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NEWS NOW

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On Capitol Hill AAFP President Proposes Blended Payment Model to Fix Medicare Payment System

By James Arvantes • Washington, D.C.

In the ongoing battle to fix the Medicare payment system for family physicians, the AAFP took its message to Capitol Hill on May 5, when the Academy was invited to testify before a House panel about alternatives to the sustainable growth rate, or SGR, formula.

Congress has to enact a Medicare physician payment system that provides greater support for team-based primary care and the patient-centered medical home, or PCMH, through a blended payment model, AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, told the health subcommittee of the Energy and Commerce Committee, during the hearing here.

"Congress, understandably, is most concerned with controlling federal expenditures for health care, especially given the rapidly rising costs for Medicare," said Goertz during his testimony. However, "There is growing and compelling evidence that a health care system based on primary care will help control these costs, as well as increase patient satisfaction and improve patient health," he added.

"Simply reforming the fee-for-service system, which undervalues preventive health and team care coordination, cannot produce the results that Congress and patients require," said Goertz. He



James Arvantes/AAFP News Now

During May 5 testimony before the health subcommittee of the House Energy and Commerce Committee, AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, proposes an alternative to the current sustainable growth rate formula for Medicare payment.

proposed a blended payment model that contains three elements:

- some fee-for-service payments;
- a care coordination fee that compensates physicians for their expertise and the time required for primary care activities, which are not paid for currently; and
- performance bonuses based on a voluntary pay-for-reporting/performance system and for care team members and services that are not eligible for fee-for-service billing.

See *On Capitol Hill*, page 2

AAFP:
House-passed Budget Proposal Threatens Care Measure Would Shift Costs Onto Patients, Physicians, Says AAFP President

The AAFP has strongly criticized a fiscal year 2012 budget proposal passed by the U.S. House that — in an attempt to hold the line on the nation's burgeoning health care expenditures — would fundamentally change the Medicare and Medicaid programs and threaten access to care for older Americans, disabled individuals and low-income working families.

"The U.S. House of Representatives' proposed 2012 budget is part of the needed discussion about controlling federal spending for Medicare and Medicaid," said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, in a prepared statement. "However, this proposal neither controls systemwide costs nor improves care for elderly, disabled and low-income working families who are our patients."

The budget proposal, H.Con. Res. 34, would convert Medicare

See *Access to Care*, page 2

JUNE HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

ALF/NCSC page 6

See what delegates did at the recent AAFP Annual Leadership Forum/National Conference of Special Constituencies.

Economic Output page 13

Office-based physicians, including family physicians, are responsible for trillions in U.S. economic output.

On Capitol Hill, *continued from page 1*

Goertz, acknowledging that it will take time to transition to a blended payment model, called for a five-year transition period with mandated payment updates that incorporate higher rates of at least 2 percent for primary care physicians for Medicare fee-for-service payments.

In addition, he noted, Congress should continue to pay the primary care incentive payment for primary care services called for by the Patient Protection and Affordable Care Act, but it should increase that incentive payment from 10 percent to 20 percent. Congress also needs to permanently extend the program that equalizes Medicaid and Medicare payment rates, Goertz said.

"Both of these programs, along with mandated

updates that are 2 percent higher for primary care physicians, will help stabilize current (medical) practices that have seen such financial turmoil in the past few years," said Goertz.

During this proposed five-year period, it also will be crucial to encourage as much innovation as possible, said Goertz. "The new CMS Center for (Medicare and Medicaid) Innovation needs to be a key focus of this effort. We believe this center can help CMS create market-based, private sector-like programs that can significantly bend the health care cost curve." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110510blendedpayment.html>.

Access to Care, *continued from page 1*

into a voucher-style premium support program, eventually requiring Medicare beneficiaries to purchase health insurance on the open market. At the same time, the proposal would turn Medicaid into a block grant program.

According to Goertz, the proposal threatens to "undermine access to care for our most vulnerable citizens and exacerbate the already serious problems — such as fragmentation and duplication of services or skyrocketing health care insurance premiums — in our health care system."

In proposing a Medicare premium support plan that eliminates guaranteed benefits and substitutes vouchers to subsidize private insurance for beneficiaries, the measure follows in the footsteps of Medicare Advantage, which, Goertz pointed out, actually *increased* costs by 12 percent "because private insurance companies declined to offer coverage without additional government support."

Goertz stressed that the private insurance industry has no track record of controlling costs, enhancing patient or provider satisfaction, or improving the quality of public programs channeled

through insurance vendors.

"Moving millions of elderly and disabled Americans to the private insurance market requires yet-to-be implemented insurance reforms — patient protection provisions such as prohibiting annual or lifetime benefit limits or requiring insurers to cover pre-existing conditions — that are currently opposed by many in Congress," Goertz said.

Without such reforms, Medicare premium support would push elderly and disabled patients into a market that locks them out by price and denies them coverage for pre-existing conditions, while capping the value of covered benefits.

"This premium support plan also creates an adverse selection in which healthy Medicare patients will flee to the low-cost, high deductible private plans, leaving the sick and disabled in Medicare, driving up premiums and reducing services," Goertz noted.

In addressing Medicaid block grants, Goertz acknowledged that block grants give states more flexibility. But a fixed federal contribution to state Medicaid programs puts the financial onus on

states to keep pace with inflation, pay unanticipated demand resulting from economic downturns while covering unexpected costs resulting from events such as epidemics or large natural disasters.

Medicaid, as currently designed, gives states the financial flexibility to weather economic downturns that generate a greater demand for services when the financial resources of a state are most strained, said Goertz.

"Required to balance their budgets, states likely will cite decreased federal support and use their new Medicaid flexibility to impose higher out-of-pocket costs on the poor, limit covered services, restrict eligibility and impose waiting lists," Goertz said.

Moreover, he added, states could slash payments to physicians and other health care providers, further compromising access to health care services under Medicaid. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110426housebudgetitr.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between Apr. 19 and May. 15, 2011.

AAFP Calls for ‘Robust Investment’ in Primary Care Physician Workforce

Federal investment in health care is necessary to “transform health care to achieve optimal, cost-efficient health for everyone,” said the AAFP in recent written testimony to the House Appropriations Committee. That is why the Academy is urging the committee to make a robust investment in the nation’s primary care physician workforce by financially supporting programs critical to building and strengthening the nation’s primary care physician pipeline.

“We recognize the difficult decisions (that) our nation’s budgetary pressures present,” said the AAFP. However, the Academy urged the House Appropriations Subcommittee on Labor, Health

and Human Services, and Education “to make a robust fiscal year 2012 investment in our nation’s primary care physician workforce ... to ensure that it is adequate to provide efficient, effective health care delivery addressing access, quality and value.”

Specifically, the Academy called on the committee to provide at least \$449.5 million for training programs covered by Title VII of the Public Health Service Act and administered by the Health Resources and Services Administration, including at least

- \$140 million for primary care training and enhancement as authorized by Title VII, Section 747, of the Public Health Service Act;
- \$10 million for development grants for teaching health cen-

ters; and

- \$4 million for rural physician training grants.

