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Congress Extends Medicare Payment Patch Through End of Month

Legislation Provides More Time to Pass Longer-term Measure

Congress has passed and President Obama has signed a Medicare physician payment bill that extends the 2009 physician payment rate through May 31, thus reinstating the payment rate that was in place on March 31 and allowing CMS to rescind a 21.2 percent reduction that went into effect on April 1 because of the sustainable growth rate, or SGR, formula.



CMS held payment of claims from April 1-15, awaiting passage of the payment legislation. According to a press release from the agency, its contractors will be processing held claims according to the new law for services provided by physicians and others who are paid according to the Medicare physician fee schedule.

"The measure faced opposition because there were insufficient budget offsets," said Kevin Burke, director of the AAFP Division of Government Relations. "However, Congress has given itself time to work the differences in a separate bill that will take the SGR to Oct. 1. We're hoping the disruption to family physicians will be as small as possible."

The House approved the Medicare extension bill on March 17. However, the Senate failed to pass the legislation before adjourning for a two-week recess on March 26, which permitted the 21 percent pay cut to take effect on April 1.

Lawmakers soon will take up legislation to extend the current payment rate until Oct. 1. Both the House and Senate have passed separate bills to accomplish this extension and negotiations about how to pay for it are ongoing. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100415sgrextension.html>.

Texas Tech School of Medicine to Roll Out Three-year M.D. Program for Family Medicine

By Barbara Bein

The Texas Tech University Health Sciences Center, or TTUHSC, School of Medicine in Lubbock has announced that its newly approved Family Medicine Accelerated Track, or FMAT, program will allow students who are com-

mitted to primary care to complete their education in three years and at half the cost of a standard four-year program.

According to a March 23 TTUHSC news release, the FMAT program was approved by the Liaison Committee on Medical Edu-

cation. The first students in the FMAT program will be recruited from this fall's incoming class.

"This is a program of national importance as we work to ensure that all Americans will have access to a primary care physician," said Steven Berk, M.D., dean of the

TTUHSC School of Medicine, in the news release. "Texas Tech is committed to taking the first steps in changing how medical schools attract and educate future family medicine doctors."

AAFP Board Chair Ted

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MAY HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

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The DEA has published an interim final rule to allow physicians to prescribe controlled substances electronically.

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The AAFP has released a number of new resources to explain the effects health care reform legislation will have on FPs.

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Epperly, M.D., of Boise, Idaho, told *AAFP News Now* that the FMAT program is an innovative model that compresses four years of medical school into three, making it "more effective and efficient."

According to AAFP member Michael Ragain, M.D., Brad-dock Chair of the TTUHSC Department of Family and Community Medicine, at the midpoint of the 2010-11 medical school year, between 10 and 12 top-notch students out of a class of 140 will be recruited for the FMAT program. The track will launch officially in July 2011.

During the coming months, the school will begin recruiting faculty — chiefly family physicians — to lead the curriculum. The standard four-year curriculum will be condensed into three years by eliminating a summer break and starting a longitudinal family medicine clerkship in the second year, thereby freeing up time so students can complete required rota-



tions by the end of the third year.

Instead of 160 weeks of instruction with breaks, the curriculum will encompass 151 weeks of instruction with limited interruption, Ragain said.

Students selected for the track will receive a one-year scholarship, which, coupled with the elimination of the fourth year, results in a medical education that costs half as much as the traditional four-year program, said Ragain. And students can enter a family medicine residency and start earning a salary a year earlier.

These incentives are designed to attract more medical students into family medicine at a time when many choose higher-paying sub-

specialties because of concerns about medical school debt.

"We wanted to improve the recruitment of U.S. medical students into family medicine," Ragain said. "This is one of the answers to help fill the shortage of family physicians."

Texas AFP EVP Tom Banning said the shorter program with the same educational requirements and rigor is a step in the right direction toward recruiting more students into family medicine. He said the response he's received from students has been "pretty positive."

"I think any innovative pilot that does not decrease the learning experience is a good thing to examine," said Banning. "The benefits are obvious: By taking a year off of time spent in medical school, you can reduce medical school debt load while still maintaining the education requirements." ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100408texas-tech-fmat.html>.

DEA Issues Interim Final Rule to Allow e-Prescribing of Controlled Substances

The DEA has issued an interim final rule that would allow electronic transmission of prescriptions of controlled substances.

The interim rule, which was published in the March 31 issue of the *Federal Register* would, among other things,

- give prescribers the option of e-prescribing controlled substances;
- permit pharmacies to receive, dispense and archive electronic prescriptions;
- reduce paperwork for DEA registrants, such as family physicians;
- help pharmacies and hospitals integrate prescription records into other medical records;
- increase efficiencies and reduce the wait time for patients having prescriptions filled; and
- potentially reduce prescription forgeries.

The Academy has long held the view that physicians should have the freedom to e-prescribe, regardless of the medication.

Jason Mitchell, M.D., assistant director of the AAFP's Center for Health IT, said the new rule contains significant changes from a 2008 proposed rule that faced opposition and, ultimately, was dropped. Mitchell said family physicians would appreciate the agency's renewed efforts to reduce the administrative burden on e-prescribers in its latest rule. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100331deainterimrule.html>.



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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between Mar. 24 and Apr. 14, 2010.

AAFP Offers Free CME Webinars on Nutrition

The AAFP has launched a series of live one-hour webinars that will present evidence-based guidelines and practical approaches family physicians can use to integrate nutrition science into their practices.

