



aafp

NEWS NOW

February 2010 • Volume 6 • Number 2

the family physician's trusted source for news

Obama Renews Call for Health Care Reform During State of the Union Address

Health Care Problems Have Not Disappeared, Says AAFP President

By James Arvantes

During his first State of the Union address on Jan. 27, President Obama said he would continue to work for passage of a health care reform bill, reviving hopes that Congress may be able to pass comprehensive reform legislation this year.

"I am encouraged that the president is still obviously concerned about health care and that he called once again for congressional action," AAFP President Lori Heim, M.D., of Vass, N.C., told *AAFP News Now*. "In his speech, the president made the same points we have been making, and that is, the problems that started the debate about health care have not changed."

Obama urged Congress "not to walk away" from health care reform, saying "after nearly a century of trying, we are closer than ever to bringing more security to the lives of so many Americans."

Obama's speech primarily focused on the economy, but in making his pitch for health care reform, he said reform of the

See Health Care Reform, page 2



President Obama delivers his first State of the Union address to a joint session of Congress in the House chamber of the U.S. Capitol.

Chuck Kennedy/White House

Federal Government Issues New Health IT Regulations

CMS Proposes Definition of EHR 'Meaningful Use'

The federal government is one step closer to defining the term "meaningful use" as it pertains to electronic health records, or EHRs. On Dec. 30, CMS and the Office of the National Coordinator for Health

Information Technology, or ONC, each issued a set of regulations that, together, lay a foundation for improving the quality, efficiency and safety of the nation's health care through the use of certified EHR technology.

The nation's hospitals, physicians and other health care professionals have a stake in the outcome of the rules process because the regulations will help implement government EHR incentive programs enacted

under the American Recovery and Reinvestment Act of 2009.

According to an HHS news release, the proposed rule issued by CMS outlines provisions governing EHR incentive programs,

See New Health IT Regulations, page 2

FEBRUARY HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

Breast Cancer Update page 6

The AAFP has updated its recommendations for breast cancer screening based on U.S. Preventive Services Task Force revised recommendations.

McNeil OTC Recall page 7

McNeil has recalled more than 500 lots of its OTC products including Roloids and Children's Tylenol due to chemical contamination.

Health Care Reform, *continued from page 1*

nation's health care system is inextricably linked to the nation's economic well-being. And he reiterated many of the points about health care reform long championed by the AAFP.

"The approach we have taken would protect every American from the worst practices of the insurance industry," Obama said. "It would give small businesses and uninsured Americans a chance to choose an affordable health care plan in a competitive market. It would require every insurance plan to cover preventive care."

In a prepared statement from the AAFP, Heim pointed out that the AAFP has supported health care coverage for everyone for more than 20 years.

"We must provide health care coverage to people who cannot afford it or who have been turned away due to pre-existing conditions," she said. "We must end the fragmentation of care; the duplication of tests and services; and the disregard for chronic disease management, prevention and wellness care in favor of medical intervention."

The AAFP will continue to work for constructive health insurance reform for all Americans while advocating for changes in health care delivery to ensure high-quality, affordable care, said Heim.

In that vein, the AAFP, along with the American College of Physicians and the American Osteopathic Association, sent a letter to key congressional leaders and the White House urging Congress to enact legislation that provides Americans with greater access to affordable health insurance coverage.

The three organizations, which represent a total of 300,000 physicians and medical students, also asked Congress to implement physician workforce and payment reforms to help ensure a sufficient supply of primary care physicians and to accelerate funding for innovative models of care, such as the patient-centered medical home.

The organizations called for other reforms, as well, including alternatives to the current medical liability tort system and a permanent end to the cycle of Medicare physician payment cuts created by the sustainable growth rate formula. Unless Congress intervenes, physicians face a 21.2 percent cut in the Medicare payment rate on March 1.

Each of the reforms is essential to achieving a sustainable, affordable and high-quality health care system for all Americans, says the letter. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100128state-of-union.html>.

New Health IT Regulations, *continued from page 1*

including the definition of meaningful use of health information technology. The interim final regulation issued by the ONC sets initial standards, implementation specifications and certification criteria for EHR technology.

In the news release, David Blumenthal, M.D., national coordinator for health information technology, said widespread adoption of EHRs would improve the efficiency, quality and safety of the nation's health care system.

"Over time, we believe the EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations throughout the health care system," he said.

CMS' proposed rule and the

ONC's interim final rule are open to a 60-day public comment period.

Steven Waldren, M.D., M.S., director of the AAFP's Center for Health IT, told *AAFP News Now* that he and his staff were reading and analyzing the 600-plus pages of rules.

He said the Academy would submit comments to CMS and the ONC within the given period after the Center for Health IT determines how it will suggest refining the rules to best fit the needs of family physicians.

"The Academy will also need to create a set of resources to help members work through this new regulatory environment," said Waldren. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100106mean-use.html>.



Sheri Porter/AAFP News Now

Family physicians who already use EHRs, such as AAFP Past President Jim King, M.D., as well as those physicians planning on implementing the technology, have been awaiting CMS' definition of "meaningful use."

**The Family Physician's
Trusted Source for News
February 2010
Volume 6 • Number 2**

The official news publication of the American Academy of Family Physicians. Published monthly by the News Department, Communications Division, to keep AAFP members informed. Opinions expressed in *AAFP News Now* do not necessarily reflect the policies of the AAFP.

Nancy Kuehl, M.B.A.
Editor

Cindy Borgmeyer
Senior Editor

Sheri Porter
Senior Associate Editor

James Arvantes
Washington Correspondent

Barbara Bein
David Mitchell
Associate Editors

Paula Haas
Contributing Writer

Brandon Temple
Design Manager

Renee Campbell
Graphics Associate

Address comments to *AAFP News Now*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2672; fax them to (913) 906-6080; call (800) 274-2237, Ext. 5225; or contact ann@aafp.org via e-mail.

