



# aafp NEWS NOW

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## CDC Reports Lab-Confirmed H1N1 Flu Cases in 36 States

*Agency's Web Site Has Guidance Documents for Docs*

By David Mitchell

The HHS has declared a public health emergency in response to an influenza A (H1N1) virus outbreak that had resulted in 286 confirmed human cases in 36 states as of May 4. Meanwhile, the World Health Organization, or WHO, has raised its global influenza pandemic alert level from phase 4 to phase 5, after cases of the illness were confirmed in a number of other countries around the world.

According to the WHO classification system, "Phase 5 is characterized by human-to-human spread of the virus into at least two countries in one WHO region. While most countries will not be affected at this stage, the declaration of Phase 5 is a strong signal that a pandemic is imminent and that the time to finalize the organization, communication, and implementation of the planned mitigation measures is short."

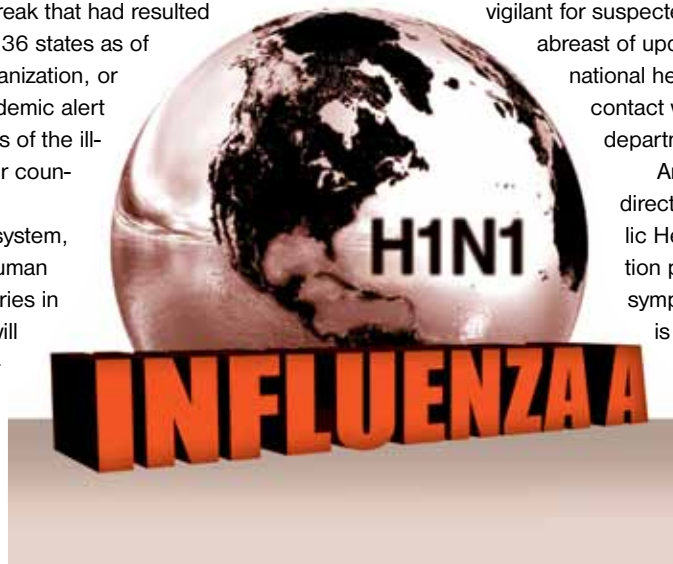
The AAFP has gone on the offensive

in response to this health emergency, calling on members to remain vigilant for suspected cases in their communities, stay abreast of updates coming from national and international health agencies, and maintain close contact with their state and local health departments during the evolving situation.

Anne Schuchat, M.D., interim deputy director for the CDC's Science and Public Health Program, said the viral infection presents with high fever, respiratory symptoms, and nausea and vomiting that is more severe than is typically seen with seasonal flu. Respiratory symptoms may include cough and sore throat.

CDC officials said physicians should consider swine flu in the differential diagnosis of patients

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## Academy Leaders Burst Onto Capitol Hill With Message About Primary Care's Key Role in Health Reform

By James Arvantes • Washington

On March 10, AAFP leaders converged on Capitol Hill, meeting with multiple lawmakers and congressional staff members to talk about the importance of giving primary care and the patient-centered medical home, or PCMH, a prominent role

in health care reform initiatives.

"We continue to drive home hard the message about primary care and the patient-centered medical home," said AAFP President Ted Epperly, M.D., of Boise, Idaho, who joined AAFP President-elect Lori Heim, M.D., of Vass,

N.C.; AAFP Board Chair Jim King, M.D., of Selmer, Tenn.; and AAFP EVP Douglas Henley, M.D., in making the Capitol Hill visits.

"Our message was very well received, and things are looking very good in regard to support for primary care and the patient-

centered medical home. That is very encouraging because Congress will start putting together a health care reform bill within the next several weeks," Epperly said.

King agreed with Epperly's assessment. "We are developing

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### MAY HIGHLIGHTS

Fee Schedule ..... page 3

UnitedHealthcare has implemented a new fee schedule based on Medicare rates from 2008 instead of 2009 drawing protest from the Academy.

Red Flag Rules ..... page 4

Implementation of identity theft rules that included physicians has been postponed, but the Academy's online resources still can help.



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## H1N1 Flu Cases, *continued from page 1*

with febrile respiratory illness. If the illness is suspected, clinicians should obtain a respiratory swab for testing, refrigerate it, and promptly contact their state or local health departments to facilitate transport and timely diagnosis at a state public health laboratory.

The CDC also will update the list of states and the number of confirmed cases daily at 11 a.m. EDT on its Web page dedicated to the outbreak at <http://www.cdc.gov/h1n1flu/>.

The agency has issued guidance on the use of antiviral medications for patients with confirmed, probable or suspected influenza A (H1N1) virus infec-

tion and their close contacts. The CDC also posted a *Morbidity and Mortality Weekly Report Dispatch* on April 28 that details the susceptibility of the virus to various antiviral medications.

Antiviral drugs work best when treatment begins within two days of symptom onset, said CDC officials, but treatment with antiviral drugs still should be considered after 48 hours of onset, particularly for hospitalized patients or people at high risk for influenza-related complications. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090429swine-flu2.html>.

## Health Reform, *continued from page 1*

contacts with the new legislators in Congress and their staff and strengthening the case for primary care as these committees start debating health care legislation," he said.

The four Academy leaders started their day by attending political action committee, or PAC, events for various House members. Epperly attended a PAC event for Rep. Walt Minnick, D-Idaho, a freshman congressman and a member of the House's Democratic Blue Dog Coalition. As a so-called Blue Dog, Minnick is one of 49 moderate and conservative Democratic members in the House whose support for health care reform will be instrumental in passing comprehensive health care reform, Epperly said.

In the afternoon, the AAFP leaders met as a group with a senior policy analyst for Sen. Max Baucus, D-Mont. Baucus is chair of the Senate Finance Committee, one of two Senate committees with jurisdiction over health care legislation.