The webinars, Nutrition and Weight Management, Nutrition and Heart Disease, and Nutrition and Digestive Health, are designed to inform family physicians about the latest research so they can help patients make changes that lead to better health.



Many components of the webinars are based on the findings of a three-year research study conducted by the AAFP's Americans in Motion-Healthy Interventions, or AIM-HI, fitness initiative. The study developed and evaluated a program to improve family physicians' delivery of effective patient-centered behavior change interventions.

The first webinar, Nutrition and Weight Management, which discusses how family physicians can help their patients make evidence-based dietary changes to manage their weight and reduce their disease risk, aired on April 15.

The second webinar in the series, Nutrition and Heart Disease, aired on May 4. The presenters discuss how family physicians can help patients make evidence-based dietary changes to lessen their risk for heart disease, as well as how to implement strategies to overcome patient resistance to healthy lifestyle changes.

The third in the series, Nutrition and Digestive Health, will air at 6 p.m. EDT on July 14.

Each of the three webinars has been reviewed and is acceptable for as many as two AAFP Prescribed CME credits. All three will be archived and available online following the live presentations.

The webinars are supported by an educational grant from General Mills Bell Institute of Health and Nutrition. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20100408nutrit-webinars.html>.

AAFP Censures Senate Regarding Medicare Payment Reduction

In a recent letter to members of the U.S. Senate, the AAFP assailed Congress for not addressing a 21.2 percent Medicare payment reduction called for by the sustainable growth rate, or SGR, formula.

"It is abundantly clear that the fee schedule formula is broken and that the time for Congress to provide a permanent fix is overdue," said AAFP Board Chair Ted Epperly, M.D., of Boise, Idaho, in the letter. "The system to address the problems caused by the flawed formula is mired in political contention. Sadly, those paying the price for this dysfunctional arrangement are first and foremost our nation's seniors and their primary care physicians. Many of these physicians work in small- and medium-sized practices, often in underserved areas, and usually with small or no operating margins."

The current 21.2 percent reduction was scheduled to take effect on Jan. 1, but Congress passed a series of short-term patches that effectively delayed the payment reductions to give lawmakers more time to find a longer-term solution to the SGR. In mid-March, the House approved a bill to provide a payment extension through April, but the Senate was unable to pass the measure before adjourning for a two-week recess on March 26. (See related story on page 1.)

"This month-to-month uncertainty about (physician) Medicare payments is disruptive and interferes with (physicians') ability to provide reliable, enduring health care, especially for patients with chronic disease conditions," said Epperly. "This broken system undermines the credibility of the Medicare program for these primary care doctors. And since the TRICARE health insurance program for military members and their families bases its payment rates on Medicare's, this impasse affects their health care, as well."

Epperly called on Congress to "address this broken system and its dysfunctional formula," by enacting a permanent fix to the Medicare payment formula. "We join the AMA and the other physician organizations in objecting to this short-sighted treatment of the major providers of health care to the Medicare population," Epperly said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100405sgrlitrofcensure.html>.

New Academy Resource Answers Questions About Effect of Health Care Reform Legislation on FPs

In the wake of passage of health care reform legislation, the AAFP has launched a new Web page designed to help members understand the effect the legislation will have on their practices and their patients.

According to AAFP EVP Doug Henley, M.D., Academy members value the resources that are available on the AAFP Web site. "At this important time, as new information becomes available about how health reform will impact our members, their practices and their patients, we wanted to make it as easy as possible to find that information in one easily accessible place," he said.

The Health Care Reform 2010 Web page at <http://www.aafp.org/online/en/home/policy/federal/hcrleg2010.html> offers information on how the new legislation will affect: primary care physicians, the practice of medicine, physician payment, family physicians as small business owners, academic family medicine, and patients.

The Web page also has information about what the AAFP thinks is missing from the final legislation. "Certainly, the AAFP would have liked to see this bill address medical malpractice reform more comprehensively and provide a permanent solution for Medicare payments to doctors," says the AAFP Web page.

According to Henley, the AAFP will continue to update the Health Care Reform 2010 Web page as information becomes available. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20100326hcreformpage.html>.

AAFP Enhances CME Tracking, Reporting System for Members

Learning Portal Provides Personalized CME Plan

The AAFP has upgraded its Web-based CME reporting program to help members track and plan their CME. The AAFP CME Learning Portal provides personalized features, including a self-assessment, customized profile, learning plan and progress tracking, to meet members' CME needs.

According to Ann Karty, M.D., CME medical director of the AAFP Division of Continuing Medical Education, the new enhancements will simplify physician, resident and student mem-

bers' education-related administrative tasks. "Members now have an electronic way to keep track of all of their state licensing requirements and their AAFP membership requirements," said Karty. "They can monitor their ABFM (American Board of Family Medicine) Maintenance of Certification schedule and select CME that is pertinent to their individual needs."

The learning portal was designed in response to members who asked the AAFP to create a system to track and

report their CME activities more efficiently, said Karty.

Members start by answering questions on the CME requirements in the state or states in which they are licensed, their ABFM diplomate status, their AAFP re-election status, and any CME requirements for hospitals or medical societies. The program then suggests relevant CME from the AAFP CME database. Searches can be refined based on body system categories or clinical topics.

From the list of suggested

CME activities, members can review the objectives of individual activities or add the activities to their personal CME plan.

According to Karty, this is the first phase of an ongoing process. Future enhancements will include data input automation, customized solutions to meet AAFP member-specific needs and further development of the CME product line portfolio. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20100330learningportal.html>.