Copyright © 2010 American Academy of Family Physicians. All rights reserved. AAFP chapters may reprint information presented in *AAFP News Now*, with the exception of "As We See It: Voices From the AAFP" contents. Please use the following source: *AAFP News Now*, February 2010, © AAFP. All other uses require prior written consent from the AAFP. Please contact copyrights@aafp.org.

Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between Dec. 23 and Jan. 20, 2009.

AAFP Rallies Member Support for Permanent SGR Fix

The AAFP has issued a Speak Out Action Alert asking members to contact their representatives in the House and Senate to tell them that family physicians should no longer have to operate with a payment system based on the flawed sustainable growth rate, or SGR, formula.

Unless Congress acts, the SGR will require a 21.2 percent cut in Medicare payment rates as of March 1.

"With health care reform nearing final passage, it's time to permanently fix the SGR," says a message about the Action Alert on the AAFP's Connect for

Reform (Members Only) Web page. "We need a lasting solution that replaces this formula with physician payment updates tied to inflation rather than specified targets."



"Many of America's family physician practices are small businesses. While they are committed to seeing their long-time patients, declining Medicare

payments will make it unaffordable for them to take new Medicare patients," says the Action Alert letter.

AAFP President Lori Heim, M.D., of Vass, N.C., says the short-term patch "limits innovation and the ability of physicians to be able to predict what their income will be."

"Our goal is to have the SGR fixed permanently," said Heim in an interview with *AAFP News Now*. "It is really up to Congress to decide whether they want to include it within the health care reform legislation or in a separate bill."

Heim, meanwhile, is convinced that AAFP members can

play a role in convincing Congress to replace the SGR formula. "When our members write in and explain how this affects their patient populations, it is very powerful," she said.

Heim worries that AAFP members may get discouraged if Congress provides only a temporary payment patch without replacing the SGR formula. "When you send your troops into battle," said Heim, "they need to know they have a chance of winning. I have a real concern that at some point our members will just say 'I am not going to win, and so I am withdrawing from Medicare.'" ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100113sgr-action-alert.html>

Congress Approves Temporary Payment Patch, President Signs Bill

Bill Gives Lawmakers More Time to Seek Longterm SGR Solution

By James Arvantes

Congress has passed, and President Obama has signed, a measure that extends the current Medicare physician payment rate for the next two months, thus blocking a 21.2 percent reduction that was scheduled to go into effect on Jan. 1 under the sustainable growth rate, or SGR, formula.

The two-month payment patch, which was passed as part of a massive defense appropriations bill, gives lawmakers more time to replace the SGR payment formula. With the short-term payment patch, CMS also will be able to implement a 2010 payment rule that eliminates Medicare payments for consultation codes and redistributes the savings to office visits and selected other evaluation and management services. This will result in higher payments for primary care physicians.

"You should know year to year that you are going to have a reliable funding stream," said AAFP President Lori Heim, M.D., of Vass, N.D., in a recent Connect for Reform video. "Any business — any small business — needs to have that."

In an interview with *AAFP News Now*, Heim said the two-month

patch is a "welcome sign to give Congress the time to do a permanent fix." The scheduled 21 percent pay cut would have been "devastating for family physicians," she noted.

"Approximately 25 percent of most family physicians' income is from Medicare."

— Lori Heim, M.D., AAFP President

"Approximately 25 percent of most family physicians' income is from Medicare," said Heim. "But we know that some family physicians have an even higher percentage of Medicare patients, so you can imagine the impact of a 21 percent cut (on them)."

Heim said, however, that the two-month SGR reprieve "continues to kick the SGR can down the road without fixing the SGR." She called on Congress to provide a permanent fix as part of a larger health care reform bill.

"The problem of the SGR magnifies every year," said Heim. "Simply ignoring it does not make the problem go away."

The AAFP has taken a leading role in lobbying Congress for the elimination of the SGR. During the past several months, AAFP leaders and members have met numerous times with lawmakers on Capitol Hill, explaining the impact of the SGR and why it must be abolished. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20091222tempsgpatch.html>

AAFP Board Adopts Principles for Accountable Care Organizations

By Sheri Porter

Innovative ideas require scrutiny before they can be fully embraced, and a new model of health care delivery, known as the accountable care organization, or ACO, is no exception. That's why the model is being looked at by the AAFP, and why the AAFP Board of Directors recently adopted Accountable Care Organization Principles.

AAFP Director Kenneth Bertka, M.D., of Holland, Ohio, chair of the AAFP's ACO Task Force, told *AAFP News Now* that physicians might be unfamiliar with the term "ACO," even though it is sprinkled throughout health care reform legislation currently winding its way through Congress.

"The foundation of an ACO is primary care and the patient-centered medical home (PCMH)," said Bertka. The concept can be loosely defined as a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the qual-

ity and cost of care provided to a defined patient population, he said.

Think of the ACO as an extension of the PCMH, said Bertka. "The ACO can be that medical home 'neighborhood' that aligns all of the health care providers outside of the patient-centered medical home practice," he said.

However, it's possible that a proliferation of ACOs could thrust primary care into a scenario similar to the managed care environment of the late '80s and early '90s, when primary care physicians basically became a source of referrals for hospitals and subspecialists, said Bertka.

"Regardless of how one looks at it, the Board felt it really needed to get engaged," he said. If this is good for primary care, the AAFP will want to promote ACOs. However, if the concept holds too many negatives, especially for small- and medium-size family medicine practices, then the AAFP "absolutely wants to be at the table and have a hand in

how ACOs are developed."

