for the elimination of the current fee-for-service payment model, saying, “if you have a model that pays for doing more, people will do more.”

“We need a payment model that will remove the enormous health care complexities that add cost as well as confusion for our patients and providers,” said Gabow, who participated in the press briefing through a video hookup in Denver. “We need a payment model that provides the appropriate incentives to doing care, which provides real value to our patients.”

Gabow also called for the creation of integrated health care models where “primary care is valued and utilized and where care is coordinated across the continuum of the patient’s life and across the continuum of their disease.” ■

For more information, visit <http://www.aaafp.org/news-now/professional-issues/20081223health-ceos.html>.

# AS WE SEE IT

Voices From the AAFP

*From the President*

## Criticism by Emergency Physician Misses Mark

By Ted Epperly, M.D.

A recent opinion piece by Jonathan Glauser, M.D., M.B.A., in the December issue of *Emergency Medicine News* created a loud outcry of “foul” from primary care physicians around the country.

Glauser’s column, titled “The Disgraceful State of Primary Care,” took direct aim at primary care physicians with little regard for the overwhelming data that shows how vital primary care is as the foundation for effective and quality patient care.

Family physicians were vocal in their disdain for Glauser’s viewpoint, and they were joined in that position by their primary care colleagues at the American College of Physicians and the American Osteopathic Association.

In response, I, along with my contemporaries at the ACP and the AOA, wrote letters to *Emergency Medicine News*. Following is the text of the letter that I wrote.

*In his column, “The Disgraceful State of Primary Care,” Jonathan Glauser raised a number of issues about the U.S. health care system. But it is the system, not primary care, that has fallen into disgrace.*

*This is a system that pays for procedures, rather than medical expertise, and results in financial, geographic and time barriers to health care for the underinsured, the uninsured, and those who live in geographically underserved areas.*

*But the solution is not to discredit primary medical care, which — according to research dating to the 1990s — undergirds all high-functioning health care systems in the world. Instead, the solution is to rebuild primary care in the United States so that doctors have the time to be doctors and patients receive the right care at the right time in the right place. And the best vehicle for rebuilding the U.S. health care system is the patient-centered medical home.*

*The patient-centered medical home is a concept of care, not a payment system. The medical home is a medical practice that gives patients a personal physician who works with a team of health professionals to care for the patient. That care is coordinated across all elements of the health care system, including subspecialist care, hospitalization, home health agencies and community services. The medical home professional uses information technology to exchange health information with pertinent colleagues and institutions, to establish registries, and to design office practices to ensure open-access scheduling, extended office hours and convenient online communication with patients. As a system of care, the medical home can provide health services to patients regardless of their insurance status or ability to pay.*



AAFP President  
Ted Epperly, M.D.

*Family medicine — the only specialty that focuses only on primary care — trains physicians in virtually all areas of medicine. Family medicine residents complete rotations on all hospital units, including surgery, inpatient care and maternity care. As a result, family physicians have the medical expertise to provide several levels of care themselves and to know when a patient requires subspecialist attention. The 2008 survey of American Academy of Family Physicians members reported that 77 percent see patients in the hospital, 38 percent see patients in coronary care units, 45 percent see patients in intensive care units, 40 percent provide emergency room care, and 30 percent do surgery, in addition to their office practices.*

*These services are particularly valued in geographical health professions shortage areas, where family physicians are the only source of medical care for millions of Americans. The AAFP survey reported that 77.5 percent of respondents provide care in rural areas. Moreover, respondents reported providing free care to an average of 9.5 patients per week. One of every 10 of survey respondents’ patients had no health insurance.*

*It is this commitment to ensuring that patients have access to comprehensive care that makes primary care uniquely capable of improving health care outcomes, reducing disparities in health care among underserved populations and controlling health care costs.*

*This has been demonstrated repeatedly in studies by researchers ranging from Johns Hopkins University’s Barbara Starfield, M.D., M.P.H., to the Commonwealth Fund’s Commission on a High Performance Health System. Pilot programs such as North Carolina’s Community Care program for Medicaid patients demonstrate the success of the primary care, patient-centered medical home in caring for low-income patients. Projects such as IBM’s patient-centered primary care initiative with Pennsylvania’s Geisinger Health System prove that a patient-centered medical home can improve outcomes and rein in costs. Throughout the country, private insurers, state governments and health systems themselves are testing this concept and, to date, determining that the medical home improves patient access to care, the quality of care, outcomes of care and cost control.*

*The uniform outcomes of these pilot projects demonstrate that the concept of a primary care, patient-centered medical home does, in fact, work to the benefit of all stakeholders. Family physicians and their primary care colleagues are proud to move beyond pointing out the serious flaws of America’s health care system and, instead, help lead the movement that is helping to solve the very problems cited by Dr. Glauser. ■*

For more information, visit <http://www.aafp.org/news-now/opinion/20081224emerphytl.mem.html> (members only).