AAFP to Test New 'Translation to Practice' CME

The AAFP is piloting a new category of CME Prescribed credit called Translation to Practice. The program allows physicians who take an AAFP Prescribed CME credit activity to earn as many as two additional AAFP Prescribed CME credits for each activity by completing the Translation to Practice activity.

According to AAFP Director Laura Knobel, M.D., of Walpole, Mass., who is the Board liaison to the Academy's Commission on Continuing Professional Development, the new credit category gives physicians an opportunity to demonstrate how they translated knowledge into practice by identifying a change, applying what they learned to incorporate the change and reflecting on the outcome.

"The Translation to Practice credit is a way for (physicians) to go back home and look at their practices to see if they are actually doing what they said they would," said Knobel. The program "takes a piece of the information they get in a lecture, puts it into practice and results in improved patient care."

Physician-learners wanting to earn the Translation to Practice CME credits can elect to participate after completing the course evaluation



form for AAFP Prescribed CME credit activities that are included in the pilot. They are then invited to fill out a commitment-to-change statement that summarizes what they learned in the CME activity, identifies the change they plan to integrate into their practice, clarifies their motivation for implementing the change, and states what they think will be improved.

Approximately 90 days later, participating physicians will be asked to fill out an AAFP Translation to Practice reflection summary, in which they will describe

- the change they made,
- the effect of the change on their practice,
- where they obtained information to implement the change,
- whether they encountered any barriers to change and
- what they did to overcome those barriers.

Finally, physician-learners will describe how their thoughts and attitudes have changed as a result of the original CME activity and how they applied what they learned in their practices. They also will describe the steps they are taking to ensure changes in their practices are maintained.

After they submit answers to all parts of the Translation to Practice activity, participants will receive as many as two additional hours of AAFP Prescribed CME credit.

The Translation to Practice CME program is being piloted with the online version of AAFP Live!; in selected courses at the AAFP Scientific Assembly Sept. 29-Oct. 2 in Denver; and in other AAFP-produced courses. The AAFP will review preliminary results of the pilot, and, if warranted, an extended pilot will commence in January. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20100407translationtopractice.html>.

FDA Warns of Risks Associated With Simvastatin

High Dose of Zocor, Use in Combination With Other Drugs Increase Risk of Muscle Injury

There is an increased risk of muscle injury in patients taking the highest approved dose of simvastatin compared with patients taking lower doses of the drug – which is marketed as Zocor – or other statins, according to a March 19 FDA safety alert.

Although myopathy is a known side effect of statin medications, the FDA said patients taking an 80-mg dose of simvastatin are at increased risk. In addition, the risk increases when simvastatin, especially at higher doses, is used with certain other drugs. Symptoms of myopathy include muscle pain, tenderness or weakness, and an elevation of the enzyme creatine kinase in the blood.

Patients with rhabdomyolysis, the most serious form of myopathy, may have dark or red urine and fatigue in addition to muscle symptoms, the FDA said. Rhabdomyolysis, which is a rare adverse event reported with all statins, also can lead to kidney damage, kidney failure and death. Patients who are 65 years and older or who have hypothyroidism or poor kidney function are at increased risk for rhabdomyolysis.

A review of prescription drug use data by the FDA found that despite dose limitations and interaction precautions included on the simvastatin drug label, physicians are prescribing higher doses of sim-

vastatin with other medications that are known to increase the risk for rhabdomyolysis.

Physicians should consider potential risks and benefits of simvastatin compared with other cholesterol-lowering therapies when prescribing the drug, said the FDA. Physicians also should review patients' medications for potential drug interactions before prescribing simvastatin.

The agency also noted that simvastatin should not be used in combination with

- itraconazole, which is marketed as Sporanox;
- ketoconazole, which is marketed as Nizoral;
- telithromycin, which is marketed as Ketek;
- nefazodone, which is marketed as Serzone;
- HIV protease inhibitors;
- erythromycin; or
- clarithromycin.

Physicians are asked to report any adverse events associated with the use of simvastatin to the FDA's MedWatch program. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100324simvastatinalert.html>.

In Brief *Health of the Public*

H1N1 Activity Spikes in Southeast

Increased incidence of novel influenza A (H1N1) virus infection in the Southeastern United States has prompted public health officials to again urge vaccination as the best defense against the flu. Anne Schuchat, M.D., director of the CDC's National Center for Immunization and Respiratory Diseases, said during a March 29 media briefing that Georgia had a spike in cases during the previous three weeks. That state has had more laboratory-confirmed cases of H1N1 hospitalizations than at any time since October. Alabama, Georgia and South Carolina all are reporting regional influenza activity. Eight other states, primarily in the Southeast, are reporting local activity. <http://www.aafp.org/news-now/health-of-the-public/20100402fluspike.html>

FDA Issues Final Rule on CFC-based Inhalers

Nearly three years after the FDA proposed that ozone-depleting chlorofluorocarbon-based inhalers be eliminated, a final rule affecting the last seven such products was published April 14 in the *Federal Register*. In an April 13 FDA news release, agency officials said that three chlorofluorocarbon, or CFC, inhalers will be phased out during the next three years. Specifically, flunisolide, which is marketed as Aerobid Inhaler System, will not be available for sale after June 30, 2011; the combination of albuterol and ipratropium, which is marketed as Combivent Inhalation Aerosol, will not be available for sale after Dec. 31, 2013; and pirbuterol, which is marketed as Maxair Autohaler, will not be available for sale after Dec. 31, 2013. The phase-out period is intended to give patients time to change their therapeutic regimens. The FDA said patients should continue using their CFC inhalers until they have talked with their physicians about switching to a medication that does not use CFCs as a propellant. <http://www.aafp.org/news-now/health-of-the-public/20100414cfc-inhalers.html>