AAFP leaders adopted 16 of the principles recommended by the task force. According to these principles, ACOs must include, among other things,

- team-based primary care that involves a voluntary partnership of physicians and other participants;
- nationally accepted clinical measures by which performance can be measured;
- health information technology systems that provide point-of-care information and that assist care coordination among multiple providers;
- payment structures that are clearly identified and agreed upon by all members and that are monitored to prevent unintended consequences, such as denial of needed care;
- sufficient numbers of patients to enable accurate measurement of the level of care provided;
- participation options that allow physicians to be involved in multiple ACOs; and

- incentives to encourage patient engagement in health and wellness activities.

The principles also call for exploration of antitrust regulations and Stark self-referral regulations to allow for full physician participation.

Four additional principles relate to physician payment under the ACO model. Bertka said the final principle in the set is aimed specifically at primary care practices that participate in an ACO and that also hold a PCMH designation. The principle says that such primary care practices should be eligible for payments in both models of care.

"The PCMH needs to be recognized, valued and rewarded for what it does," said Bertka. Any payments that are earned and awarded through the work of the entire ACO should be separate, he added. ■

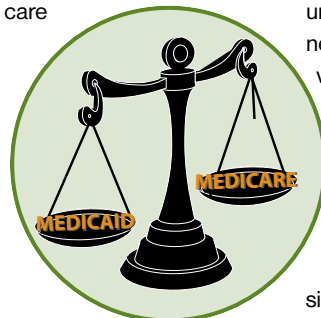
For more information, visit <http://www.aafp.org/news-now/practice-management/20091216aco-principles.html>.

AAFP, Other Groups Urge Congress to Equalize Medicaid, Medicare Payment Rates

The AAFP has joined more than 100 other organizations in calling on lawmakers to equalize Medicaid and Medicare payment rates as part of any comprehensive health care reform bill passed by Congress.

Both the House and Senate health care reform bills — H.R. 3962 and H.R. 3590, respectively — would expand Medicaid coverage to more low-income individuals. Only the House bill, however, includes a \$57 billion provision that would adjust Medicaid payments for primary care to at least 100 percent of Medicare rates.

In a letter to House and Senate leaders, the AAFP and 117 other physician, patient and labor organizations urged Congress to "ensure meaningful access to care under the proposed Medicaid expansion by adopting the House provision to bring Medicaid reimbursement rates for primary care in line with comparable Medicare rates within four years."



"While we strongly support expanding Medicaid to extend health coverage to low income individuals, we are very concerned that failure to address reimbursement disparities will weaken an already fragile network of Medicaid providers at a time when the demand for their services will be growing," says the letter, signed by the AAFP, the American College of Physicians, the American Osteopathic Association and the American Academy of Pediatrics, among others.

The letter points out that Medicaid rates average just 66 percent of Medicare rates for primary care services and are "woefully inadequate to cover the cost of providing care."

"According to the Congressional Budget Office, the planned expansion will increase enrollment in Medicaid and the Children's Health Insurance Program by as many as 15 million beneficiaries," says the letter, which was sent to Senate Majority Leader Harry Reid, D-Nev., House Speaker Nancy Pelosi, D-Calif., and other congressional leaders who head key committees with a direct impact on health care legislation. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100113-equal-med.html>.

ACC, AHA Update Guidelines for Beta Blockers

Therapy Should be Started Well in Advance of Elective, Noncardiac Surgery

The use of beta blockers in patients undergoing noncardiac surgeries should be initiated well in advance of procedures and titrated up as blood pressure and heart rate allow, according to an update of guidelines from the American College of Cardiology, or ACC, and the American Heart Association, or AHA.

Kirsten Fleischmann, M.D., M.P.H., associate professor of medicine at the University of California-San Francisco and chair of the group that reviewed new evidence on the perioperative use of beta blockers, said in a news release that physicians must be vigilant in assessing patients' cardiac risk and weighing that risk against potential side effects of therapy.

"These updated guidelines are intended to provide guidance for the appropriate use of beta blockers to help reduce the risk of cardiac com-

plications," Fleischmann said.

The ACC and AHA released guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery just two years ago. However, the organizations released a focused update last month, prompted by results of a study in which fixed, higher doses of the beta blocker metoprolol were started in more than 8,000 patients on the day of noncardiac surgery.

That study confirmed a reduction in cardiac events, including cardiovascular death, myocardial infarction and cardiac arrest, with perioperative beta-blocker therapy. However, the benefit was offset by an increased risk of stroke and total mortality.

The ACC and AHA said the findings "suggest that routine administration of high-dose beta

blockers in the absence of dose titration is not useful and may be harmful to beta-blocker-naive patients undergoing surgery."

The organizations said evi-

"These updated guidelines are intended to provide guidance for the appropriate use of beta blockers to help reduce the risk of cardiac complications."

— Kirsten Fleischmann, M.D., M.P.H.
University of California-San Francisco

dence suggests that when possible and where indicated, beta blockers should be started days to weeks before elective surgery. Furthermore, the dose should be titrated to achieve adequate heart rate control to increase the likelihood that the patient will receive the benefit of the medica-

tion while minimizing the risks of hypotension and bradycardia.

The updated guidelines did not change the organizations' recommendation to continue beta blockers perioperatively in patients who are already receiving them. The ACC and AHA advise that beta blockers are reasonable to consider in

- patients at high risk for heart attacks or other cardiac complications because of abnormal stress test results or known coronary artery disease who undergo vascular surgery; and
- high-risk patients undergoing intermediate risk surgery or in those with multiple risk factors for complications, such as diabetes, a history of heart failure or significant kidney disease, who undergo vascular surgery. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20091215betablockers.html>.