They then met separately with other lawmakers and congressional staff members to urge them to provide a long-term fix to Medicare's broken payment system and to block scheduled reductions in



AAFP President-elect Lori Heim, M.D., right, stresses the need for an adequate primary care physician workforce during a Capitol Hill meeting with Sen. Kay Hagan, D-N.C.

the Medicare payment rate.

Heim met with newly elected Sen. Kay Hagan, D-N.C., who serves on the Senate Health, Education, Labor and Pensions, or HELP, Committee, which also has jurisdiction over health care legislation. According to Heim, one of the reasons for her visit was to establish a relationship with the new senator.

"As a new senator and a member of the HELP committee, I want to make sure she understands the role of primary care and knows about the patient-centered medical home," said

Heim. "I hope (the senator) will come to see the Academy as a source of solutions and ideas and a resource for her."

During his visits with Congress staff members, King said he got the unmistakable impression that Congress wants to enact health care reform legislation this year. "They seem very open to suggestions for us to work with them," he said. "I really feel they want something to happen this year." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090324cap-hill.html>.

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# Health Insurance Giant Changes Physician Payment Rules

## *AAFP, Others Slam UnitedHealthcare's Decision*

**O**n April 1, UnitedHealthcare, or UHC, one of the nation's largest health insurance plans, implemented a new fee schedule methodology for its physician contracts that bases physician payment on Medicare's 2008 resource-based relative value units, or RVUs. The move has sparked protest from the AAFP and four other medical specialty groups.

Essentially, UHC's action locked in the lower 2008 RVUs, a money-saving move for the insurer that creates a pay freeze for 70,000 physicians, including nearly 14,000 family physicians who hold UHC contracts.

If UHC refuses to reverse its decision, family physicians face

a decrease in the payment rate for CPT code 99213 of almost 8 percent from what it would have been if UHC had used Medi-



care's 2009 RVUs. Code 99213 is the most common service code used by family physicians.

In response to physicians' concerns, the Academy and four other medical specialty organizations urged UHC to reconsider its decision in a March 31 letter to UHC Senior VP Reed Tuckson, M.D. The AAFP, American College of Physicians, American Academy

of Neurology, American Osteopathic Association and Infectious Diseases Society of America highlighted UHC's actions and noted that the insurer is

- taking advantage of the budget-neutrality adjusted work RVUs previously used by Medicare and ignoring the RVU gains in the 2009 Medicare physician fee schedule;
- taking advantage of these Medicare-adjusted work RVUs, even though UHC is not bound by the same budget-neutrality requirements as Medicare;
- freezing its payment rates at 2008 levels for 2009 and beyond unless physicians renegotiate their UHC contracts;
- refusing to reveal the percentage of physicians who suc-

cessfully renegotiate their contracts;

- ignoring physicians' increasing practice costs; and
- neglecting to say whether the company also froze customers' insurance premiums.

The physician groups told UHC that without corresponding increases for general inflation, UHC's physician fee schedules were "reducing physicians' salaries in relative terms."

The five organizations also took issue with UHC's oft-repeated statement that physicians can renegotiate their UHC contracts, saying the health insurer's claim contradicts what the organizations hear from their members. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20090409uhc-fees.html>.

# AAFP Rallies Support for House Budget Resolution

By James Arvantes

**T**he AAFP has issued a Legislative Alert through its newly launched Connect for Reform campaign to urge members of Congress to support the House version of a recently passed budget resolution.

The House and Senate each have passed budget resolutions that lay out spending parameters for the upcoming fiscal year. Both resolutions address the need to support primary care and include reserve funds for health care reform. Only the House version, however, would allow Congress to enact legislation to block physician payment reductions scheduled to take place this year without making cuts to other federal programs or relying on tax increases. The Senate-approved version would require nearly \$300 billion in offsetting revenue increases or cost reductions elsewhere in the federal budget.

"The provisions in the House budget make real reform of physician payment much more likely," says the Legislative Alert. "The Senate version does not contain these same provisions."

The alert urges AAFP members to call their members of Congress to tell them to support the House budget committee's provisions to improve physician payment. "Physician payment hangs in the balance," it warns.

The alert contains a list of 10 talking points to put the issue of physician payment reform into proper perspective and to help AAFP members convey their message to legislators. "For the last six years, the statutory formula used to determine how Medicare will pay physicians and other health care providers has produced steep reductions in payment rates," says the document. "To prevent these reductions, Congress has every year postponed the scheduled payment rate but has

allowed these reductions to accumulate."

If Congress does not act this year, Medicare would have to pay physicians 21 percent less, notes the document. "Before Congress can address long-term payment reforms, it must address this debt.

"Clearly, the provisions in the House budget resolution make it much more feasible to turn to real reform of the physician payment formula."

This year, unlike past years, the House and Senate budget resolutions and the president's 2010 budget proposal all address the need to adequately support primary care. The House budget resolution, for example, calls for improving payment accuracy to encourage efficient use of resources while ensuring primary care receives appropriate compensation. The Senate budget resolution calls for "measures to encourage physicians to train in primary care residencies and (to) ensure an adequate supply of residents and physicians."

This language is partly a result of the work done by the AAFP and other primary care organizations, says Kevin Burke, director of the AAFP's Division of Government Relations.

As Congress and the Obama administration debate health care reform, there is a growing recognition that primary care is a key component of any health care reform effort and that it must be strengthened, Burke notes. He cautions, however, that the congressional budget resolutions and the president's budget are simply words that do not have any real impact on policy. "It is not a done deal yet." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090408leg-alert-budget.html>.

## FTC Delays Compliance Deadline for Federal 'Red Flags' Rule

The Federal Trade Commission, or FTC, won't start enforcing the Identity Theft Red Flags Rule until August 1. According to an April 30 press release, the FTC determined that entities covered under the new federal law needed an additional three months to develop and implement identity theft programs.

The Identity Theft Red Flags Rule requires family physicians to determine what identity theft red flags may occur in their practices and have a plan for responding to those red flags.