FDA Recommends Temporary Halt to Use of Rotarix

The FDA is recommending that physicians temporarily suspend use of GlaxoSmithKline's Rotarix rotavirus vaccine because DNA from porcine circovirus 1, or PCV1, has been detected in the vaccine. FDA Commissioner Margaret Hamburg, M.D., said during a March 22 conference call that PCV1 is not known to cause disease in animals or humans. She said the Rotarix rotavirus vaccine, which was approved in 2008, has an excellent safety record, and the recommendation to suspend its use was made out of an abundance of caution. It is unclear how PCV1 got into the Rotarix vaccine. It also is unclear whether the material is a DNA fragment or an intact virus. Hamburg said the material was found in the vaccine, cell bank and the viral seed from which the vaccine is derived. That means the material has been present since Rotarix's early development stages, including during clinical trials. <http://www.aafp.org/news-now/health-of-the-public/20100323rotarix.html> ■

IOM Report Says Primary Care Docs Lack Knowledge About Hepatitis B, Hepatitis C

Committee's Call for Increased Screening Conflicts With AAFP, USPSTF Recs

According to a report from the Institute of Medicine, or IOM, inadequate resources are being allocated to viral hepatitis prevention, control and surveillance programs in the United States, and a lack of awareness among health care professionals and people in at-risk populations is creating a barrier to prevention and control efforts.

Many health care providers — especially primary care health professionals — are unaware of the high prevalence of hepatitis B virus, or HBV, and hepatitis C virus, or HCV, infection in some U.S. populations and often fail to identify infected individuals and those at risk for infection so they can be managed appropriately, says the report.

The report singles out primary care providers (e.g., physicians, physician assistants and nurse practitioners) and social services providers (e.g., staff of drug treatment programs, needle-exchange programs and immigrant services centers) as having “generally poor” knowledge of chronic hepatitis B and hepatitis C.

The IOM committee defined a two-part process for identifying infected individuals:

- risk-factor screening (i.e., determining whether a person is at risk for being chronically infected or becoming infected with HBV or HCV, such as by being born in a country where the disease is prevalent or engaging in specific high-risk behaviors, including illicit drug use and having multiple sexual partners) and
- serologic testing (i.e., laboratory testing of blood specimens for biomarker confirmation of hepatitis B or hepatitis C viral infection).

Both the AAFP and the U.S. Preventative Services Task Force, or USPSTF, recommend using serologic testing to screen all pregnant women for HBV during their first prenatal visit. However, the two groups recommend against routinely screening the general asymptomatic population for chronic HBV infection, saying that strategies used to identify individuals at high risk have poor predictive value because 30 percent to 40 percent of infected individuals don't have any easily identifiable risk factors.

The IOM report is similarly critical of primary care health professionals' knowledge about hepatitis C, although it acknowledges that far less research has been published on this topic.

The AAFP and the USPSTF recommend against routine screening for HCV infection in asymptomatic adults who are not at increased risk. In addition, the Academy and the task force have found insufficient evidence to recommend for or against routine screening for HCV infection in adults at high risk for infection. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20100407iom-hep-rpt.html>.

Most Primary Care Physicians Lack Resources to Fight Obesity, Surveys Find

By James Arvantes

Most primary care physicians lack the resources to appropriately counsel their patients about weight management, creating a situation in which many patients who are overweight or obese are not receiving the right type of information about how to manage their condition. That's according to two separate but companion reports commissioned and released by the Strategies to Overcome and Prevent, or STOP, Obesity Alliance.

Nearly 90 percent of primary care physicians believe it is their responsibility to help patients who are overweight or obese lose weight. That's according to research conducted by Harris Interactive that found 72 percent of 290 primary care physicians surveyed said no one in their practice had been trained to deal with weight-related issues.

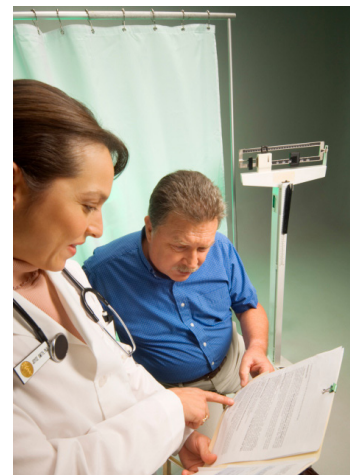
The survey shows that even if primary care physicians had more time to discuss weight with their patients, many would “still be missing needed information about weight-loss tools and existing programs,” said Richard Carmona, M.D., a former U.S. surgeon general and the health and wellness chair of the STOP Obesity Alliance.

Primary care physicians should check patient height and weight at every office visit, said Carmona. One of the overriding goals is to use this type of information as a tool to “drive your patients toward a better health status,” he said.

But, he adds, physicians have to track progress. “Is this actually something (physicians) note on the chart,” Carmona asked, “or do they say, ‘You gained five pounds since last year, and I notice your blood pressure is a little higher and your lipids are a little higher?’”

The STOP Obesity Alliance also recently released a white paper highlighting approaches to help address obesity within primary care. The paper describes obesity as a “complex condition caused by a combination of factors with no ‘one solution fits all’ answer.” The complexity of the issue and the treatment of the condition make care coordination and integration essential, according to the white paper.