In Brief *Clinical Digest*

Erythromycin Ophthalmic Ointment Supply Increasing

A nationwide shortage of erythromycin (0.5%) ophthalmic ointment appears to be nearing its end, but hospitals and other customers are being asked to limit their orders to quantities that meet their immediate needs. The FDA said on its Web page dedicated to drug shortages that production has increased and is expected to increase again after the first quarter of 2010, allowing customers to build inventory. The AAFP strongly recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum. The American Academy of Pediatrics and the U.S. Preventive Services Task Force, or USPSTF, also recommend this prophylaxis, which is required by law in most states. <http://www.aafp.org/news-now/clinical-care-research/20091215ointment-shortage-ends.html>

FDA Approves Seasonal Flu Vaccine Intended Specifically for Seniors

The FDA has approved Fluzone High-Dose, an inactivated seasonal influenza vaccine for people ages 65 years and older. Each 0.5 mL dose of Fluzone High-Dose contains 60 mcg of influenza virus hem-

agglutinin of each of the three influenza virus strains in the vaccine, for a total of 180 mcg. Other seasonal influenza vaccines for adults are formulated with 45 mcg of influenza virus hemagglutinin (15 mcg of each of the three influenza strains per dose). <http://www.aafp.org/news-now/news-in-brief/20100113wkly-nws-brfs.html>

Pneumococcal Infections Spike During Flu Pandemic

The CDC's National Center for Immunization and Respiratory Diseases, said during a media briefing last month that the agency has seen an increase in serious pneumococcal infections across the country. The agency said common bacteria can invade the lungs when there's a viral infection like influenza. Vaccination is the best way to protect against serious pneumococcal infections, but only one-fourth of high-risk adults younger than 65 have received the pneumococcal polysaccharide vaccine, or PPSV. Concerns about coinfection prompted the CDC to issue a letter to physicians in November, urging them to immunize patients with indications for PPSV, especially those with high-risk conditions. <http://www.aafp.org/news-now/clinical-care-research/20091223pneumo-vacc-flu.html> ■

Annual Report on Cancer

Colorectal Cancer Diagnoses, Deaths Plummeting

Colorectal cancer rates fell 22 percent from 1975 to 2000 in the United States, and deaths attributed to the disease fell 26 percent during the same period because of increased screening, changes in risk factors and improved treatment, according to an annual report on cancer.

The declines might become even more dramatic, said researchers from the National Cancer Institute, the CDC, the American Cancer Society and the North American Association of Central Cancer Registries, who were responsible for the report. According to the researchers' modeling, Americans could see a 36 percent decline in colorectal cancer mortality if current trends persist. Furthermore, researchers said that with accelerated cancer control efforts, colorectal cancer mortality could be cut in half by 2020.

The prediction is based on potential reductions in risk factors, such as smoking, obesity and red meat consumption, and also includes factors that could decrease risks, including exercise and supplement use.

"The extraordinary progress on colorectal cancer shows what



Endoscopic image of adenocarcinoma of the sigmoid colon.

can be achieved by coordinated and targeted efforts to apply existing knowledge to cancer control at the state and federal level," said John Seffrin, Ph.D., chief executive officer of the American Cancer Society, in a news release. "Increases in colorectal cancer screening have been achieved through a variety of efforts, including education of the public and medical community and advocacy for health insurance coverage of the full range of colorectal cancer screening tests."

The CDC launched a Colorectal Cancer Control Program in September. That program provides screening services in 26 states to low-income men and women aged 50-64 years who are underinsured or uninsured.

"We have tremendous potential to reduce the disparities that exist in colorectal cancer screening and to save lives," said CDC Director Thomas Frieden, M.D., M.P.H., in the news release.

Researchers found that from 2002 to 2006, new cases of colorectal cancer fell 3 percent in men and 2.2 percent in women, while deaths declined by 3.9 percent in men and 3.4 percent in women.

Colorectal cancer is the third most frequently diagnosed cancer in American men and women and the second-leading cause of cancer deaths in the nation. Although overall rates are declining, researchers expressed concern about increasing incidence rates among men and women younger than 50 years.

From 1997 to 2006, rates of new colorectal cancer cases decreased for men and women in all racial and ethnic groups except American Indian/Alaska natives. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20091215colorectalcancer.html>.

Updated AAFP Breast Cancer Screening Recommendations Stress Communication

The AAFP has updated its recommendations for breast cancer screening based on evidence summarized by the U.S. Preventive Services Task Force, or USPSTF, which revised its recommendations in November.

In the wake of controversy created by the new USPSTF recommendations, which initially recommended "against routine screening mammography in women aged 40 to 49 years," the AAFP's updated recommendations stress that family physicians should discuss with all women the potential benefits and harms of screening tests and develop a plan for early detection that minimizes potential harms.

These discussions, the Academy's recommendations add,

should include information about the evidence regarding each type of screening test, the risk of breast cancer and individual patient preferences.

The Academy's updated recommendations for breast cancer screening address various age ranges and screening modalities.

- The AAFP recommends that the decision to conduct screening mammography before age 50 should be individualized and take into account patient context, including the patient's risk factors, as well as her values regarding specific benefits and harms. That change was made as a level C recommendation, which means that although the AAFP recommends against routinely providing the service and there is at least

moderate certainty that the net benefit is small, there may be considerations that support providing it in an individual patient.

- The AAFP recommends biennial screening mammography for women between ages 50 and 74.
- The AAFP recommends against clinicians teaching women breast self-examination.
- The AAFP concludes that the current evidence is insufficient to assess the benefits and harms of screening mammography in women ages 75 and older.
- The AAFP concludes that the current evidence is insufficient to assess the benefits and harms of clinical breast examination for



women ages 40 and older.

- The AAFP concludes that the current evidence is insufficient to assess benefits and harms of either digital mammography or MRI instead of film screen mammography as screening modalities for breast cancer. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20100115aafp-brca-recs.html>.

2010 Childhood, Adolescent, Adult Immunization Schedules Released

New options for human papillomavirus, or HPV, vaccination are among the notable changes highlighted in the 2010 adult immunization schedule which was released in the Jan. 15 issue of *Morbidity and Mortality Weekly Report*, or *MMWR*.

Developed by the CDC's Advisory Committee on Immunization Practices, or ACIP, in conjunction with the AAFP, the American College of Physicians, and the American College of Obstetricians and Gynecologists, the updated recommendations reflect a number of actions taken in 2009.