The new federal regulation, which will be administered by the Federal Trade Commission, or FTC, requires financial institutions and creditors — including physician practices — to develop and implement written identity theft prevention programs as part of the Fair and Accurate Credit Transactions Act of 2003.

Initially, the Academy and several other medical specialty organizations tried to convince the FTC to exclude physicians from the regulation. Despite their efforts, however, the FTC decided that many physicians are creditors and, therefore, are subject to the rule.

"The red flags rule is intended to address all forms of identity theft, including those involving the provision of health care," says a Feb. 4 letter from the agency. "Although identity theft most commonly is associated with financial transactions, there are increasing concerns about identity fraud in the context of medical care."

To help Academy members prepare for the approaching compliance deadline, the AAFP's Practice Support Division has created an online resource. The Identity Theft Red Flags Rule Web page at <http://www.aafp.org/online/en/home/prac->

[ticemgt/regulatory-compliance/id-theft.html](http://www.aafp.org/online/en/home/practice/identity-theft.html) includes a members-only PowerPoint presentation on complying with the rule; responses to a number of frequently asked questions; and a list of additional Web sites that may prove helpful to physicians.

Visitors will find documents that define terms, explain the purpose of the rule, spell out what is required of physicians and give some examples of how the red flags rule may apply to a physician's practice.

Under the heading, "What is a Red Flag?" users will find a checklist that ticks off particular activities that could alert practice staff to possible identity theft. Examples include:

- altered or forged patient documents;
- inconsistent patient identification information, including a personal description or photograph that doesn't match the patient;
- invalid phone numbers;
- suspicious addresses that could indicate a post office box or prison; and
- similar or identical social security numbers or addresses presented by multiple patients.

The red flags rule materials also guide physicians through specific steps to help them comply with the rule, such as

- developing a written program to identify, protect and respond to possible risks of identity theft;
- updating the program periodically;
- identifying an individual within the practice who will oversee the program; and
- reporting, at least annually, on the program's effectiveness. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090416id-theft-rule.html>.

## New Merck Programs Address Uncertainty of Insurance Coverage for HPV Vaccination

Merck & Co. Inc. is launching two new programs for its quadrivalent human papillomavirus, or HPV, vaccine, in an attempt to take the uncertainty out of insurance coverage issues for patients and payment issues for physicians.

According to the CDC, early data indicate only about 10 percent of eligible, privately insured women ages 18-26 have received the first dose of the three-dose series for Merck's HPV vaccine, which is sold as Gardasil.

Merck sources say some physicians are reluctant to provide same-day



Gardasil vaccinations to women in this age group because of uncertainty about insurance coverage. Instead, physicians are encouraging patients to ask their health plans whether the vaccine's costs are covered. Patients then can return to their physicians for vaccination. The uncertainty about coverage, combined with a lack of follow-up by patients, has contributed to low vaccination rates in this age group.

Merck's new Confidence in Coverage Status program will provide doctors with patients' benefit information before office visits. Participating physicians will determine which of their privately insured 19- to 26-year-old female patients who are scheduled for office visits in the next one or two weeks are candidates for vaccination with Gardasil. They then can submit these patients' names, birth dates and insurance information to Merck online or by faxing the information to (866) 209-9051.

Within three to five days, physicians can expect to receive faxed reports that include coverage status and, if applicable, copay, coinsurance and deductible amounts.

Merck said the service, provided by Covance Market Access Services, complies with requirements of the Health Insurance Portability and Accountability Act.

Merck also is launching a second program, dubbed the Patient Rebate Program for Gardasil. In this program, eligible privately insured 19- to 26-year-old female patients who receive Gardasil doses from April 1, 2009, through April 30, 2010, will be eligible for a rebate when their out-of-pocket costs for Gardasil exceed \$30 per dose. The maximum rebate is \$130 per dose. Patients must file for the rebate within 90 days from the date each dose was administered. Merck says patients will receive the rebate within six to eight weeks of submission. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090408gardasil-prog.html>.

## Adding Athletic Trainers to Care Team Can Increase Docs' Productivity

By David Mitchell

According to the National Athletic Trainers' Association, or NATA, nearly 8,000 of its members worked in hospitals, clinics and physician offices last year, and the number is growing. That figure, which represents more than a quarter of the association's members, is up more than 4 percent since 2001. The services these health professionals provide can bring significant value to a medical practice, says one family physician.

Thomas Kohl, M.D., who maintains a private practice and serves as medical director at the Comprehensive Athletic Treatment Center in Wyomissing, Pa., told *AAFP News Now* that the six full-time and one part-time athletic trainers he employs increase overall productivity and improve patient outcomes.

"They do rehab, review exercises, fit braces, do orthotics, perform testing — things I don't have time to do, but they can do and generate revenue in doing it," Kohl said.



Thomas Kohl, M.D., left, a family physician at the Comprehensive Athletic Treatment Center in Wyomissing, Pa., and athletic trainer John Howell talk with patient Patti DeGrasse about her chronic knee condition.

"Athletic trainers have an expertise in musculoskeletal health and practice this every day," said John Howell, who is a certified athletic trainer, a certified strength and conditioning specialist, director of human performance services and director of industrial medicine services at Comprehensive Athletic Treatment Center.

"We can take a patient's history, go through a necessary evaluation using special testing to better address a patient's health

issue and also recognize specific mechanisms of injury that could steer the assessment in a particular direction," he added. "Athletic trainers are also valuable for post-assessment initiation of a treatment plan. Whether it be bracing, splinting, casting or something as simple as home exercise program prescription, athletic trainers excel in such areas while decreasing a physician's needed face time."

According to a NATA report, having athletic trainers — not to be confused with personal trainers — working as "physician extenders" allows physician offices to see 12 more patients per day by moving patients through the evaluation and management processes faster.

Kohl said his patients like working with the athletic trainers, who help them better understand their path to recovery.

"About 25 percent of visits in a family medicine practice are musculoskeletal-based — back pain, shoulder pain, etc.," said Kohl. "I have taken new athletic trainer graduates and molded them to be excellent assistants by teach-

ing them 'other medicine' and allowing them to use their skills in musculoskeletal medicine."