“Often, patients are best or more successfully treated by simultaneous interventions from health professionals in many fields,” says the paper. It outlines five areas that could lead to significant advancements in patient outcomes in the area of obesity, including: monitoring weight, health indicators and risk; assessing patient motivation; defining success; increasing integration and care coordination; and implementing electronic health records. ■



For more information, visit <http://www.aafp.org/news-now/professional-issues/20100330stopalliance.html>.

IRS to Refund Payroll Taxes for Some Medical Residents

Agency Concedes That Residents Met Student Exception Requirements

The Internal Revenue Service, or IRS, has decided that medical residents are exempt from paying Social Security and Medicare payroll taxes for tax periods that ended before April 1, 2005.

In a March 2 press release, the IRS said it has accepted the position that medical residents are excluded from the taxes based on the student exception.

Hospitals, medical schools and medical residents began filing refund claims for Federal Insurance Contributions Act, or FICA, taxes in the 1990s, arguing that residents are students who are eligible for the student exception to FICA taxes.



These taxes fund Social Security and Medicare.

The IRS, which disputed

the argument that the student FICA exception applied, held the claims until the issue was resolved. After losing several court cases on the matter, the IRS made an administrative determination to accept the position that medical residents are excluded from FICA taxes for tax periods before April 1, 2005. This is the date when new IRS regulations went into effect that specifically exclude any employee who works 40 hours a week or more for a school, college or university from eligibility for the student exception.

Institutions that employed medical residents, as well as individual medical residents, are

eligible to receive refunds if they filed FICA refund claims on time. The period for filing a claim has expired, but individuals who were medical residents before April 1, 2005, and who did not file an individual FICA refund claim, may be covered by a FICA refund claim filed by their employer. Contact your employer or former employer to see if they filed a FICA refund claim.

The IRS will contact hospitals, universities and medical residents who filed refund claims for FICA taxes regarding their refunds. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100402irsrefunds.html>.

MedPAC Recommends New Performance-Based System for GME Funding

System Would Be Funded Through Existing Excess IME Payments

The Medicare Payment Advisory Commission, or MedPAC, has approved five recommendations aimed at improving graduate medical education, or GME, through Medicare payments to teaching hospitals. Its primary recommendation is that Congress should authorize HHS to establish a performance-based GME program that would start in three years.

According to a presentation made during MedPAC's April 1-2 meeting, funding for the performance-based GME program would come from removing \$3.5 billion in indirect medical education, or IME, funding and redirecting that sum to the new performance-based GME program.

The \$3.5 billion is an amount that exceeds what presenter Cristina Boccuti, M.P.P., a principal policy analyst for MedPAC, called the "empirically justified" amount intended to cover Medicare's share of higher patient care costs associated with teaching.

Thus, she said, no increase in Medicare funding would be required to implement the proposed program.

Currently, Medicare payments to teaching hospitals do not vary based on the performance of residency programs or their supporting institutions in fostering the workforce skills needed in a health care delivery system that holds costs in check while maintaining or improving quality.

"Medicare makes no distinction in its payments for low- or high-performing programs and institutions," Boccuti said during the meeting.

"The commission has discussed a need for Medicare payments to take a stronger role for encouraging delivery system reform," she

added. "And that is where we are starting to pair this."

Incentive-based payments should evolve through consultations with representatives from education, insurer and provider communities and should be scaled to reflect performance levels, according to Boccuti.

Boccuti noted during the meeting that the Accreditation Council on Graduate Medical Education has been moving to increase empha-



sion on educational outcomes assessment as part of its accreditation process, specifically by integrating outcomes-based objectives into its core competencies.

However, a 2009 RAND Corp. working paper that assessed how internal medicine residencies are adapting their teaching to prepare physicians to practice within the current health care delivery system found that the residency programs have been slow to achieve these goals. One reason stipulated in the paper was varying levels of support from the residencies' institutional sponsors.

Scaling incentive-based payments to reflect performance levels of residency programs and their sponsoring institutions should help shore up that support, Boccuti said. Moreover, she added, delaying the launch of the new performance-based program for three years would allow time for HHS to develop standards for distributing the funds. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100414medpac-gme.html>.

MGMA Research Results

Many Physicians Think Meeting ‘Meaningful Use’ Criteria Could Slow Productivity

Many physician practices say they expect to experience a drop in productivity during the coming months as they attempt to meet new government regulations for “meaningful use” of electronic health records, or EHRs, according to new research from the Medical Group Management Association, or MGMA.

Nearly 68 percent of 450 physician practices that responded to a questionnaire from the MGMA said that changes in practice operations necessary to meet the federal government’s 25 proposed criteria would slow physicians’ daily work. In addition, 31 percent said productivity would decrease by more than 10 percent.

Physicians have a financial stake in meeting the federal criteria for EHRs because doing so will make them eligible for Medicare and Medicaid incentive payments beginning in 2011.

Of the practices that responded to the survey, nearly 99 percent were aware the federal government was offering incentives to encourage physicians to implement and use EHRs in a meaningful way. And nearly 82 percent of respondents said they planned to implement an EHR during the next six to 36 months.

The MGMA survey also found that

- slightly more than 41 percent of practices said their EHR vendors had told them that their systems would allow providers to qualify for incentives,
- nearly 83 percent of practices said it was likely or very likely that some providers would attempt to qualify for bonuses by the end of 2011, and
- just more than 61 percent of practices said the incentive payments would help their practice establish or upgrade its EHR systems.