In October, the ACIP recommended routine use of Cervarix, a bivalent HPV vaccine manufactured by GlaxoSmithKline Biologicals, after it was approved by the FDA for the prevention of cervical cancer and precancerous lesions caused by HPV types 16 and 18 in girls and women ages 10-25.

Like Gardasil, Merck & Co. Inc.'s quadrivalent HPV vaccine, Cervarix is administered in a three-dose series. Cervarix does not protect against the HPV types that cause genital warts, but either vaccine can be used to prevent cervical cancer and precancerous lesions in young women.

The HPV footnote in the adult schedule also includes new information indicating that ACIP supports permissive use of the quadrivalent vaccine in males as old as 26 for the prevention of genital warts.

Similar updates about the new bivalent HPV vaccine in girls and young women and the use of the quadrivalent vaccine in boys and young men also appear in the 2010 adolescent immunization schedule, which — along with the children's immunization schedule and the child and adolescent catch-up schedule — was produced by the ACIP in conjunction with AAFP and the American Academy of Pediatrics.

The 2010 adult schedule includes several other changes including a revised footnote for measles, mumps and rubella, vaccine and an updated footnote for the tetravalent meningococcal conjugate vaccine or MCVA. The hepatitis A footnote has been updated to include an indication for unvaccinated people who anticipate close contact with an international adoptee from a country where hepatitis A is endemic.

The hepatitis B footnote has been updated to include scheduling information for the three-dose vaccine series.

Other changes to the children's schedule include revisions of recommendations for the inactivated poliovirus vaccine. The last dose in the series now is recommended to be administered on or after a child's fourth birthday and at least six months after the previous dose. If four doses are administered before age 4 years, a fifth dose should be administered at age 4 through 6 years.

Finally, revaccination with MCV4 is recommended for children who remain at increased risk for the disease. Children should be revaccinated after three years if the first dose was administered at age 2 through 6 years, or after five years if the first dose was administered at age 7 or older. ■

For more information, visit <http://www.aafp.org/online/en/home/publications/news/news-now/clinical-care-research/20100115immun-skeds.printerview.html>.

McNeil Recalling Hundreds of Lots of Contaminated OTC Medications

FDA Criticizes Manufacturer for Handling of Investigation

Family physicians and their patients should be aware of a massive product recall being undertaken by manufacturer McNeil Consumer Healthcare.

McNeil has recalled more than 500 lots of its OTC products — including Benadryl, Roloids, multiple variations of both Motrin and Children's Motrin and numerous variations of Tylenol and Children's Tylenol — because of chemical contamination.

A complete list of affected products and lot numbers can be accessed through a McNeil news release at http://www.jnj.com/connect/news/all/20100115_100000.

McNeil said in the Jan. 15 release that it has received consumer complaints of moldy, musty or mildew-like odor that, in some cases, was associated with temporary and non-serious gastrointestinal events, including nausea, stomach pain, vomiting or diarrhea.

The manufacturer said the products contain trace amounts of a chemical called 2,4, 6-tri-bromoanisole, a degradant of 2,4,6-tribromophenol, which is a pesticide and flame retardant used to treat wooden pallets. The company's action follows a voluntary recall in December of Tylenol Arthritis Relief caplets based on the same complaint.

Although McNeil said reported adverse events have not been serious, the FDA leveled harsh criticism at McNeil and its parent company Johnson & Johnson in a warning letter dated Jan. 15.

The FDA said in the letter that an inspection of a McNeil facility in Puerto Rico completed Jan. 8 identified "significant violations of the current good manufacturing practice regulations for finished pharmaceuticals." The agency added that McNeil failed to submit alert reports after becoming aware of problems.

McNeil has 15 working days from its receipt of the letter to notify the FDA in writing of the specific steps it has taken to correct violations. ■



For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100118mcneilrecall.html>.

CMS Proposes Rule to Rein in Medicare Advantage Plans

Physicians concerned about time-consuming policies and directives dispensed by Medicare Advantage organizations — health plan options for beneficiaries that are included in the Medicare program — should be aware of a CMS proposed rule that aims to provide some relief.

The rule, which was published late in 2009, proposes revisions to the advantage plan program and to the prescription drug benefit program.

In response to the proposed rule, the AAFP, AMA and more than 80 other professional medical organizations commend the agency for its suggested

changes in a joint comment letter to CMS Acting Administrator Charlene Frizzera.

In the December letter, the medical organizations say they agree with language in the proposed rule that says Medicare Advantage plans shouldn't force physicians to duplicate Medicare enrollment requirements. "Requiring an additional fraud, waste and abuse certification imposes an additional unnecessary burden on physicians," says the letter.

The organizations also agree with CMS that it is unfair of Medicare Advantage plans to require that their network physicians take education courses in fraud, waste

and abuse compliance. "The result is that the same education requirement, which has already been met by every physician who has a Medicare provider number, is being duplicated many times over," says the letter. The organizations view the requirement as "substantially increasing the hassle factor" for physicians whose patients are enrolled in Medicare Advantage plans.

In addition, the letter commends CMS for seeking to increase its oversight of the plans and points out that physicians have reported "extremely burdensome audits" of their patients' charts. Advantage plans that initiate audits rarely reimburse prac-

tices for the resources required to pull, photocopy and refile patient charts, says the letter.

The letter also speaks on behalf of Medicare beneficiaries when it says that patients find the rapid proliferation of Medicare prescription drug and advantage plans "bewildering." The medical organizations support CMS' proposals calling for advantage plan choices that differ enough to provide beneficiaries "meaningful options," and standardized templates in beneficiary communication materials. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100112cms-medcr-advant-rule.html>.