He added that athletic trainers also can assist in medical weight loss and helping design diet and exercise plans.

But the bottom line, said Howell, is that athletic trainers do more for a practice from a financial standpoint than just increasing physician productivity.

"Adding an athletic trainer to your staff opens up other services to a practice," he said. "You can start prescribing and giving home exercise programs, which are billable. You can offer durable medical equipment, which, if done correctly, can add huge value to a practice. Casting and splinting of nondisplaced, nonsurgical fractures can also be added to any practice where a physician feels comfortable with (trainers handling) simple fracture management." ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090403athl-train.html>.

## AAFP Invites Members to Sign Up for Health Care Notification Network

By David Mitchell

The AAFP has reached a partnership agreement with the Health Care Notification Network, or HCNN, a free online system that rapidly informs clinicians of FDA-mandated patient safety alerts by replacing the "Dear Doctor" letters traditionally delivered via standard mail with electronic communications.

"Unlike paper-based 'Dear Doctor' letters delivered via the United States Postal Service, ... online alerts from the HCNN are delivered immediately to a physician's (e-mail) inbox," said Henry DePhillips, M.D., HCNN's chief medical officer.

Electronic receipt of an alert is verified when a physician logs into the HCNN system to view the alert. Registered physicians who don't open an electronic alert within 72 hours are mailed a paper copy of the alert.



Under the terms of the agreement, if at least 5 percent of active AAFP members register for the HCNN program at <http://www.aafp.org/online/en/home/membership/resources/hcnn.html> and respond to an HCNN alert within 72 hours, the AAFP will receive a nominal fee from HCNN.

DePhillips said HCNN alerts are specialty-specific, targeted to appropriate prescribers, and contain no advertising or extraneous information. The system has sent three alerts regarding four prescription drugs since October, he added. All three alerts were sent to family doctors. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20090422hcnn-redux.html>.

# When It Comes to Cost of Care, Family Physicians Provide Added Value, According to Study

By James Arvantes

**F**amily physicians are a cost-effective usual source of care, especially when compared with subspecialists or even internists, according to a study conducted by the AAFP's Robert Graham Center and published in the March/April issue of *Health Affairs*.

The study found that the cost when a subspecialist served as a patient's usual source of care was \$1,430 higher on average per year than the cost of having a family physician as a usual source of care. The study also found — unexpectedly — that total health care costs for adults who used a general internist as their usual source of care were \$1,201 higher on average than for patients who named a family physician as their usual source of care.

"I thought we would find that primary care was different than subspecialty care as a usual source of care," said Robert Phillips, M.D., director of the Graham Center. "I didn't expect to find that internists would look different, and, in fact, so different that they look like subspecialists — that was quite surprising."

According to the study, adult per-patient spending on office-based services at general internal medicine offices was \$247 higher on average than spending on office-based services for FPs. In addition, the adult per-patient cost of a visit to a subspecialist's office was \$226 higher on average than the per-patient cost of a visit to an FP's office.

**"I didn't expect to find that internists would look different, and, in fact, so different that they look like subspecialists ..."**

— Robert Phillips, M.D., Robert Graham Center

In the area of prescription drug costs, adult patients who used general internists as their usual source of care spent \$409 more on prescription drugs than patients who relied on FPs as their usual source of care. Additionally, adult patients who accessed care from subspecialists on a regular basis spent \$206 more on prescription drugs than patients who saw FPs on an ongoing basis.

The study also found that children with a family physician as their usual source of care had lower annual costs than those with subspecialists or even pediatricians as a usual source of care. The annual cost for children who relied on FPs as their usual source of care was \$751 on average per year, per child, compared with \$858 for pediatricians and \$1,561 for subspecialists.

Spending on office-based care averaged \$177 a year for a child who relied on an FP as his or her usual source of care, compared with \$228 for a pediatrician and \$334 for a subspecialist. Similarly, the annual prescription drug cost for a child who used an FP for ongoing care averaged \$106 per year, compared with \$134 for a pediatrician and \$332 for a subspecialist. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20090407grhm-cntr-usualsource.html>.

## In Brief *Clinical Care & Research*

### FDA Warns About Risk of Wearing Patches During MRIs

The FDA has issued a public health advisory warning patients that certain transdermal patches pose a safety risk. The agency said the patches, if worn during MRI scans, can conduct electricity, generate heat and cause skin burns. The patches in question contain metallic components, such as aluminum or other metals, in the backing of the patches. Both brand-name and generic products and both prescription and OTC products are included in the advisory. Although many of these products already carry a warning about the risk of skin burns, FDA officials have determined that not all manufacturers include such safety warnings. <http://www.aafp.org/news-now/news-in-brief/20090330news-brf-clinupd.html>

### ACG Updates Recommendations for Irritable Bowel Syndrome

The American College of Gastroenterology, or ACG, has published new recommendations for the treatment of irritable bowel syndrome, or IBS. The recommendations note that certain probiotics may be effective in reducing symptoms; tricyclic antidepressants and selective serotonin reuptake inhibitors in low doses have been shown to reduce bloating and discomfort; the nonabsorbable antibiotic rifaximin is effective for patients with diarrhea and bloating; and lubipro-

tone, a chloride channel activator, benefits women with constipation. In addition, although patients often think that some foods exacerbate their symptoms, there is insufficient evidence to show that food allergy testing or exclusion diets are effective in ameliorating symptoms, so routine use of such regimens is not recommended.