In addition, nearly 46 percent of respondents said it would be difficult or very difficult to meet the proposed requirement that 80 percent of all patient requests for an electronic copy of the patient’s health information be fulfilled within 48 hours.

Nearly 54 percent of respondents said they would have a difficult or very difficult time attaining the requirement that 10 percent of all patients have electronic access to their health records within 96 hours of the information becoming available. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100414mgmausecriteria.html>.

Macy Foundation

Conference Report Offers Multiple Proposals for Future of Primary Care

By Barbara Bein

A new conference report on primary care in the United States notes that “the lack of a strong primary care infrastructure across the nation has had significant consequences for access, quality, continuity and cost of care in this country.” And it adds that to meet the needs of an aging population with higher care requirements and expectations, health care models and education need to be developed to ensure the country has a strong primary care base.

The conference report resulted from a national conference — Who Will Provide Primary Care and How Will They Be Trained? — which was sponsored by the Josiah Macy Jr. Foundation.

The 49 conference participants recommended that medical schools, nursing schools and other schools for the health professions work to increase the number of students and trainees who choose primary care careers by

- establishing programs to prepare and attract a more socioeconomically, racially and geographically diverse student body;
- revising admissions standards to include more emphasis on social science and humanities and the personal qualities of applicants;
- implementing and expanding scholarship and loan repayment programs in partnership with health systems, government agencies and communities for those pursuing careers in primary care;
- promoting early exposure to primary care practices for all students;
- creating longitudinal immersion clinical experiences in community primary care settings;
- implementing special primary care tracks for students and trainees; and
- establishing and strengthening departments of family medicine within schools of medicine.

Conference participant and AAFP member, John Fogarty, M.D., dean of the Florida State University College of Medicine in Tallahassee, told *AAFP News Now* that he was pleased with the medical education recommendations.

“The consistent discussion by medical schools of attracting and recruiting the ‘best and the brightest’ has, I believe, led to admissions policies that emphasize science over humanities,” said Fogarty. “Focusing only on MCAT (Medical College Admission Test) scores misses some remarkable students who are from rural or underserved areas and who are more likely to return to (those areas) some day.”

He added, “More emphasis on ambulatory experiences, clinical rotations/experiences in community rather than medical center settings, and longitudinal experiences where the focus is on relationships rather than the disease or diagnosis is critical to developing the kind of doctors that America really needs.”

Conference participants also included recommendations about changing the way primary care is valued, delivered and integrated into the health care system. They recommended that financial and other incentives be created for the development of innovative models of primary care and the advancement of knowledge about outcomes. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100331macyreport.html>.



MedPAC Reviews Medical Malpractice Reforms

By James Arvantes • Washington

The ongoing failure of the current medical malpractice system has led to an increase in both direct and indirect medical costs, prompting consideration of alternative malpractice initiatives at the state and federal levels, according to a report from the Medicare Payment Advisory Commission, or MedPAC.

Senior MedPAC analyst Ariel Winter, M.P.P., who presented the report's findings during a MedPAC meeting here in early April, said the medical malpractice system has not done a good job of compensating patients who are harmed by medical negligence. In addition, the current system has failed to reduce medical errors.

"In fact, the adversarial and punitive nature of the (current) malpractice system may hamper efforts to improve patient safety by discouraging transparency

around errors," said Winter.

Moreover, periodic spikes in malpractice premiums have led to reductions in affordability and availability of coverage, further contributing to direct and indirect medical costs.

Thomas Dean, M.D., of Wessington Springs, S.D., the only family physician on MedPAC, noted during the question-and-answer segment of the meeting that the indirect forces of medical malpractice are "very powerful, and the fear that pervades the physician community is not a rational response oftentimes."

"I work at a community health center, and I am covered under the federal tort claims act, so I don't even have to worry about buying insurance," said Dean. "But it still affects my practice."

Winter also described various state reforms outlined in the report, including caps on

noneconomic damages, pretrial screening panels, attorney fee limits, periodic payments and statutes of limitations, among other reforms.



Only caps on noneconomic damages have an effect on key outcomes, Winter said. "There is evidence in the literature that caps reduce the average payment per malpractice claim in

the range of 20-30 percent," she said. "They modestly constrain the growth of premiums over time, they modestly improve physician supply, and they reduce defensive medicine for some services."

Winter also discussed two innovative reform approaches, including modifications to the current system and alternative compensation systems.

"These approaches have had limited or no implementation in the United States, and, therefore, there is a very small evidence base," said Winter. "However, based on the limited evidence and theoretical predictions, the authors of the report concluded that many of these reforms appear promising and may merit further experimentation." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100414medpactortreform.html>.

Certification Process for EHRs Set to Expand

CCHIT Makes Changes to Prepare for New Government Program

By Sheri Porter

The Certification Commission for Health Information Technology, or CCHIT, has announced that it will adjust its current certification programs for electronic health records, or EHRs, as a result of new regulations in the American Reinvestment and Recovery Act, or ARRA, which was passed in 2009.

The organization said it will separate its CCHIT Certified program, which has been operational since 2006, from its Preliminary ARRA program, which launched in October.

In addition, CCHIT said it would

- reopen vendor applications and product testing on April 7,
- update CCHIT's Web site to clarify the status and objectives of both programs, and
- prepare for a prompt conversion of the Preliminary ARRA program into the permanent federally approved program.

CCHIT has been the sole entity designated by the federal government as a recognized certification body for EHRs since October 2006. But CCHIT Communications Director Sue Reber expects multiple certifying organizations to come onboard in the near future because the ARRA mandates the development of a national EHR certification program.