In Brief *Government*

Two FPs Tapped for Terms on New MACPAC Commission

The U.S. Government Accountability Office, or GAO, has announced the appointment of 17 members to the Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission, or MACPAC. Two AAFP members — David Sundwall, M.D., of Salt Lake City, executive director of the Utah Department of Health, and Steven Waldren, M.D., M.S., of Kansas City, Mo., director of the AAFP's Center for Health IT — will serve on the new commission. According to the Dec. 23 GAO press statement, the MACPAC was created as part of the Children's Health Insurance Program Reauthorization Act of 2009 to review Medicaid and CHIP access and payment policies and advise Congress on a wide range of Medicaid and CHIP issues. The commission will commence operations in early 2010. <http://www.aafp.org/news-now/government-medicine/20100104macpac.html>

HIV Screening Now a Preventive Service Covered by Medicare

CMS recently announced that Medicare will cover HIV screening for Medicare beneficiaries who are at increased risk for the infection, as well as for any beneficiary who requests the service. The final decision was announced in a Dec. 8 news release and was effective as of that date. The Medicare Improvements for Patients and Providers Act of 2008 gives CMS the authority to expand Medicare's list of covered preventives services; previously, only Congress was authorized to do so. More information about Medicare's new HIV screening benefit is available in CMS' final decision memorandum. <http://www.aafp.org/news-now/news-in-brief/20091216wkly-nws-brfs.html> ■

Pharmacy-related Administrative Processes Frustrate Physicians

AAFP Board Chair Ted Epperly, M.D., of Boise, Idaho, reached out to dozens of health plans recently as part of the Academy's ongoing efforts to ease the daily administrative burdens placed on family physicians, especially as concerns pharmacy benefits.

"Let us find ways for family physicians and health and pharmacy benefits entities to collaborate to diminish the physician practice's time spent meeting your plans' pharmacy benefit requirements," wrote Epperly in letters to such payers as Blue Cross and Blue Shield companies, UnitedHealthcare, CIGNA HealthCare and WellPoint Inc.

In the Dec. 8 letter, Epperly reminded health plans of the results of a 2004 Medical Group Management Association survey that calculated the costs of pharmacy-related administrative processes. The price tag was about \$137,000 a year for an average 10-physician practice.

In addition, Epperly cited a 2009 *Health Affairs* study in which researchers estimated that the median annual costs for a primary care physician to interact with health plans was more than \$47,000.

Third-party payers have long argued that physicians are paid for the time spent on administrative processes through evaluation and management codes. But that's just bad math, said Epperly.

"The payment levels for office visits fail to fully account for the amount of time actually necessary, including the time spent related to prescription drug activities," said Epperly. "For instance, for the most common office visit code, 99213, the post-service work dedicated to the patient's treatment plan is only five minutes." ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20091222pharmbenefitsltr.html>.

Study: Health Center, Family Medicine Residency Pairing Is ‘Match Made in Heaven’

Resident Training, Patient Care Benefit From ‘Hybrid Partnerships’

By Barbara Bein

Training family medicine residents in community health centers, or CHCs, may provide a solution to the primary care workforce shortage, according to a study by two family physicians in Seattle. Such affiliations can be encouraged through changes in graduate medical education, or GME, funding and other proposals being discussed as part of health care reform, say the two FPs.

The study by Carl Morris, M.D., M.P.H., associate director of the Group Health Family Medicine Residency, Seattle, and Frederick Chen, M.D., M.P.H., assistant professor in the University of Washington Department of Family Medicine, Seattle, appears in the November/December issue of *Annals of Family Medicine*.

In the study, the authors quote one health center administrator as describing this type of affiliation as a “match made in heaven.” Located in rural and other underserved areas, the CHCs that employ such arrangements get dedicated physicians to staff their clinics, the residents get the rigorous and wide-ranging clinical training CHCs can provide, and the patients receive high-quality care, they say.

“We were impressed by the benefits to both sides of this partnership,” Chen said in an interview with *AAFP News Now*. “The CHC benefits from having a regular stream of young physicians committed to and trained in their system of medicine for the underserved. We also found that both CHCs and residency programs felt that the quality of care and teaching was higher in these partnerships.”

Moreover, residents who train in a residency-affiliated CHC are four times more likely than those from nonaffiliated programs to continue to work in CHCs, according to the study.

“Best of Both Worlds”

The study’s recommendations are similar to those in the Academy’s recently released workforce policy, which says CHCs should be better utilized as teaching and training sites for physicians and should be funded to do so. The centers also are a way to improve access to primary care at a time when health care reform proposals are expected to expand coverage, the policy says.



According to a health center administrator quoted in a recently published study, training family medicine residents in a community health center setting can be a heaven-sent opportunity.

AAFP Board Chair Ted Epperly, M.D., of Boise, Idaho — who also is program director and CEO of the Family Medicine Residency of Idaho, Boise — agrees wholeheartedly with the study’s findings and recommendations. He told *AAFP News Now* that his residency program was rejuvenated when it officially was designated as a federally qualified health center look-alike in 2007.

“These hybrid partnerships are a win-win whose time has come,” Epperly said. “They bring together the best of both worlds by providing increased teaching to residents, service to many underserved people who need it and improved cost-based financing to residency programs to stabilize their bottom lines.”

Two Sides of Same Coin

The study describes how family medicine residencies, or FMRs, and CHCs face different aspects of the primary care workforce crisis in the United States: The residencies suffer from declining student interest in primary care and threats to their financial solvency; the CHCs, also known as federally qualified health centers, face serious physician shortages.

A solution is the CHC-FMR affiliation, the study says. But even though both sides agree on the mutual benefits, the number of these partnerships has remained at 25-30 for the past two decades. According to the study, two barriers to expansion have been lack of a sense of shared mission and financial problems.

Granted, both CHCs and FMRs share a mission of service to the medically underserved and their communities. But for the residencies, that calling has to be reconciled with their programs’ primary mission of educating tomorrow’s doctors. The most successful affiliations created joint mission and vision statements, communicated those concepts clearly and adhered to them throughout all levels of both organizations, says the study.