Failure to provide adequate funding for Title VII programs “would destabilize ongoing efforts to increase education and training support for family physicians, exacerbating primary care shortages and further straining the nation’s health care system,” said the AAFP.

“We urge the committee to increase the level of federal funding for primary care training to 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.”

The AAFP called for other funding increases, as well, including President Obama’s requested funding of \$418.5 million for the National Health Services Corps and at least \$405 million for the Agency for Healthcare Research and Quality, or AHRQ.

“AHRQ’s investment in patient-centered outcomes research will help Americans make the informed decisions we must make to focus on paying for quality rather than quantity,” said the AAFP. “By determining what has limited efficacy or does not work, this important research can spare patients from tests and treatments of little value.”

Among other programs that are critical to the primary care physician pipeline, according to the AAFP, is the teaching health center program, which provides resources to qualified, community-based, ambulatory care settings that operate as primary care residency programs. These settings include federally qualified health centers, rural health clinics, community mental health centers, health centers operated by the Indian Health Service and centers that receive Title X grants. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110420aproptestimony.html>.



Latest Tally: CMS Pays Out More Than \$400 Million in PQRS, Electronic Prescribing Incentives

CMS has released 2009 data on results from the Medicare Physician Quality Reporting System, or PQRS – formerly known as the Physician Quality Reporting Initiative – and its electronic prescribing, or e-Rx, programs. The resulting incentive payments put nearly \$400 million into the pockets of family physicians and other program participants.

According to CMS, nearly 120,000 physicians and other eligible health care professionals in more than 12,000 practices received more than \$234 million in incentive payments in 2009 for successfully reporting quality measures data. This amount is well above the \$36 million paid to physicians and other eligible professionals in 2007, which was the first year of the program, said CMS. “On average, 2009 bonus payments for satisfactory reporters in the Physician Quality Reporting System were \$1,956 per eligible professional and \$18,525 per practice,” said CMS.

On average, participation in the PQRS has grown by about 50 percent every year since the program began in 2007, said CMS.

“The significant growth in the Physician Quality Reporting System shows us that the health care community shares CMS’ commitment to improving the quality and safety of care our beneficiaries receive,” said CMS Administrator Donald Berwick, M.D.

CMS also said health care professionals in the program are complying more often with evidence-based care practices. “These increased reporting rates could signal a positive trend in the quality of health care Medicare beneficiaries receive from professionals who report data through the Physician Quality Reporting System,” the agency said.

“Based on reported data on the 55 measures that have been a part of the (PQRS) since it began in 2007, providers have improved the frequency for which they deliver recommended care by about 3.1 percent on average. Similarly, of the 99 measures that were part of the (PQRS) in 2008 and 2009, performance improved (by) about 10.6 percent on average.”

CMS also announced that it paid out \$148 million to more than 48,000 physicians and other eligible health care professionals in 2009 for its e-Rx program. Physicians and other health care professionals in the e-Rx Incentive Program receive incentive payments for successfully prescribing medications electronically.

Eligible professionals who were successful e-prescribers received an average bonus payment of more than \$3,000 per individual and \$14,501 per practice. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110504pqrsincentives.html>.

New Mobile App Lets Users Access *AFP* by Topic Anytime, Anywhere

Accessing the best, most up-to-date content *American Family Physician* has to offer on common medical topics just got a whole lot easier. That's because *AFP* by Topic: Editors' Choice of Best Current Content is now available as a mobile app that can be downloaded — for free — from the Apple Store and the Android Marketplace.

AFP by Topic collects the top content on more than 45 health topics featured in *AFP* online into one place; the new mobile app gives users the ability to access that content anytime, anywhere and on virtually any Web-enabled device. *AFP* editors continually re-evaluate and update these collections to ensure they remain helpful, relevant and timely.

The *AFP* by Topic collections themselves include pertinent *AFP* review articles, editorials and department items; summaries of practice guidelines; patient education handouts; articles from *Family Practice Management*; AAFP policies; and other Academy resources, such as performance improvement modules developed as part of the AAFP's Measuring, Evaluating and Translating Research Into Care program. The content in each collection is organized into relevant categories, such as prevention, screening and diagnosis, treatment, and complications and special situations.

Users navigate the app by opening the main page, which lists the topic collections. Selecting a topic brings the user to a page that shows the categories displayed for that topic. When the user chooses a category, all content within that category is displayed. Clicking on the desired content title links the user directly to that online material.

Content available via the *AFP* by Topic mobile app is subject to the same restrictions as that available from *AFP* online. That is, only AAFP members and paid subscribers may access content posted within the past year and must login to do so. Older content may be viewed by all users. ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20110504afpmobileapp.html>.

Physician Education Key Element of Plan to Reduce Opioid Abuse

Bill Proposes Mandatory CME, FDA Announces Voluntary REMS

By David Mitchell

Physicians and other health care professionals seeking to obtain or renew a DEA registration number would be required to complete CME related to responsible opioid prescribing practices under the terms of a plan announced April 19 by the Obama administration.

In addition to required CME, the FDA announced it is requiring manufacturers of long-acting and extended-release opioids to develop a Risk Evaluation and Mitigation Strategy, or REMS. The manufacturers will provide educational programs for prescribers, as well as materials health care professionals can use when counseling patients about the drugs.

Although the REMS physician training called for by the FDA will be voluntary, the administration plans to close that loophole with legislation mandating opioid-related CME. In March, Sen. Jay Rockefeller, D-W.Va., introduced a bill, S. 507, that would amend the Controlled Substances Act. Rockefeller's legislation calls for prescribers to complete 16 hours of training every three years on the following topics:

- treatment and management of opioid dependent patients;
- pain management treatment guidelines; and
- early detection of opioid addiction, including screening, intervention and referral for treatment.

The plan announced by the Obama administration was not unexpected. Daniel Ostergaard, M.D., AAFP's vice president for health of the public and interprofessional activities, told *AAFP News Now* that a group of staff members representing multiple Academy divisions has been working for more than a year in anticipation of potential regulatory actions related to opioids.

In addition to physician and patient education, the administration's plan calls for increased tracking and monitoring of opioid use, proper disposal through efforts such as increased take-back programs and events, and improved enforcement of statutes aimed at eliminating improper or illegal distribution of these drugs.

Prescription drug abuse has been classified as an epidemic by the CDC. According to the Substance Abuse and Mental Health Services Administration, from 1998 to 2008, there was a 400 percent increase in substance abuse treatment program admissions among people ages 12 and older who reported any pain reliever abuse. A total of 257 million opioid prescriptions were dispensed in 2009, a 48 percent increase compared with figures for 2000, according to the Office of National Drug Control Policy.

More than 700,000 physicians are authorized by the DEA to prescribe extended-release opioids.

The FDA's recent announcement means the agency is acting against the advice of one of its joint committees, which voted 25-10 against the REMS on July 23, 2010. The FDA's Anesthetic and Life Support Drugs and Drug Safety and Risk Management advisory committees rejected the plan because it called for voluntary, rather than mandatory, physician training.