HHS recently announced a proposed rule calling for the estab-

lishment of a temporary certification program that eventually will be replaced by a permanent program.

According to the certification process outlined by the Bush administration, "we were a recognized certification body, and we continue in that status today," said Reber.

However, she added, the Obama administration will use a different certification process to qualify products under the ARRA.

Reber noted that HHS has not yet released final rules and applications for the new accreditation process, "but as soon as they do, our intent is to apply."

She added that vendors who have CCHIT's Preliminary ARRA certification will be well prepared to qualify for future certification and will be fast-tracked on a priority basis by CCHIT.

Reber said it's important for CCHIT to prepare vendors now so physicians will be able to get their hands on certified EHR products quickly in the future. Physicians who implement an EHR to qualify for government incentives "are on a short timeline," said Reber.

The first physician incentives are scheduled for payout in 2011. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100401cchitchanges.html>.

University of Florida Research

Alcohol/Energy Drink Combo Leads to Higher Intoxication, Driving Risk

By Hannah DeClerk

Energy drinks combined with alcohol can create a lethal combination in college-age adults, according to a recent study by University of Florida researchers that was published in *Addictive Behaviors*.

Researchers focused on evaluating alcohol and drug use in young adults by surveying 1,255 exiting patrons at bars that cater specifically to college students. The results indicate that when participants combined energy drinks and alcohol, they were three times more likely to leave the bar highly intoxicated and were four times more likely to drive after drinking.

The study's lead researcher, Dennis Thombs, Ph.D., an associate professor in the University of Florida College of Public Health and Health Professions' Department of Behavioral Science and Community Health in Gainesville, told *AAFP News Now* that one of the major risks in combining energy drinks with alcohol is that consumers perceive that they are OK to drive when they are not.

"Caffeine appears to reduce subjective perceptions of alcohol intoxication, but it does not ameliorate the performance deficits produced by alcohol," said Thombs. "(Individuals) are more

alert but just as behaviorally impaired as if they did not consume caffeine."

Among those who completed the entire survey process, 6.5 percent reported consuming energy drinks mixed with alcohol during the past 12 hours. Those participants were almost three times more intoxicated than those who stuck with alcohol alone, according to the study.

Researchers found that when mixing energy drinks and alcohol, users may become desensitized to the symptoms of alcohol intoxication. This may increase the potential for alcohol-related harm.

FP Steven Masley, M.D., medical director at the University of South Florida in St. Petersburg, told *AAFP News Now* that he does not see a problem with energy drinks, per se.

"From a health perspective, if a person keeps drinks to a minimum, there is really no high risk," said Masley. College-aged adults may feel better when they have caffeine because they often are overly tired, but when energy drinks are mixed with alcohol, the combination offsets normal fatigue. "There is now a 7.9 percent increase (in these individuals) staying out later, leaving a bar drunk and believing (they are) OK to drive," said Masley.

He noted that he has incorporated an "age-appropriate" survey about the issue in his practice.

"Asking if my patients mix alcohol and energy drinks is an important question," said Masley. "It is like asking any high-risk question; it is like asking if you smoke. These are all very warranted questions for adults to ask their college-aged patients."

Masley said that if a patient indicates that he or she does mix alcohol with energy drinks, then Masley will ask that patient to give his or her perception about mixing the two. "It is important to let the patient clarify why he is engaging in such a high-risk behavior," said Masley. "After I let the patient talk, I then go in and ... explain why they should not be mixing the two together."

According to Masley, the most important step in building the physician/patient relationship among college-aged patients is allowing them to explain their points of view. ■

For more information, visit <http://www.aaFP.org/news-now/clinical-care-research/20100401alcoholenergydrinks.html>.

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Passage of Health Care Reform Only a Starting Point for Physicians

AAFP President Expects Physicians to Be Closely Involved in Implementation

By James Arvantes • Washington

Physicians need to be closely involved as the recently enacted health care reform legislation begins to take effect, according to AAFP President Lori Heim, M.D., of Vass, N.C. "It is the implementation of (health care reform) that we have to be intimately involved with," said Heim, during a March 22 Capitol Hill rally sponsored by Doctors for America. "We are the ones who know how this system should work. We are the ones who have all of the stories about the patients. We know the programs that need to be modified."

Heim told the gathering of more than 300 physicians, nurses and other health care professionals that "there is some great language in the (recently enacted) bill, but there is much that needs to be improved."

During her remarks, Heim

acknowledged the presence at the rally of other primary care organizations, as well as subspecialists and nursing organizations. "This is the team that takes care of this nation," she noted.

Heim said passage of the health care reform bill would end some of the worst discriminatory practices on the part of the insurance industry. "There is no reason why my intensive care unit is filled up with patients who shouldn't be there except for the fact that they couldn't even afford an office visit to get a \$4 a month antihypertensive," Heim said.

Rep. Jim McDermott, D-Wash., a psychiatrist by training, also addressed the rally, calling for free tuition for medical school students who attend state medical schools. "This simple proposal would absolutely change the dynamic and the

delivery of health (care) in this country," said McDermott.

He added that today's medical students are constrained by such large amounts of debt when they graduate from medical school that it limits their options.

Heim also attended a March 24 Capitol Hill health care rally that was sponsored by the AARP and which featured Senate Majority Leader Harry Reid, D-Nev., and Sens. Max Baucus, D-Mont.; Tom Harkin, D-Iowa; Chris Dodd, D-Conn.; and Robert Menendez, D-N.J.