The Almighty Dollar

Money often is a key factor in establishing and maintaining such affiliations, the study said. Financial benefits to both partners include higher reimbursement, cost-savings realized through improved recruitment of physicians and residents, and liability coverage afforded to CHCs under the Federal Tort Claims Act.

On the other hand, some costs related to affiliation are not reimbursed, such as those associated with the increased administrative requirements of residency training, increased direct and indirect clinic costs, and decreased productivity, the study said.

The authors are cheered by proposals in Congress to change GME funding, particularly funds for teaching health centers, which are described as residency-CHC hybrids. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100106chc-fmr.html>.

FPs Can Help Victims of Haiti Earthquake

As many as 3 million people are in dire need of food, water and medical supplies in the wake of the Jan. 12 earthquake disaster in Haiti. Relief organizations, including Heart to Heart International, or HHI, and the International Medical Corps, or IMC, already are on the scene providing humanitarian aid and care.

The AAFP Foundation is offering Academy members the opportunity to support those efforts. To learn about opportunities to give, visit the foundation's Web site.

By donating to the foundation, members can help HHI send shipments of medications and supplies to the devastated Caribbean island nation. In a Jan. 13 news release, HHI said it par-



A woman in Port-au-Prince, Haiti, tends to an injured baby in the aftermath of the Jan. 12 earthquake.

Photo courtesy of Mike Jensen/Heart to Heart International

ticularly wants to send medical supplies that address waterborne and airborne illnesses.

In addition to medications and supplies, medical care also is des-

perately needed. Physicians interested in volunteering with IMC, a nonprofit global humanitarian organization, can contact its recruiting department by clicking on "How You Can Help" at the top of the Foundation Web page and choosing "Volunteer."

According to a Jan. 14 press release, an IMC team already is providing medical care to hundreds of people who have congregated outside the general hospital near the collapsed Haitian presidential palace.

HHI also is taking the names of physicians interested in future deployment. Call (913) 764-5200. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20100115haiti-relief.html>.

FamilyDoctor.org Launches First Content For Consumer Alliance Program

The AAFP posted the first patient education content linked to its Consumer Alliance Program on its consumer Web site, FamilyDoctor.org, today. The content, which is supported by an educational grant from The Coca-Cola Co., includes information on sweeteners and hydration that is designed to help patients make informed nutrition choices, according to the AAFP.

FamilyDoctor.org has patient information and patient education handouts on a number of topics. Now, the site has added handouts on sugar and sugar substitutes and on hydration in the Healthy Living: Food & Nutrition section of the Web site. Topics include added sugar, sugar substitutes and why hydration is important.

According to the AAFP, the information in the handouts underwent a rigorous review process, and the Academy had complete control of developing it.

"The Consumer Alliance program is consistent with the AAFP's mission, values and vision as we seek to improve the health of the public through public education," said AAFP President Lori Heim, M.D., of Vass, N.C., in an interview with *AAFP News Now*. "Our goal in this first alliance with The Coca-Cola Co. is to educate the public about the choices that they make regarding beverages."

The AAFP's Consumer Alliance program is a mechanism for the Academy to work with corporate partners to educate consumers about the role products play in making choices related to living a healthy, active and balanced lifestyle. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20100112famdoc-cap-content.html>.

Connecting family physicians and employers.

AAFP CareerLink

Accessible 24/7, CareerLink connects family physicians with employers from around the nation. Search by geographic and professional criteria in minutes.

www.AAFCareerLink.org



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

CMS Revises Consultation Services Payment Policy

Effective Jan. 1, Medicare will no longer recognize CPT consultation codes for payment of services provided to Medicare Part B beneficiaries.

CMS is deleting several consultation codes — 99251 to 99255 and 99241 to 99245 — and replacing them with the CPT codes noted below.

Cynthia Hughes, C.P.C., an AAFP coding specialist, said physician services currently billed as consultations should be reported as initial hospital care or initial nursing facility care (CPT codes 99221 to 99223, or 99304 to 99306) in inpatient settings and as office or other outpatient evaluation and management services (CPT codes 99201 to 99215) in outpatient settings.

CMS published instructions for physicians on the new system in a recent issue of *MLN Matters*, the agency's online newsletter dedicated to informing participating health care professionals about Medicare news.

"If physicians admit patients to the hospital after Jan. 1, they will have to append the CPT code for the initial care charges with the newly created "AI" modifier to indicate that they are the admitting physician," said Hughes.

Hughes said she gleaned two key points of interest from a CMS conference call on the issue. Physicians should note that

- Medicare patients cannot be billed for consultation services even when the patient is provided with an advance beneficiary notice, and
- Medicare Advantage and Medicaid plans will make their own determinations as to whether they will pay for services reported with consultation codes.

The question of how to handle billing when Medicare is the secondary payer on the claim is addressed in the *MLN Matters* article. Hughes urged AAFP members to share the article with office staff whose duties include billing, coding or compliance. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20091223rev-cpt-codes.html>.

IOM Report: National Institute Could Improve Continuing Education System for Health Professionals

According to a new report from the Institute of Medicine, or IOM, there are a number of deficiencies with the current continuing education, or CE, system for health professionals in the United States. The report is calling for the creation of a national, interprofessional CE institute to achieve a new vision of continuing professional development for health professionals, with the goal of improving patient care and health care delivery.

The report, *Redesigning Continuing Education in the Health Professions*, calls out five messages regarding the current system of continuing education for health professionals — including those in medicine, nursing and pharmacy. According to the report,

- there are major flaws in the way CE currently is conducted, financed, regulated and evaluated;
- the science behind CE for health professionals is fragmented and underdeveloped;
- continuing education efforts need to bring health professionals from various disciplines together in tailored learning environments;
- a new vision of professional development for health care professionals is needed to replace the current culture; and
- establishing a national, interprofessional public-private institute to foster improvements in CE may help improve the overall system.