<http://www.aafp.org/news-now/news-in-brief/20090330news-brf-clinupd.html>

### Exercise Lowers Risk for Colon Cancer, Study Says

A study published in the *British Journal of Cancer* reports that people who exercised the most were 24 percent less likely to develop colon cancer than subjects who exercised the least. Researchers from Harvard University in Boston and the Washington University School of Medicine in St. Louis sought to estimate the magnitude of potential risk reduction by reviewing more than 50 previous studies examining the relationship between exercise and colon cancer risk. The researchers said in a news release that the protective benefits applied to all types of exercise for both men and women. <http://www.aafp.org/news-now/news-in-brief/20090330news-brf-clinupd.html>

## MedPAC Chair Urges Greater Support for Primary Care During Congressional Testimony

By James Arvantes • Washington

Primary care is essential for a high-functioning health care system, according to the chair of the Medicare Payment Advisory Commission, or MedPAC, who recently urged Congress to revise Medicare's payment policies to better recognize and reward the provision of primary care services.

Glenn Hackbarth, J.D., testified before the House Ways and Means Subcommittee on Health here on March 17 that the Medicare payment system undervalues primary care despite overwhelming evidence that primary care produces better outcomes and lower costs. He urged Congress to make changes to the Medicare Resource-Based Relative Value Scale, or RBRVS, to better compensate primary care physicians for providing health care services.

He also said Congress should allocate a separate payment increase for primary care physicians and expedite a patient-centered medical home pilot project.

Hackbarth appeared as a sole witness before the subcommittee to present MedPAC's 2009 Medicare Payment Policy Report to Congress. The report asked Congress to provide a 1.1 percent increase for physician payment rates in 2010 based on an expected 2.4 percent increase in the inflation rate and a 1.3 percent productivity growth offset. In the report, MedPAC commissioners expressed concern that "primary care services are undervalued and are at a significant risk of being under-provided, despite some recent increases in payments for primary care services."

"To underscore the urgency

of this issue, the Commission voted to reiterate its previous recommendation that Congress increase payments for primary care services when provided by practitioners who focus on primary care," the report said. "This adjustment would be budget neutral within the fee schedule."

Hackbarth decried the lack of medical students opting for careers in primary care. He said the declining number of medical students going into primary care is a direct result of public and private payment systems. He also criticized the current fee-for-service Medicare payment system as perpetuating uncoordinated and fragmented care, and he urged Congress to

move away from the fee-for-service system and adopt a system that rewards care coordination and outcomes. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090330medpac-tstimony.html>.



Rep. Pete Stark, D-Calif., left, discusses Medicare payment policies with MedPAC Chair Glenn Hackbarth, J.D., immediately after Hackbarth testified before the House Ways and Means Subcommittee on Health.

James Arvantes/AAFP

## New Association Management System Aims to Enhance AAFP Services

*Members Gain Ability to Input, Edit Many of Their Own Records*

By Cindy Borgmeyer

The AAFP recently launched an innovative association management system, or AMS, that promises greater efficiencies in the organization's day-to-day handling of member-related data and enhanced functionality for chapters, members and other Academy customers. One of the most novel aspects of the new system — known as netFORUM Enterprise — is that it allows members direct access to their CME transcripts, financial transactions with the AAFP and numerous other records.

Offering an example of the heightened level of service the new system will provide, Academy EVP Douglas Henley, M.D., noted that staff in the Academy's Contact Center now will have ready access to information about each member through the new system. That, in turn, will enable Contact Center staff to answer members' questions more easily, he said, "whether it's about their CME record or registering for a meeting or paying their dues."

For AAFP members who prefer a hands-on approach, however, some of the new features offered through the netFORUM system that members can start taking advantage of right away include:

- All member applications now can be completed online and are

entered into the system automatically; there's no need for staff to re-key those entries.

- The system offers members enhanced online dues-paying capabilities, including options that allow them to pay their annual dues in installments and set up an auto-pay option for the following year's dues. They also can generate invoices and paid receipts reflecting those payments.
- Members can register for conferences, courses and other events online and obtain copies of their paid receipts for those activities.
- Members can view all of their financial transactions with the AAFP online, so they can track and verify that information.
- CME transcript functions also have been overhauled. Members can access their CME records online; add, delete or edit CME and non-CME entries in their own words and with the help of a medical spell-checker feature; and then generate a PDF of their CME record that can be e-mailed wherever they choose. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20090413new-ams.html>.

## AAFP Joins California Academy in Supporting Residency Program Under ‘Assault’ by CMS

**T**he AAFP is going to bat for the Stanislaus Family Medicine Residency Program at Doctors Medical Center of Modesto, Calif., after CMS decided to stop supporting the residency with funds for graduate medical education and demanded repayment of more than \$19 million in Medicare payments to the facility. CMS has given no regulatory justification for its actions, which could increase health care costs and hurt patients’ access to care, says the Academy.

Calling CMS’ decisions an “assault” on the residency program, the Academy says in a sharply worded letter to CMS Acting Administrator Charlene Frizzera that even though the federal agency can’t point to any regulations to justify its actions or to any misuse of funds, “CMS staff are demanding nothing less than closure of the residency program and a discharging of all staff and trainees.”

“It appears that CMS is unwilling to be satisfied with anything other than complete dismantling of this important community resource,” AAFP Board Chair Jim King, M.D., of Selmer, Tenn., says in the letter, which asks Frizzera to investigate the situation.

According to a March 18 press release from the California AAFP, the dispute centers on reclassification of the residency. In 1997, the 34-year-old residency program moved to Doctors Medical Center of Modesto when Stanislaus County was forced to close its insolvent county hospital in the underserved Central Valley of California.

At that time, CMS ruled that the residency was a “new” program and, consequently, it decreased the per-resident payment from \$115,000 to \$70,000. The agency then proceeded to pay for Medicare services provided at the facility.

However, in 2007, CMS began an investigation based on rules that were not yet written in 1997 when the residency moved and was designated as a new program. Application of these more recent rules resulted in a decision to discontinue Medicare support for graduate medical education at the facility and to demand repayment of more than \$19 million, despite the fact that “at no time has any malfeasance or misappropriation or misuse of funds by the program or hospital been claimed,” according to the letter from the Academy.