The FDA said at the time that a mandatory program would require a legislative change to give the agency the authority to require training as part of DEA registration. ■



For the complete story, visit <http://www.aafp.org/news-now/practice-professional-issues/20110427opioidsplan.html>.

Survey: Many Young Women Ignore Tanning Risks

Swimming pools in many parts of the country will be opening this month, and many Americans — young women, in particular — likely will be flocking to those pools or their local tanning salons to get started on their summer tans. That's despite repeated warnings from multiple organizations — including HHS, the National Cancer Institute and the World Health Organization, or WHO — about the health hazards of tanning.

According to the results of a recent American Academy of Dermatology, or AAD, survey of nearly 4,000 white females ages 14-22 years, more than 80 percent of respondents indicated they had tanned outdoors frequently or occasionally in the past year, and nearly one-third said they had used a tanning bed during the same time period.

Of those who used tanning beds, 25 percent said they had done so at least once a week. Nearly 90 percent of respondents who used tanning beds said they knew tanning beds can cause cancer.

Convincing young people to protect themselves from the sun — and to avoid tanning beds — is challenging despite the health warnings, said Martin Mahoney M.D., Ph.D., associate professor in the health behavior and medicine departments at Roswell Park Cancer Institute, Buffalo, and associate professor of family medicine in the School of Medicine and Biomedical Sciences at State University of New York at Buffalo.

"This is a difficult message to communicate because adolescents and young adults have a sense of invincibility," Mahoney told *AAFP News Now*. "And soci-

ety continues to promote the misinformed image of a 'healthy tan.' I try to explain that a tan is really the body trying to protect itself from too much sunshine, or UV radiation, leading to premature skin changes and aging."

Both HHS and the WHO have noted that natural and artificial sources of ultraviolet light can cause cancer, and the use of tanning beds can increase a person's risk of skin cancer by 75 percent, says the AAD. Overall, one in five Americans will develop skin cancer in their lifetime.

According to the U.S. Preventive Services Task Force, or USPSTF, more than 2 million cases of skin cancer are diagnosed each year in the United States, and incidence of melanoma — which accounts for 75 percent of skin cancer deaths — is increasing. In fact, statistics presented by the American Melanoma



About one in three young women used an indoor tanning bed in the past year, says a recently released survey, while four out of five tanned outdoors.

Foundation indicate that melanoma is the most common form of cancer among people ages 25-29 years, and it is the second-most common form of cancer among those ages 15-29 years. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20110518tanningsurvey.html>.

In Brief *Health of the Public*

FDA Approves Meningococcal Vaccine for Infants, Toddlers

The FDA has approved the use of Sanofi Pasteur's quadrivalent meningococcal conjugate vaccine, which is marketed as Menactra, in children as young as 9 months for the prevention of invasive meningococcal disease caused by *Neisseria meningitidis* serogroups A, C, Y and W-135. The FDA said in an April 22 news release that the safety of quadrivalent meningococcal conjugate vaccine, or MCV4, was evaluated in four clinical studies in which more than 3,700 children received the vaccine. Children were given a two-dose series at ages 9 months and 12 months. <http://www.aafp.org/news-now/health-of-the-public/20110427meningvaccine.html>

Drugmakers to Standardize Pediatric Liquid Acetaminophen Product Concentration

Manufacturers of single-ingredient OTC pediatric liquid acetaminophen products plan to convert all such products to a single concentration, which means that infant products — such as Infants' Concentrated Tylenol Drops and its generic equivalents — no longer will be available in an 80 mg/0.8 mL formulation. Instead, all pediatric liquid acetaminophen products will have the 160 mg/5 mL formulation used in Children's Tylenol Suspension and generic versions of that product. The purpose of this transition is to help minimize the poten-

tial for medication errors due to confusion between infants' and children's acetaminophen products having different concentrations, said McNeil Consumer Healthcare, the maker of Tylenol, in a May 4 letter to health care professionals. <http://www.aafp.org/news-now/health-of-the-public/20110516acetaminophendose.html>

Pediatric Infectious Diseases Society Rejects 'Personal Belief' Immunization Exemptions

The Pediatric Infectious Diseases Society, or PIDS, recently released a position statement opposing any legislation or regulation that would allow children to be exempted from mandatory immunizations based on their parents' — or, in the case of teens, their own — secular personal beliefs. The statement calls for any legislation or regulation regarding personal belief exemptions to include provisions such as the personal belief against immunization must be sincere and firmly held; children should be barred from school attendance and other group activities if there is an outbreak of a disease that is preventable by a vaccination from which they have been exempted; and states that adopt provisions for personal belief exemptions should track exemption rates and periodically reassess the impact that exemptions may have on disease rates. <http://www.aafp.org/news-now/health-of-the-public/20110504pidsvaccstmt.html> ■

Race for NCSC Offices Ends as Delegates Pick New Leaders

AAFP constituent chapter representatives who attended the Academy's National Conference of Special Constituencies, or NCSC, May 5-7 elected colleagues to fill various leadership positions.

AAFP Board of Directors new physician Board candidate: Robyn Liu, M.D., of Tribune, Kan. (Note: This candidate is to be approved by the 2011 Congress of Delegates in Orlando.)

New physician alternate delegates to the AAFP Congress of Delegates: Kisha Davis, M.D., of North Potomac, Md., and Christina Kelly, M.D., of University Place, Wash.

Special constituency alternate delegates to the AAFP Congress of Delegates: Leila Hagshenas, M.D., of New York; Kevin Wang, M.D., of Seattle; Asim Jaffer, M.D., of Peoria, Ill.; Tamaan Osbourne-Roberts, M.D., of Denver; Joseph Perez, M.D., of New London, Conn.; and Karla Booker, M.D., of Lilburn, Ga. (Note: The special constituency delegates and alternate delegates represent the following constituency groups: gay, lesbian, bisexual and transgender, or GLBT, physicians; international medical graduates, or IMGs; minority physicians; and women physicians.)

AAFP delegates to the AMA Young Physicians Section: Melissa Jefferis, M.D., of Columbus, Ohio, will serve with Ajoy Kumar, M.D. of Saint Petersburg, Fla., who is completing his second term.

2012 NCSC convener: Jay Lee, M.D., M.P.H., of Long Beach, Calif.

2012 special constituency co-conveners: Hagshenas and Wang (GLBT constituency); Sarah Jacob, M.D., of Garden City, Mich., and Jaffer (IMG constituency); Osbourne-Roberts and Perez (minority constituency); and Booker and Rachel Franklin, M.D., of Oklahoma City (women's constituency).

Thirteen chapters sent full delegations to the conference, with at least one representative from each of the five constituencies. A total of 152 people participated in this year's NCSC, including 67 first-time attendees. The delegates considered 58 resolutions.

In addition, 199 individuals attended the concurrent Annual Leadership Forum. ■

ALF/NCSC

Academy Leaders Respond to Member Concerns About AAFP Actions, Resources During Town Hall Meeting

By Nancy Kuehl • Kansas City, Mo.