The report notes that although some CE programs focus on the goals above, overall, the U.S. approach to CE has a number of flaws. For example, notes the report, health professionals and their employers tend to focus on meeting regulatory requirements rather than identifying personal knowledge gaps.

In addition, many current approaches to CE use didactic learning methods, such as lectures and seminars; traditional settings, such as auditoriums and classrooms; frequently mandated intervals; and teacher-driven content that may or may not be relevant to the clinical setting.

The report also notes that although scientific literature offers guidance about general principles for CE, it offers little specific information about how to best support learning, and CE providers often cannot determine the effectiveness of their methods.

In medicine, for example, says the report, pharmaceutical and medical device companies have taken a lead role in financing the provision of and research on CE, raising questions about conflicts of interest.

"Such commercial funding has raised and continues to raise concerns about conflicts of interest and whether some companies are using CE to influence health professionals so as to increase market share," the report says.

According to AAFP President Lori Heim, M.D., of Vass, N.C., the AAFP currently is looking at the 184-page report. "The AAFP has a long history of providing excellent quality CE to its members," said Heim. In addition, she noted, "There are a number of ways in which the Academy already is looking to the future, and many programs that have been initiated to improve the overall quality of our CE product to meet the ongoing needs of our members. The AAFP has been a leader in looking at models of learning and incorporating learning at the point of care."

The report suggests that the federal government work with stakeholders to develop a public-private institute — called the Continuing Professional Development Institute, — that would be devoted to continuing professional development and fostering the delivery of high-quality health care. The report makes a number of other recommendations. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20091223iom-cme-report.html>.

AS WE SEE IT

Voices From the AAFP

Editorial

Materials From Consumer Alliance Program Can Help Patients Make Informed Decisions

By "Voices Staff"

In today's digital world, one of the best ways to communicate accurate, evidence-based health information is to post it on a popular and trusted Web site. The AAFP has just such a Web site — the award-winning FamilyDoctor.org, which welcomes, on average, 3.5 million unique visitors each month. Now, the Academy has a new program that's designed to expand the scope and depth of the information on FamilyDoctor.org.

The new Consumer Alliance program creates partnerships between the Academy and selected consumer products companies that want to see Americans become better educated about health issues related to the company's products. Grants from the partner companies give the Academy the opportunity to address those issues on FamilyDoctor.org, while also providing critically needed revenue to support other important Academy activities on behalf of members.

The Academy does not endorse the products of its Consumer Alliance partners, and the partners have no influence over the AAFP's policy development process or the content developed for FamilyDoctor.org. The AAFP maintains complete editorial control to ensure creation of balanced, evidence-based content that can help consumers make informed decisions. The content then is extensively reviewed by family physician editors, members of the AAFP Commission on Health of the Public and Science, and credentialed expert consultants.

The First Alliance: Member Concerns Acknowledged

The first materials funded by the Consumer Alliance program, which recently posted to FamilyDoctor.org, were supported by a grant from the program's first partner, The Coca-Cola Co., or TCCC. The 10 patient education handouts that were added to FamilyDoctor.org address the health consequences of added sugar in the diet, provide information about six types of sugar substitutes and discuss the importance of proper hydration — critically important topics, because the empty calories of added sugar are a key cause of obesity, and obesity is such a problem in America today.

Last October, the Academy's announcement of TCCC as the first Consumer Alliance partner sparked an outcry from some AAFP members. What concerned most of them was TCCC's production of red-can Coke and other sugar-sweetened beverages that contribute to the epidemic of obesity. They also were worried that TCCC might influence the materials created for FamilyDoctor.org. A few suggested that the AAFP raise its member dues to eliminate the need to find more non-dues revenue. Some threatened to — and a small number did — resign their AAFP membership to protest the partnership with TCCC.

However, the just-published handouts should allay the fears about any TCCC influence over content on FamilyDoctor.org. TCCC had no role whatsoever in the development of that content, and the handouts don't pull any punches about sugar-sweetened beverages. Indeed, they note that "sugary drinks, including soft drinks, sports drinks and fruit drinks, are the number one source of added sugar in the American diet," and they caution that too much added sugar can contribute to many health problems, including tooth decay, obesity and diabetes. Of course, Americans still may drink red-can Coke after reading these handouts — but it won't be because they don't know the facts.

Other Benefits of the Consumer Alliance Program

The Consumer Alliance program can help the Academy and its members in other ways, too. Currently, member dues account for 27 percent of the Academy's total revenue. Through the Consumer Alliance program, the AAFP Board of Directors hopes to tap into new sources of non-dues revenue for the Academy. That effort is driven in part by a significant drop in revenue from the Academy's traditional revenue sources, such as journal advertising and funding for the Annual Scientific Assembly. Overall, AAFP revenue from the pharmaceutical industry has declined from \$34 million in fiscal year 2005-2006 to \$25.5 million in 2007-2008.

This downward revenue trend required the Academy to go through a difficult and thorough assessment of all programs in 2008-2009. The result was a 14 percent reduction in budget and elimination of more than 50 AAFP staff positions. Current information strongly warns that a large dues increase to support AAFP programs would not be well received by members.

Tapping into new revenue sources also is a response to member concerns about the Academy's reliance on pharmaceutical industry funding. Those concerns have percolated through the AAFP Congress of Delegates during the past few years, and the Board has listened. At the same time, the Board realizes that modest annual increases in dues at the national level cannot begin to offset the other revenue sources the Academy depends on to provide programs and services to members.

As a result of the Board's effort, the AAFP has placed new emphasis on pursuing government and foundation grants to fund its activities. Now, through the Consumer Alliance program, the AAFP is turning to grants from consumer product companies as well, but the Academy will always maintain a definite separation between those companies and Academy-created content and policies. ■