The AAFP joins the California AAFP in urging CMS to preserve funding for the residency program. In the press release from the state Academy, CAFP President Jeffrey Luther, M.D., of Long Beach, Calif., says creating upheavals in the program will worsen primary care physician shortages in rural areas of the state.

The AAFP letter tells CMS that the loss of the residency, a major clinical resource for the area’s poor and disenfranchised populations, “will undoubtedly result in increased health care costs as people are forced to use local emergency departments for care of their more advanced illnesses.” ■

For more information, visit <http://www.aaafp.org/news-now/resident-student-focus/20090401stanislaus.html>.

## Prescription Assistance Program Loosens Eligibility Guidelines, Expands Access

**T**ogether Rx Access, a prescription savings program sponsored by some of the nation’s largest pharmaceutical companies, has loosened its income eligibility requirements, thereby expanding the number of health consumers who qualify for the program.

According to a March 19 announcement, the program now is available to nearly 90 percent of uninsured Americans.

That’s good news family physicians can pass along to their patients who are feeling pinched by America’s faltering economy.

The income guidelines that now must be met to qualify for Together Rx Access are

- a maximum annual income of \$45,000 for a single person (formerly \$30,000);

- a maximum of \$60,000 for a family of two (formerly \$40,000);

- a maximum of \$75,000

for a family of three (formerly \$50,000); and

- a maximum of \$90,000 for a family of four (formerly \$60,000).

Other rules remain the same. Eligible participants cannot be Medicare-eligible or have any other prescription drug coverage and must be legal residents of the United States or Puerto Rico.

A Kaiser Health Tracking Poll released in February 2009 and cited by Together Rx Access verifies that the American public is having trouble keeping up with health care costs. According to that poll, 53 percent of Americans surveyed said cost concerns had caused them to cut back on health care in the past year.

The survey also found that 21 percent of respondents had let a prescription go unfilled, and 15 percent said they cut pills in half or skipped doses of medicine.

The program currently has 1.8 million cardholders and, by its own accounting, has saved patients more than \$81 million since the initiative launched in 2002.

The AAFP applauded the program’s new enhanced coverage with a statement of support. “Americans may face financial challenges in meeting their health care needs, resulting in skipped doctors’ visits and unfilled prescription medicines for chronic conditions,” says the AAFP statement. “We must work together to establish safety nets for those in need to help them better access medical treatments and live healthier lives.”

According to the March 19 announcement by Together Rx Access, participants in the program can save 25 percent to 40 percent on more than 300 brand-name prescription products; many generic drugs also are covered. ■



For more information, visit <http://www.aaafp.org/news-now/health-of-the-public/20090325together-rx.html>.

## Primary Care Docs Need to ‘Step Up’ Their Health Behavior Talks With Teens, Says Study

By Barbara Bein

**W**hen Sharon Lee, M.D., of Kansas City, Kan., does physical exams on her adolescent patients, she launches her “rap.” It’s a talk about drugs, alcohol and sex, she says, and how it’s up to the teen to make choices. But according to a recent study, she and her like-minded family medicine colleagues may be exceptions to the rule.

The study, “Adolescent Preventive Services: Rates and Disparities in Preventive Health Topics Covered During Routine Medical Care in a California Sample,” says that primary care professionals are doing a substandard job of addressing a number of health-related issues with their adolescent patients, including tobacco, alcohol and drug use; STDs; seat belt and helmet use; violence;



Family physician Sharon Lee, M.D., practices her ‘rap’ about how teens have to make choices that will affect their health with Tyler Truesdell, 13.

physical activity; and nutrition.

According to the study, which was conducted by researchers at the University of California-San Francisco and published online in the *Journal of Adolescent Health* in December, “Preventive care is a crucial element of quality primary care for adolescents,” because most morbidity and mor-

tality in this age group derives from preventable causes. In addition, many health and lifestyle behaviors established during this time can have significant health effects later.

Although the rates of discussion for all of the topics were low, when there were discussions, the teens most frequently talked about nutrition (76.4 percent) and physical activity (75.7 percent) with their physicians, according to the study. Least frequently discussed was violence (15.4 percent).

Compared with teens ages 15-17 years, adolescents ages 12-14 years discussed safety issues more and use of substances, nutrition and STDs less. Compared with males, females talked more about exercise and STDs. And compared with white teenagers, Hispanic youths reported more discussion on

most of the topics, black youths reported more discussions on nutrition, and Asian youths reported more discussions on seat belt and helmet use.

Contrary to the researchers’ expectations, teens from minority, uninsured and lower-income groups reported higher rates of discussing these health topics than did white teens and those in insured and higher-income groups, the study says.

“Increased investment and effort are required to improve the delivery of preventive services, so that all adolescents may benefit from adequate knowledge about the importance of healthy behaviors across the life span,” the study authors conclude. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20090327teen-talks.html>.

## AAFP Joins AAP, Others in Urging Review of Vaccine Injury Decision

**T**he AAFP has endorsed an “amicus curiae” (friends of the court) brief supporting review of a Georgia Supreme Court ruling that threatens to undermine the National Childhood Vaccine Injury Act of 1986. The American Academy of Pediatrics, or AAP, filed the brief with the U.S. Supreme Court in support of a petition for a writ of “certiorari” (judicial review) from vaccine manufacturers Wyeth and GlaxoSmithKline.

Last October, the Georgia high court ruled in *American Home Products Corp. v. Ferrari* that Marcelo and Carolyn Ferrari’s civil lawsuit against Wyeth and GlaxoSmithKline on behalf of their son is not barred by the terms of the National Childhood Vaccine Injury Act.

The 1986 federal law sought to ensure a stable and adequate national vaccine supply and to provide fair and timely compensation to children injured by vaccines by establishing the National Vaccine Injury Compensation Program. Federal and state judges have consistently ruled that civil suits are pre-empted by the vaccine injury act and the associated compensation program.

The Ferrari lawsuit claimed that the vaccine makers named as defendants in the suit could have and should have manufactured childhood vaccines without thimerosal.