A question about the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, and what the AAFP is doing to address the RUC's shortcomings led off a spirited exchange of queries, comments and ideas between AAFP members and leaders during the May 6 Town Hall meeting here at the Annual Leadership Forum/National Conference of Special Constituencies.

AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, was the first to respond to the question, which arose out of recent calls for the AAFP to withdraw from the RUC to protest a mechanism that has often undervalued primary care when recommending Medicare physician payment rates. (See related story on page 7.)

"The Board has had in-depth, considered and serious discussions about the RUC," said Goertz. But a decision about whether or not the AAFP should withdraw from the RUC cannot be made lightly, he noted, and the Board needs to consider all the ramifications of withdrawing on family physicians and their patients. A decision is forthcoming, but the Board has to have more discussion before that can happen, Goertz added.

Board Chair Lori Heim, M.D., of Vass, N.C., chimed in to further explain the Board's discussions about the RUC, which was formed by the AMA to make recommendations to CMS regarding physician work relative values for CPT codes. "The RUC is a really thorny issue," said Heim. The AAFP is fully committed to ensuring that primary care physicians are fairly paid for the value they bring, she said, but, "the Board spent over two days discussing it, and we're not done yet." She assured members, however, that as soon as a decision is made, they will know about it.

Accountable care organizations, or ACOs, were the next issue of concern. Audience members wanted to know what the AAFP's position is on proposed ACO regulations from CMS that are currently in the open comment period.

Goertz agreed that the proposed regulations are a concern. He noted that comments from the AAFP are in development and will be released by mid-May.

AAFP President-elect Glen Stream, M.D., of Spokane, Wash., noted that the AAFP was at the table when the rule was first being discussed, but not all of the Academy's requests are reflected in the final proposed rule. "We're disappointed our input was not reflected in the final rule," said Stream.

Marguerite Duane, M.D., of Washington, D.C., sparked applause with her question on the health care reform law. It's not really health care reform, said Duane. It's really an insurance reform law. She asked what the Academy is doing to advance alternative health care models that modify actual care and incorporate innovative payment models.

Goertz responded that individual state laws make it hard for the AAFP to endorse any one model, but the Academy's position has always been that if a model works for family physicians and their patients, that is a good thing. "We cannot predict how any one model will work, but we can advocate for innovative approaches," he said.

Stream agreed that regulations vary a lot among the states, and that makes it difficult for the AAFP to support just one proposal. However, he noted, the AAFP can serve as a central repository for such innovations and provide information on how the models are working for the practices piloting them. ■



AAFP member Marguerite Duane, M.D., M.H.A., of Washington, D.C., asks Academy Board members if the AAFP is open to innovative models of payment reform. Duane's question came during the Town Hall meeting at the 2011 Annual Leadership Forum/National Conference of Special Constituencies.

David Mitchell/AAFP News Now

Delegates Send Message to AAFP Leaders: Withdraw From the RUC

By James Arvantes • *Kansas City, Mo.*

Frustration about the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, was strongly evidenced by delegates at the AAFP's National Conference of Special Constituencies, or NCSC, here May 5-7, when they adopted a resolution calling on the AAFP to withdraw from the RUC.

The resolution, which was introduced during the Reference Committee on Advocacy hearing, calls on the AAFP to formally withdraw its representative from the RUC and to create a task force to identify alternative means of valuing primary care services. The resolution also asks the AAFP to make this task force's recommendations available to CMS and other payers.

The RUC acts as an expert panel and makes recommendations to CMS on the relative values of CPT codes. However, many family physicians are convinced

those recommendations tend to undervalue primary care services.

"We came to the consensus that now is the time for us to go ahead and pull out of the RUC to delegitimize it — to state publicly that it does not represent primary care, to state publicly that it does not represent 100,000 family physicians," said Robyn Liu, M.D., a new physician delegate from Tribune, Kan., and a co-author of the resolution, during testimony at the May 6 advocacy reference committee hearing.

"If you are not at the table, you are on the menu; but I feel like we are at the table, and we are still on the menu," said new physician delegate David Gilchrist, M.D., of Worcester, Mass.

Jay Lee, M.D., M.P.H., of Long Beach, Calif., the 2012 NCSC convener, expressed support for the "spirit of the resolution," but he had concerns about pulling out of the RUC without

having some alternative.

"I think we have come a long way in terms of building our political capital in Washington," Lee said. "But I don't believe we have the political weight that we would need to be able to walk away from the RUC just yet."

The advocacy reference committee recommended that the resolution be adopted, and recommended that it be referred to the 2011 Congress of Delegates, instead of the usual trek to the AAFP Board of Directors for further determination.

Ryan Kauffman, M.D., of Bellefontaine, Ohio, expressed appreciation during the May 7 business session for the consideration the reference committee gave the resolution. However, he said, the Board currently is discussing the AAFP's involvement with the RUC. Instead of deferring the issue until the Congress of Delegates, it is important



James Arvantes/AAFP News Now

Anne Kittendorf, M.D., a new physician delegate from Dexter, Mich., voices support for a resolution that calls for the AAFP to withdraw from the AMA/Specialty Society Relative Value Scale Update Committee during the NCSC Reference Committee on Advocacy hearing.

that members make their voices heard now, said Kauffman.

In the end, delegates adopted the resolution and sent it to the Board rather than the Congress of Delegates. ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20110511ncscruc.html>.

NCSC Delegates Direct Academy to Develop Procedures Log

By David Mitchell • *Kansas City, Mo.*

The AAFP currently tracks members' CME activities as a member benefit. Now, delegates to the National Conference of Special Constituencies, or NCSC, have called on the Academy to offer a similar service for logging the procedures members perform.

"People love the CME log, and we're expanding on that," said new physician delegate Ravi Shah, M.D., of Oak Park, Ill., co-author of a resolution NCSC delegates adopted on May 7, during an interview with *AAFP News Now*. "A procedures log would have a similar effect."

Viviana Martinez-Bianchi, M.D., who is associate program director of the Duke Family Medicine Residency Program in Durham, N.C., testified in favor of the resolution during a May 6 hearing of the Reference Committee on Practice Enhancement.

"From a faculty perspective, I would find it extremely valuable to have a place my residents' procedures are tracked, that graduates can access at a later date," Martinez-Bianchi told *AAFP News Now*. "They'll need that in the future to show a credentialing committee and get privileges. It would be very helpful to have that service in a centralized place, just as we do with our CME credits. If you had that service through the Academy, no matter where you go, you would have access to that log. It's portable.

"They can also continue adding new procedures once they are in practice," she added.

According to Martinez-Bianchi, who also is chair of the AAFP Com-

mission on Membership and Member Services, a procedures log would add "significant value" to membership. That could prove attractive to the roughly 30 percent of first-year new physicians who do not retain their AAFP memberships after they leave residency, she said.