A Georgia trial court ruled against the Ferraris in 2005, finding that the vaccine act preempted the plaintiffs’ design defect and other

claims. The Georgia Court of Appeals, however, overturned that ruling in 2007, and the Georgia Supreme Court upheld the reversal last year. In its ruling, the Georgia high court said plaintiffs are entitled to a determination as to whether a vaccine’s side effects were unavoidable before the federal law’s preemption is applied.

According to the AAP brief, if the Georgia ruling stands, vaccine manufacturers would have to defend their products on a case-by-case basis in state courts, which threatens to create a situation similar to what existed before the creation of the National Vaccine Injury Compensation Program.

Nearly 300 vaccine injury lawsuits against seven vaccine manufacturers were filed between January 1980 and March 1985, says the brief. This drove some manufacturers out of the U.S. market because of concerns about increasing litigation and insurance costs; other manufacturers halted development of new vaccines.

If other states follow the Georgia precedent, the AAP said, that could lead to reduced immunization rates and a resurgence of preventable diseases.

The AAFP agreed, saying in a statement that all children and adults should have access to all immunizations recommended by the Academy. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20090415ferrari-vacc-case.html>.

# Retail Health Clinic Chain Offers Free Health Care to Newly Unemployed

By Sheri Porter

**T**ake Care Health Systems, operator of the nation's second largest chain of retail health clinics, stepped into the spotlight March 31 when it announced the launch of a short-term plan to provide existing clinic patients with free health care.

The Take Care Recovery Plan offers consumers who lost their jobs on or after March 31 and who qualify for the program free treatment for illnesses and injuries at Take Care Clinics for themselves and their dependents. To qualify for the plan, consumers cannot have health insurance. In addition, they or

one of their dependents must have been a patient at a Take Care clinic before the family breadwinner became unemployed.

Take Care Health Systems, a wholly owned subsidiary of Walgreens, oversees 342 Take Care clinics in 19 states. According to a March 31 press release, the offer of free treatment for acute conditions, such as respiratory illness, seasonal allergies, urinary tract infections and minor skin conditions, is good through the end of 2009.

Lauren Nestler, director of communications for Take Care Health Systems, told *AAFP News*

Now the company is taking this action because "this is the right thing to do. Patients should not have to sacrifice basic health care or choose among basic necessities, such as health care, food or housing, in a challenging economy."

AAFP President Ted Epperly, M.D., of Boise, Idaho, was cautious in his praise for the program. He recognized the precarious position of laid-off Americans and said he appreciated the efforts that Walgreens and Take Care were making to help.

However, he also wondered about ulterior motives.

"There is a fine line between

intent and reality. This isn't a magnanimous, unbelievable gesture of generosity," said Epperly. "This is a way to try to capture increased revenues by using health care as a loss leader. I find it disingenuous."

Epperly said shrewd business people run the clinics, and they are betting that the majority of people who come in to use the clinic are going to get their prescriptions filled in the store. Before they leave, "those same people are going to buy toilet paper and flashlight batteries, too," he added.

Epperly pointed out that many family physician practices — including his own — have procedures in place to help patients through tough financial times. For instance, Epperly said he offers a sliding fee scale for hardship patients and sometimes even writes services off.

"Family physicians are doing what they can," but many practices operate on slim margins, he said. First and foremost, family physicians need to keep their doors open to patients. "We can't say something as outlandish as 'We'll provide free health care to the nation's uninsured' because we're not in business to also sell prescription drugs and other retail goods in our offices."

Epperly said uninsured consumers who take advantage of Take Care's new program also should watch their pharmacy expenditures by tapping into Wal-Mart's \$4 prescription program. His advice to patients? "Make sure that you're getting the \$4 medication instead of the \$44 medication." ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20090408take-care.html>.

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## Higher Cigarette Tax Might Help Some Smokers Quit

*AAFP Cessation Program Provides Resources*

By David Mitchell

**T**he 62-cent-per-pack federal tax increase on cigarettes recently signed into law by President Obama pushed the nation's average cost of a pack of cigarettes to approximately \$5 when it took effect April 1. That, say FPs interviewed by *AAFP News Now*, may prompt some smokers to consider kicking the habit.

According to numbers provided by the Campaign for Tobacco-Free Kids, the increase means that smokers now pay between \$2 and \$3 in state and federal taxes for a pack of cigarettes in 14 states. They pay \$3 or more in taxes in 13 states and the District of Columbia. New York smokers have the highest tax burden, with a combined \$3.76 in state and federal taxes for every pack. And those numbers don't include local cigarette taxes, such as the \$1.50 per pack paid by New York City smokers.

Every 10 percent increase in the price of cigarettes reduces youth smoking by 7 percent and overall consumption by 4 percent, says the Campaign for Tobacco-Free Kids.

AAFP President Ted Epperly, M.D., of Boise, Idaho, said the



combination of the increased taxes and the weak economy should cause many smokers to think about quitting.

"This is a wonderful opportunity for family physicians to engage their patients and tell them why they must stop," Epperly said. "Smoking is the most preventable health care problem in the world, and these taxes provide another reason to stop."

The Academy's Ask and Act program recently updated its "Patient Stop Smoking Guide," which walks patients through the steps of quitting. Another new resource is a wait-

ing room brochure that warns parents about the dangers of second-hand smoke. The program also is in the process of creating an online tobacco cessation training program for constituent chapter liaisons.

"There is a synergy with the Ask and Act tools for the patient and their families," Epperly said. "If we bring together individual counseling with the doctor, medication to stop and the support of the patient's loved ones, that combination can be very powerful." ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20090303smoke-tax.html>.

## AAFP Steps Up Messaging on Payment Reform in Response to House Letter Touting Subspecialist Pay

By James Arvantes

**T**he AAFP is reinforcing its message on Capitol Hill that a primary care-based health care system could generate significant cost reductions for the nation's Medicare program. The heightened emphasis comes in response to a letter two House members are circulating that asks Congress to *not* provide increases in payment for primary care physicians by cutting payments to subspecialists.