New physician delegate David Nystrom, D.O., of Coon Rapids, Iowa, another co-author of the resolution, told *AAFP News Now* that residents receive CME credit during residency but don't start tracking their CME until they become new physicians. They do, however, start tracking their procedures as residents.

"This would be a hook right away for residents," Nystrom said. "You could say, AAFP is where it's at for this service, and it's going to be there forever."

The reference committee voiced overwhelming support for the resolution in its report. Committee members said that in addition to tracking procedures for residencies and members seeking privileges, data could be collected regarding what residencies are teaching, which also could be helpful in identifying proctors skilled in various procedures. The committee agreed that such a system would benefit membership recruitment and retention and that it would "outweigh the considerable costs to develop and maintain it." ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20110511ncscprocedures.html>.

Family Physician Efforts Put Rhode Island on Front Line of PCMH Implementation

By James Arvantes

The Rhode Island AFP has emerged as part of a growing medical home movement in Rhode Island. Family physician practices, public and private payers, and government officials have all come together in an ongoing effort to revamp the delivery and provision of health care services in the state. The result is that Rhode Island now has the highest number of physicians per capita who are practicing in recognized patient-centered medical homes, or PCMHs.

According to state officials, Rhode Island ranks eighth in the country in terms of the number of physicians in practices that have received PCMH recognition from the National Committee for Quality Assurance, or NCQA. In the process, Rhode Island has emerged as a haven for primary care and the PCMH. Even the state's governor has reportedly said that every state resident should have a medical home.

"We want to make Rhode Island a great place to practice primary care," says Christopher Koller, the state's health insurance commissioner. "We want primary care docs to come here because it is a great environment for primary care, and ultimately, we want businesses to locate here because of our primary care infrastructure."

For their part, family physicians have played a major role in pushing the PCMH forward in the state by participating in various collaboratives and committees and by sharing their knowledge and expertise with other primary care practices.

In addition, the Rhode Island AFP has become increasingly active in medical home efforts, thanks to chapter President David Ashley, M.D., of Saunderstown. "When I got up and gave my acceptance speech as the new chapter president last May, I said the medical home was going to be my mission for the next year — to get us out in front of this whole issue and involved in this cutting edge stuff," says Ashley, a primary care partner with University Family Medicine in East Greenwich, R.I.

Physicians at Family Health and Sports Medicine, a family physician practice in Cranston, R.I., also are enthusiastic about the PCMH model. The practice was one of the first in the state to achieve medical home recognition status from the NCQA, and it repeatedly demonstrates the value of the PCMH model by controlling costs, enhancing access and improving the overall quality of health care.

"Patients are really responding to us because they feel they are getting much more attention and, therefore, better care," says Al Puerini, M.D., one of three physician partners in the practice. "We are able, as primary care physicians, to direct what happens with our patients much more efficiently."

Creating the Future

Rhode Island's emergence as a leading proponent of primary care and the PCMH is a result of several converging factors and circumstances. As a small state geographically, Rhode Island is conducive to implementation of pilot projects that test innovative delivery and payment models, such as the PCMH. And as a small state, it is able to spread the lessons of pilot projects across the entire state more readily than a larger state might be able to.

Rhode Island enjoys other advantages, as well. In 2009, Koller ordered the state's commercial insurers to invest more in primary care as a condition of having their rates approved. At the time, commercial insurers were spending about 6 percent of their medical expenses on primary care, far less than the amount spent by large integrated health systems, such as Kaiser and Geisinger.

In addition, Koller was instrumental in developing the Chronic Care Sustainability Initiative, also known as CSI Rhode Island. This multipayer medical home project now involves 13 practices and 47,000 patients, and includes commercial payers, Medicaid fee-for-service and a Medicaid managed care plan.

Family Physician Leadership

Rhode Island has been able to capitalize on other initiatives to strengthen the PCMH in the state. For example, the state's family medicine residency program at Brown University, under the leadership of Jeffrey Borkan, M.D., has incorporated training on the medical home into its curriculum, creating another base of support for the PCMH.

Puerini, Ashley and other family physicians are convinced that Rhode Island represents the future of health care in this country.

"We have been going through a very bad time in health care because of its volume-based nature," Puerini says. "The more tests you do, the more operations you do, the more money you make with absolutely no attention to quality."

The medical home, however, turns that model upside down by basing care and payment on the value of care and not on volume, says Puerini. "As the medical home evolves, it is going to become even more dominant. Little by little, we are going to have more input into what happens with our patients, and (we will) create a health care system that puts the patient at the center and rewards all providers based on the quality of care they give." ■



FP David Ashley, M.D., of University Family Medicine in East Greenwich, R.I., right, spends time going over patient Gary Cavanaugh's electronic health record.

Scott Indemaur/AAFP News Now

AAFP Changes CME Reporting Process to Reflect New AMA PRA Category 1 Credit Rule

Because of a new rule governing the AMA's Physician's Recognition Award, or PRA, Category 1 Credit that will take effect on July 1, the AAFP has made changes in the way physician-learners can claim credit for some of its learning materials, including those from *American Family Physician*, *Family Practice Management*, *FP Essentials* and *FP Audio*.

The new rule applies to all accredited CME providers, including the AAFP, which is accredited by the Accreditation Council for Continuing Medical Education to award AMA PRA Category 1 Credit in addition to AAFP Prescribed credit.

According to the rule, AMA PRA Category 1 Credit will be awarded only to participants who meet a minimum performance level for journal-based and self-study CME activities, including those presented in audio, CD-ROM, online, print, video and other formats. Each accredited provider is tasked with setting that minimum performance level.

Currently, the AAFP Commission on Continuing Professional Development has approved a minimum performance level of 80 percent to earn AMA PRA Category 1 credit for AAFP CME activities.

As a result of the new rule, AAFP physician-learners must submit credit online for CME content published on or after July 1. Paper quiz cards, answer sheets and evaluations will no longer be available after July 1.

To help AAFP members and other physician-learners meet the new requirements, the AAFP is in the process of upgrading its online quizzes. The upgrade will enable members to complete quizzes on their iPhone or Android smartphones, iPads or other Web-enabled mobile devices and receive instant credit.

Individuals who receive a mailed copy of *American Family Physician* in their own name or who have full online access will be able to take the quizzes online beginning July 1.

For materials published before July 1, quiz cards, answer sheets and evaluations will continue to be accepted until the expiration date published on these materials, which typically is either one or two years from the date of publication. ■

For the complete story, visit <http://www.aafp.org/news-now/education-professional-development/20110427amaprachanges.html>.

Vast Majority of Family Physicians Participate in MC-FP, Study Finds

By Barbara Bein

Although large numbers of family physicians across the country and in different practice sites participate in the American Board of Family Medicine's Maintenance of Certification for Family Physicians, or ABFM MC-FP, program, those practicing in poorer and medically underserved areas are more likely than their colleagues in non-medically underserved and more affluent areas to let their board certification lapse. Those are among the findings of a study published in the May/June *Annals of Family Medicine* that suggests various policy actions may be needed to support physicians in these areas.

The study involved all active family physicians who were initially certifying, recertifying or attempting certification after they had previously failed. Active physicians were defined as those directly caring for patients, doing research, teaching or working in administrative functions who were still active in their employment.

Using a combination of ABFM administrative records, 2009 AMA Physician Masterfile records and various geographic indices (e.g., 2000 Census Bureau tabulations, federally designated health professional shortage areas and medically underserved areas), the study found that 85 percent of the more than 70,000 active family physicians included in the study group have current board certification. Of those currently certified, 91 percent are participating in MC-FP.

"Participation in MC-FP appears to be robust," said the study authors, several of whom hail from the AAFP's Robert Graham Center in Washington and the ABFM. "Large numbers of family physicians are embracing MC-FP and meeting its requirements in a timely fashion."

What also came to light, however, was that FPs who are not participating in MC-FP tend to work in poorer and underserved areas. In fact, there were significantly higher percentages of physicians working in health professional shortage areas, in medically underserved areas, with medically underserved populations, and in poorer neighborhoods who had lapsed certifications.

"As more studies have linked quality of medical care to board certification, it is particularly troubling that physicians who have not maintained certification tend to be practicing in underserved areas or caring for underserved populations," said the study authors.

Among the study's other findings are the following:

- the likelihood of engaging in MC-FP decreases with increasing age;
- although 90 percent of female FPs participate in MC-FP, only 83 percent of male FPs do so;
- among internationally trained FPs, U.S.-born international medical graduates, or IMGs, are more likely than foreign-born IMGs to have allowed their certification to lapse or have not achieved certification;
- FPs in direct patient care, either office- or hospital-based, and in medical teaching are more likely to be engaged in MC-FP than those in medical research, administrative and other nonpatient care roles;
- FPs in group practice are more than twice as likely to be board-certified and are 10 percent more likely to be engaged in MC-FP than are solo FPs;
- FPs employed by the military are more likely to be certified and involved in MC-FP than those employed by local government health agencies; and
- rural FPs are slightly more likely than urban FPs to maintain their certification. ■

"Participation in MC-FP appears to be robust. Large numbers of family physicians are embracing MC-FP and meeting its requirements in a timely fashion."

— Authors of "Family Physician Participation in Maintenance of Certification" *May/June Annals of Family Medicine*

For the complete story, visit <http://www.aafp.org/news-now/education-professional-development/20110509mc-fprates.html>.

ACOs Top List of Concerns at Family Medicine Conference

By James Arvantes • Washington, D.C.

The government's proposed regulations for accountable care organizations, or ACOs, were a top concern among attendees at the 2011 Family Medicine Congressional Conference here on May 9. Many attendees were worried about how the model would affect family medicine and their practices, but AAFP President Roland Goertz, M.D., M.B.A. of Waco, Texas, was quick to remind them that they have an important role to play in health care reform.

The Patient Protection and Affordable Care Act emphasizes prevention and wellness, which puts primary care and family medicine in a position to drive systematic and sustained changes in how care is delivered and paid for, noted Goertz during the conference.

Even as Congress is riven by partisan strife regarding the Affordable Care Act, "we have a message that can cut through (the bickering) because we can

offer, at least in the health care arena, something (Congress) can do," Goertz told the nearly 200 family physicians, medical students and state chapter officials attending the conference.

He urged meeting participants to "think about the core message that represents family medicine and how we take care of patients."

Still, CMS' proposed Medicare ACO rule, which is in the commenting phase until June 6, was a concern for many attendees. FP Paul Lazar, M.D., of Flint, Mich., described the proposed regulation as "very complicated." In the final analysis, ACOs could shortchange physicians and their patients, said Lazar during a session on ACOs presented by Jonathan Blum, deputy administrator of CMS and director of the Center for Medicare Management.

ACOs are a key part of the Affordable Care Act, said Blum, but he stressed that participation

in the organizations by physicians and other providers is voluntary.

However, one of the overriding goals of the Medicare ACO program is to encourage lots of different organizations to participate, Blum said. "Our notion here is not to think one size fits all, but to encourage all kinds of organizational models to come into the program," he explained. This includes large and small physician practices, integrated delivery systems, and hospitals that employ physicians.

Blum noted that, as currently proposed, ACO regulations would require participating entities to report on 65 different quality measures in five patient quality domains. However, he added, "We're already hearing concerns that this is too many measures, too aggressive."

Family physician Stephen Albrecht, M.D., of Olympia, Wash., asked Blum if he could be retroactively assigned a patient who had already received



James Arvantes/AAFP News Now

AAFP President Roland Goertz, M.D., M.B.A., urges attendees at the AAFP's Family Medicine Congressional Conference to "think about the core message that represents family medicine and how we take care of patients." That message, he said, will cut through political contentiousness on Capitol Hill.

expensive and, possibly, unnecessary care from subspecialists.

Yes, said Blum, adding, "It gets complicated with how you assign patients." The hope is that patients will recognize that their care is better managed and delivered through the ACO and, in turn, will want to continue receiving care through an ACO, instead of seeking care from disparate providers and venues. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110518fmc.html>.

FPs Can Use CMS Checklist to Guide Exams for Power Mobility Devices

By Barbara Bein

Family physicians who need to prescribe power mobility devices, or PMDs, for their patients who have ambulation and mobility difficulties that impair their ability to perform activities of daily living in the home now have a checklist that can aid them during the face-to-face examination that is part of determining eligibility for Medicare coverage of such devices.

According to CMS, for a patient's PMD to be covered by Medicare Part B, physicians must provide the medical equipment supplier with the requisite prescription and portions of the patient's medical record that support the medical necessity for the PMD. As part of documenting the need for that PMD, the physician must conduct a face-to-face examination, which consists of a personal visit and a medical evaluation.

Presented as part of a recent *MLN Matters* article, the checklist guides physicians to include a detailed description of required items in the patient's medical record. For example, the checklist says the medical record should include a history of

- signs and symptoms that limit ambulation,
- diagnoses that are responsible for the signs and symptoms,

- medications or other treatments prescribed for the signs and symptoms,
- progression of ambulation difficulty,
- other diagnoses that may relate to ambulatory problems, and
- a history of falls.

In addition, the checklist flags physicians about physical exam findings that should be included in the patient's medical record, such as information on height and weight, strength and balance, and the results of musculoskeletal and neurological examinations. Details are vital in assessing whether the physical examination findings support a patient's need for a PMD, according to CMS, and physicians should describe the patient's ability to transfer or walk and include specifics about mobility problems associated with respiratory, cardiovascular and neuromusculoskeletal illnesses.

CMS stresses that the checklist is intended as a guide and does not replace the underlying medical records. As such, its use confers no guarantee that a patient's PMD claim will not be denied. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-professional-issues/20110518scooter.html>.

Candidates Vie for AAFP Leadership Positions

Review Stances, Pose Questions via Candidates' Web Page

Nine candidates are seeking election to Academy offices and the AAFP Board of Directors. The AAFP Congress of Delegates will elect officers and new directors Sept. 14 in Orlando. Before then, find out what the candidates' views are on issues that matter to you by checking out the "2011 Candidates" Web page at <http://www.aafp.org/online/candidates/home.html>.