"Recently, some have proposed financing increased Medicare payments for some physicians and services by cutting payments to other physician specialties," says a letter being circulated by Reps. Shelley Berkley, D-Nev., and Mark Kirk, R-Ill. The

letter asks members of Congress to sign on to a letter addressed to House Speaker Nancy Pelosi, D-Calif., and House Minority Leader John Boehner, R-Ohio.

"Many ideas have been offered about how to reform Medicare's physician payment system," says the sign-on letter. "One idea we cannot support is a proposal to finance increased reimbursement for one physician specialty or one set of physician services by simply cutting reimbursement for all others. While we must find ways to help Americans better manage their care, we do not support proposals that would establish a reimbursement structure that would threaten patients' access to the life-saving

care that other physician specialties are trained to provide."

"The health care system needs primary care, and primary care physicians need improved payment," says Kevin Burke, director of the AAFP Division of Government Relations. He adds that the AAFP is not proposing that those increased payments come from other specialties' Medicare payments.

In fact, in correspondence and meetings with congressional members, the AAFP continues to stress that basing health care reform on primary care would create system-wide savings by reducing and, in some cases, preventing more expensive types of care, such as emergency

room visits, hospitalizations, and excess costs from duplicative laboratory and imaging services. To achieve those savings, however, lawmakers must strengthen the primary care infrastructure by paying primary care physicians adequately, says Burke.

The Berkley-Kirk letter is "premature," adds Burke, because it attempts to take one possible solution for increased primary care payment off the table. "In an environment that so strongly stresses cost control, it is wrong to take anything off the table that could help pay for primary care increases." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090415house-letter.html>.

# AS WE SEE IT

Voices From the AAFP

## Letters to the Editor

### Academy Concerns With Sunshine Act Cause Consternation

To the Editor:

Thank you for your article in *AAFP News Now* titled "AAFP Expresses Concerns About Revised Physician Sunshine Act" (<http://www.aafp.org/news-now/professional-issues/20090209sunshine-act.html>).

As a patient, a family physician and an AAFP member, I think Dr. Ted Epperly's comments expressing concern with the requirement to report gifts below \$500 and concern that items such as consulting fees, honoraria, entertainment, education and research would be counted as gifts miss the point.

First off, companies don't make "gifts" — they disguise their gifts as honoraria, consulting fees, etc. Eliminating these from the reporting requirements would gut it so as to make it useless.

As a patient, I want to know before I choose a doctor just how much he or she is financially intertwined with industry. The goal of the Sunshine Act is to achieve transparency. Share the data, and let the patients and public decide if it matters or not. Trying to raise the reportable limit and exclude certain items from reporting interferes with transparency and undermines the tremendous potential of this bill.

**Andrew Schechtman, M.D.**  
**Faculty, San Jose - O'Connor Hospital**  
**Family Medicine Residency**  
**Adjunct Assistant Clinical Professor,**  
**Stanford University School of Medicine**  
**Palo Alto, Calif.**

To the Editor:

I was disappointed to read about the AAFP's opposition to the latest version of the 2009 "Sunshine Act," which has bipartisan co-sponsorship and would disclose payments and gifts made to physicians from pharmaceutical and medical device companies.

I suspect most family physicians, especially in the younger generation, already see the problems with influence of pharmaceutical marketing in the practice of medicine. Most of us already have decided to not take pharmaceutical company gifts or meet with marketers. The AAFP should do the same. Transparency is the new trend, both on Wall Street and in politics, and the AAFP's support for this bill would signal that (we) physicians are ready to clean up our exam rooms, as well.

This bill would not prohibit gift-giving, but only put the light of day to the practice. In fact, the legislation — contrary to (what was reported in) the article in *AAFP News Now* — would allow physicians to clarify any errors that are posted on public access sites. The best way for an individual physician to remain off the list, of course, would be to not take any gifts. The bill also exempts any items, such as medication samples,



that are used directly to improve patient care.

In the meantime, we should encourage our colleagues to attend "pharm-free" CME — as we have with our annual meeting here in Washington state — so we can eliminate undue bias that leads to inappropriate prescribing, higher costs and potentially unsafe care (e.g., Vioxx, Avandia and others).

The AAFP should reconsider supporting this bill again, as it did last year, and show by example that the medical profession is ready to eliminate conflicts of interest that compromise patient care.

**Jeff Huebner, M.D., Seattle, Wash.**

Response:

Communication is key to high-quality health care, and family physicians have consistently advocated for transparency not only in the physician-patient relationship, but also in interactions between physicians and other members of the health care community.

Nowhere is this transparency more important than in the dealings between physicians and the manufacturers of pharmaceuticals, medical supplies and devices, and biologicals that form the foundation of many patients' treatment plans.

The AAFP and I personally hold the tenet of transparency to be among the most important elements of professionalism. That's why I was somewhat surprised by the response to my recent comments about the Physician Payments Sunshine Act of 2009, a bill that requires manufacturers to disclose gifts, financial agreements and other dealings they have with physicians.

The intent of my comments was to emphasize the need for legislation that provides for reasonable reporting on physicians, allows recourse if mistakes were made in that reporting, and ensures that physicians would not have yet another law demanding unnecessary or redundant administrative paperwork. The AAFP continues to study the bill and will be following its progress through the legislative process.

The AAFP is not disparaging the Sunshine Act, and we are not taking the industry side on this. We are looking for transparency legislation that

- minimizes the administrative burden reporting requirements would place on physicians,
- enables the physician to correct incorrect reporting data before companies release it for publication, and
- ensures reporting requirements do not have a chilling effect on efforts to educate physicians about research and new developments in diagnosis and treatment.

Such provisions will improve an already important legislative effort.

**Ted Epperly, M.D., AAFP President**

For more information, visit <http://www.aafp.org/news-now/opinion/20090306sunshine-ltrs.mem.html>.