You also can ask questions of this year's candidates via the "2011 Candidates Question & Answer Forum" option shown on the main candidates Web page or by using the "Question & Answer Forum" link shown in the left-hand column of each individual candidate's page. Each office also has its own Web page with a link to the Q&A forum for the candidate or candidates for that office. After you've posed your question, be sure to check back later to see the candidates' responses.

If you find you share common ground with certain candidates on issues important to you, your practice and your patients, consider asking your chapter delegates to the AAFP Congress to vote for those candidates. ■

For President-Elect



Jeffrey Cain, M.D.
Aurora, Colo.



George Shannon, M.D.
Columbus, Ga.

For Speaker

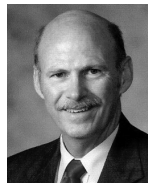


John Meigs Jr., M.D.
Centreville, Ala.



Javette Orgain, M.D., M.P.H.
Chicago

For Director



John Carroll, M.D.
Carroll, Iowa



Jose David, M.D.
Albany, N.Y.



Wanda Filer, M.D., M.B.A.
York, PA



Daniel Spogan, M.D.
Reno, Nev.



Julie Wood, M.D.
Kansas City, Mo.

AAFP Releases Principles for Health Insurance Exchanges

As states move forward with creating the individual state health insurance exchanges called for in the Patient Protection and Affordable Care Act, the AAFP has created a set of eight principles designed to help its constituent chapters address insurance exchange issues with state legislators and regulators.

The state health insurance exchanges essentially are marketplaces that will be set up so individuals and small businesses can compare and purchase private health insurance plans. HHS will establish initial guidance on the formation of the exchanges, but states have flexibility in how the exchanges operate, what benefits will be included, and how patients and physicians will interact with insurers and their products.

The flexibility in how the exchanges are structured provides an opportunity for family

physicians to push for delivery system reforms that will enhance patient care, such as the patient-centered medical home, or PCMH, said Greg Martin, AAFP manager of state government relations, in a letter to AAFP chapters.

The document comprises eight principles:

- **Fair representation of stakeholders** — According to the AAFP, the governing body of an exchange should include at least one seat for consumers and one seat for primary care physicians, and these seats should be in equal proportion to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders.

- **Enhanced access and payment for the PCMH** — Benefits in the exchanges should include enhanced access via e-visits, open scheduling and expanded hours. In addition, physicians should receive enhanced

payments for care coordination and the PCMH.

- **Standardized contracting** — All plans should use the same standard physician contract, just as enrollee applications are standardized. States that create multi-state exchanges or that enter into interstate compacts for purchasing insurance should harmonize contracting rules across all participating states, and "all products" clauses should be prohibited.

- **Primary care targets** — Exchanges should set targets for primary care spending by participating plans.

- **Require robust primary care-based essential benefits** — States should require health plans to offer primary care services beyond those required by the federal essential benefits regulation.

- **Presume eligibility** — Upon submitting an application, enrollees should receive provisional enrollment so they can

receive essential preventive and primary care services.

- **Reward quality** — Quality measures should be aligned across plans in the exchanges and with the state's Medicaid, Children's Health Insurance Plan, and state and local employee health benefits plans. Such measures also should coordinate with Medicare, when possible.

- **Protect consumers and physicians** — If they are not incorporated into the administrative framework of the exchange, consumer assistance and information offices should work closely with a state's exchange. Patients and physician practices should be allowed to access the services of such programs for concerns about insurance products purchased both inside and outside the exchange. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110427exchangeguidance.html>.

AAFP Foundation Grant Provides Hope for Patients of Volunteers in Medicine Clinic

By Nancy Kuehl • Palm Bay, Fla.

For many of its residents, the Atlantic coast of Florida is a paradise. But for others, the area's economic decline has led to job losses and strained financial circumstances. For those who have lost their insurance coverage along with their jobs, finding health care seems all but impossible. But that's where the nonprofit organization Volunteers in Medicine, or VIM, steps in.

VIM clinics provide free health care to the working uninsured in various areas of the country. The program brings together the

medically indigent with volunteer health care professionals in a clinic setting that is supported by the surrounding community.

The first VIM clinic launched in 1994 in South Carolina. Since then, the program has grown to 84 clinics across the United States, including six clinics in Florida, where the newest clinic, Space Coast Volunteers in Medicine, or SCVIM, in Palm Bay, Fla., recently opened.

VIM clinics, which provide care only for patients ages 19-64 who are not eligible for government aid and who earn less than

200 percent of the federal poverty level, also are the newest project of the AAFP Foundation. The Foundation recently launched its Family Medicine Cares program with a \$25,000 grant to the SCVIM clinic.

Family Medicine Cares is part of a new strategic direction for the AAFP Foundation, says Foundation President Richard Roberts, M.D., J.D., of Madison, Wis. The new direction aims to focus the Foundation's efforts so they have more impact and are more effective.

In particular, says Roberts,

members wanted the Foundation to focus on helping people who do not have access to health care. And, that need is great. According to Foundation figures, 50.7 million people in the United States were uninsured in 2009, and more than three-fourths of these individuals were part of working families who were earning low to moderate incomes.

The Family Medicine Cares program will gather all the resources AAFP members can provide, from financial support to volunteer support. "Family Medicine Cares is designed to bring (family physicians) together to help address this overwhelming need in the United States and to bring visibility to the caring nature and importance of family medicine," says the Foundation.

"Volunteers in Medicine quickly and obviously proved to be the best partner for us," says Roberts. "They have a good track record, and they think through the process (of opening new clinics)."

Roberts says the careful research done by the Foundation will pay off in the partnership with VIM, but he notes "the Foundation will not be an ongoing bank for (individual) clinics," given that its focus is on new clinics and helping them get off the ground. "We cannot provide (clinics) with the money to keep them going, but we can provide seed money," says Roberts, adding that a clinic's ongoing success will depend on the level of community support it gets. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20110510scvimclinic.html>.



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From Residency to Reality

Managing Medical Practice is Focus of Redesigned Curriculum For Residents, New Physicians

By Barbara Bein

To ensure family medicine residency program directors have the most up-to-date educational resources they need at their fingertips, the AAFP has redesigned its practice management curriculum for physicians-in-training. The *From Residency to Reality* curriculum now comes preloaded on one CD-ROM that is formatted for both PC and Mac users. Curriculum modules are provided as PDFs, as well as PowerPoint slides.

The curriculum was redesigned to be easier for members to use and teach, according to Katy Jaksa, AAFP education services and special projects manager. The older product, she explained, just wasn't very user-friendly and had instructors flipping back and forth from electronic to hard copy resources.

"This new design is a turn-key, off-the-shelf, ready-to-use product in that the speakers' notes and pre- and posttest answers are right there in the PowerPoint presentation and PDF files," said Jaksa.

Produced by the AAFP in collaboration with TransforMED, its wholly owned subsidiary, and the Center for Health IT, the goal of the curriculum is to teach residents — as well as practicing family physicians — the knowledge, skills and approaches they'll need to successfully manage a practice and achieve long-term professional and personal success in the new health care reform environment.

"As practices and health care settings evolve, residents and prac-

ticing physicians will experience a continuing spectrum of change in organization, finance, administration and patient care," said AAFP Vice President for Education Perry Pugno, M.D., M.P.H.

"Physicians must understand practice management to make appropriate personal choices, advocate for the highest standard in the delivery of patient care, and fulfill ethical and legal responsibilities," he told *AAFP News Now*.

In addition to program directors, faculty and residents, the curriculum will be useful to new-to-practice physicians, who need point-of-care resources to help them establish a practice, and to established physicians, who need to revise their current methods and processes.

The redesigned curriculum features more than 100 hours of content on financial management, change management, cost/benefit decision-making, care coordination and physician-patient communication. It discusses practice innovations, such as the patient-centered medical home; family medicine practice competencies, including leadership, management and team-based care; and issues facing new and practicing family physicians.

Program directors and others can order *From Residency to Reality* at a price of \$350 for the initial copy and \$75 for additional copies by calling the AAFP Contact Center at (800) 274-2237. ■

For the complete story, visit <http://www.aafp.org/news-now/education-professional-development/20110511r2redesign.html>.

Office-based Physicians Responsible for \$1.4 Trillion in Economic Output

In 2009, office-based physicians contributed \$1.4 trillion to U.S. economic activity and supported 4 million jobs nationwide, according to a report recently released by the AMA. And AAFP members, who are nearly 90 percent office-based, were top contributors to those numbers.

Office-based physicians added more to state economies than a number of other industries, including hospitals, nursing homes, home health services and even legal enterprises, says the AMA report *The State-Level Economic Impact of Office-Based Physicians*.

The economic impact of office-based physicians varies greatly from state to state and depends on two factors: the number of physicians in the state and the characteristics of the state's economy, says the report.

It uses four variables — output, jobs, wages/benefits, and tax revenue — to gauge the economic impact of office-based physicians. Specifically, the report assesses the direct impact of the value of output, jobs, wages/benefits, and taxes produced from patient care activities provided in physician offices, as well as the indirect impact of the same activities generated in industries supported by physicians' offices.

According to the report, in 2009, the office-based physician industry supported

- \$1.4 trillion in total economic output, with each physician

supporting an average of \$2.2 million in output;

- 4 million jobs, with each office-based physician supporting 6.2 jobs, including his or her own; and
- \$833 billion in wages and benefits, with each physician supporting \$1.3 million in those areas.

In addition, the office-based physician industry generated \$63 billion in total state and local tax revenues in 2009, with each individual office-based physician generating an average of nearly \$100,000 in state and local tax revenues.

In 2007, the AAFP's Robert Graham Center did a similar study that measured the economic

impact of a single family physician and the cumulative effect of FPs in each of the 50 states and the District of Columbia.

The finished work, "Economic Impact of Family Physicians," is a series of issues briefs — one for each state — that details information on the economic benefits family physicians provide and that includes a state map with federally designated primary care health professional shortage areas.

According to the Graham Center data, California FPs topped the list as economic drivers, with an economic impact of nearly \$986,000 per family physician per year. The total annual impact of family physicians in the state was more than \$8.2 billion in 2007. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-professional-issues/20110419amaeconomicimpact.html>.



AS WE SEE IT

Voices From the AAFP

Editorial

As AAFP Membership Continues to Grow, We Will Consolidate Our Influence

By "Voices" Staff

If you'll recall, in January, AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, told you that the AAFP had hit an all-time membership high of more than 97,000 members. Well, that number has just kept growing, and now membership in the AAFP is at the 100,300 mark, making the Academy the second largest subspecialty physician membership organization in the United States. In fact, we trail only our primary care colleagues in the American College of Physicians. The next largest group is the American College of Surgeons, which has a membership of approximately 70,000.

The membership growth in the Academy is impressive given that many associations are struggling with declining membership.

AAFP members, however, trust the Academy to support them throughout their career, said Goertz in a recent press release. "Family physicians look to the AAFP to advocate on their behalf in the formation of health care policy; to enhance their practices and help them meet their career goals; to provide the latest in quality, innovative medical education; and to promote the health of the American public. A growing membership shows that our organization is working hard to fulfill those needs."

Those increased membership numbers mean increased clout for the Academy. Not only does it help us get our message heard on Capitol Hill — after all, what congressional representative wants to hear from more than 100,000 angry physicians and medical students? — it increases our visibility and influence among our professional colleagues. All of this comes at a time when health care in the United States is undergoing some serious changes.

Family medicine needs to be at the forefront of those changes. It is vital for the future of health care in this country that we transform the system to one that is based on a solid foundation of primary care. To get there, we are going to need to have that increased influence in all aspects of health care.

And there is ample evidence that our influence is growing. For example, Goertz was recently invited to testify before a House panel about the Academy's ideas for alternatives to the sustainable growth rate, or SGR, formula which regulates Medicare physician payments. Goertz was one of only two leaders of a subspecialty physician group to testify, and he was the only leader of a primary care association.

In addition, AAFP leaders have been very active in Washington recently, meeting with congressional representatives to discuss ongoing concerns about the health care system. And Academy leaders and members continue to work with government agencies as the rules and regulations of the Affordable Care Act are rolled out. Being able to point to such a large membership means AAFP members are taken seriously as they provide input and guidance that benefits family physicians and their patients.

For example, we were quite vocal in our concerns about the recent regulations proposed by CMS regarding accountable care organizations, or ACOs. Although ACOs have the potential to shift the U.S.

health care system from strictly fee-for-service to something that gives equal weight to patient satisfaction and quality of care, as proposed, the regulations put too many barriers in place for physicians to actively participate. In addition, as proposed, the regulations would disenfranchise small and medium-sized practices in favor of large groups, which could lead to more problems than it would solve.

We also have provided resources for AAFP chapters to help them work with state governments as health insurance exchanges are set up in individual states. We have pressed Congress to take into account the need for increased federal investment in educating family physicians as legislators negotiate the federal budget, and we've joined with our physician colleagues from other specialties to demand an end to the broken system of Medicare physician payment.

We've come a long way from our humble beginnings; in 1950, for example, we had only 13,000 members. The growth in membership in the Academy signals that family medicine is a force to be reckoned with. Our issues must be heard, for the good of our patients and U.S. health care in general.

So to reiterate President Goertz's January message "If you renewed your membership in 2010, thank you for your loyalty and solidarity in supporting the specialty we all love. ... If you're a new member, welcome to the Academy, and thank you for supporting family medicine. ... Powerful together, we will make a significant difference in the coming months." ■

"Family physicians look to the AAFP to advocate on their behalf in the formation of health care policy; to enhance their practices and help them meet their career goals; to provide the latest in quality, innovative medical education; and to promote the health of the American public."

— Roland Goertz, M.D., M.B.A.,
AAFP President