In his remarks, Reid, who acknowledged the presence of the AAFP and other health care organizations there, said American seniors are among the biggest winners in the health care reform legislation. "This year, we



AAFP President Lori Heim, M.D., says during a rally on Capitol Hill that the enactment of health care reform will end some of the worst discriminatory practices on the part of the insurance industry.

James Arvantes/AAFP News Now

will finally start to crack down on insurance companies who think it is OK to charge someone a higher premium because they are old or because they have a pre-existing condition," Reid said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100324heim-hcr-rally.html>.

Patient-Centered Collaborative Puts Stakeholders in Position to Drive Changes

'Meaningful Use' Is Key to Improving Health, Efficiency, Says National Health IT Chief

The Patient-Centered Primary Care Collaborative, or PCPCC, has made major contributions toward reforming the nation's health care system by giving primary care physicians and other stakeholders the necessary information and tools to implement and sustain the patient-centered medical home, or PCMH. That was one of the key themes to emerge from a PCPCC stakeholders meeting in Washington on March 30.

Panelists and other participants at the meeting discussed numerous topics and issues, including the advancement of care coordination, the alignment of incentives for sustainable

value, practice transformation in the medical home and implementation of the medical home itself.

David Blumenthal, M.D., M.P.P., the national coordinator for health information technology at HHS, addressed the stakeholders meeting. He praised the collaborative for its forward-thinking approach to health information technology, or health IT, as a critical component of PCMH implementation. "You understood that information is the life blood of medicine, that any clinician is only as good as the information they have available to make decisions, and the best way, the most effective way to circulate that information is through electronic

health information systems," he told meeting participants.

Last year, Congress passed the American Recovery and Reinvestment Act of 2009, an economic stimulus package that made substantial investments in health IT education and training programs for primary care physicians. The legislation contained two operative words to enhance the support structure for health IT: "meaningful use."

"Meaningful use is the key, in my view, to unlocking the potential of not only health information technology but of primary care, specialty care, hospital care — indeed the potential for using that information in the most sophisti-

cated ways for the purposes of improving health and improving efficiency," said Blumenthal.

He also talked about the creation of a nationwide health information network made up of organizations that have agreed to share information in a secure way. Network participants could share information about outcomes, processes of care and effectiveness of care, said Blumenthal. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100412pcpcc-stkhltdrs.html>.

AS WE SEE IT

Voices From the AAFP

Guest Editorial

Physicians-in-Training Should Beware of the Potential Impact of Social Networking Site Posts on Professionalism

By George Harris, M.D., M.S.

During the past decade, the popularity of user-generated content on sites such as MySpace, Facebook, YouTube, Twitter and Flickr has escalated and become a normal component of many medical students' and residents' daily activities and interactions.

This type of communication allows them to promote, project and propagate themselves like never before. However, this mode of communication also has the capability of removing inhibitions and leading students and residents into trouble.

I have the unique perspective of working with medical students, as well as with family medicine residents at various levels of training. Nationally, students and residents have received media attention because of incidents of profanity, discriminatory language, depiction of intoxication and sexually suggestive material on social media sites. In addition, some students have posted information about patients, the care patients received and even specific patient encounters. This is occurring on campuses across the nation and not just in medical schools. However, for medical students and residents, such behavior leads to violations of professionalism and patient confidentiality that can have severe consequences.

These consequences can range from placing an undeserved "black mark" on a student's or resident's reputation to impugning the reputation of another student, colleague, peer, patient or faculty member. Social networking posts are public information, so posting such information could jeopardize careers or affect the ability to attend a chosen residency or obtain a job position. In addition, it can result in discrimination against a patient and limit his or her access to care.

The Accreditation Council for Graduate Medical Education has identified specific competencies that should be taught and achieved during medical school and residency training. These competencies are part of learning what it means to be a physician, including the obligation to maintain patient privacy and confidentiality and the importance of being ethical. These standards need to be taught at various levels of interaction, including in the classroom, the hospital, the clinic and on the personal computer.

A Dec. 22, 2009, study in the *New England Journal of Medicine* demonstrated that unprofessional behavior in medical school was a strong predictor of disciplinary action by a state medical board of a physician in medical practice. Common violations included drug abuse, unprofessional conduct, negligence and inappropriate prescribing. These physicians were likely to be disciplined for multiple violations.

In the study, unprofessional behavior was shown to be a better indicator of later discipline than more traditional measures, such as college admission test scores and poor grades early in medical school.

Patients want more from their physician than an effective treatment

or a correct diagnosis. Patients want a physician who has empathy, confidence, shows respect toward them and is thorough. Patients usually are not concerned about their physician's technical competence because it is difficult for them to assess. However, patient satisfaction usually rises when a physician demonstrates specific interpersonal skills that are tied to professionalism and quality of care.

Medical practices present an array of situations and decisions intertwined with personal demands and obligations every day. Each time you open the door, the patient on the other side represents a new encounter and a new opportunity to reveal your humanism and integrity.

The profession of medicine asks its members to possess not only the requisite scientific knowledge and clinical and technical skills, but also to have the integrity and goals to fulfill the oath taken, to serve with honor, and to dedicate themselves to the principles and responsibilities of the profession. Professionalism and humanism must be top priorities.

The curriculum in medical schools may need to develop to include a digital media component that teaches students about the risks of using social networks and the proper way to use these networks, privacy settings, and sharing patient stories that are de-identified and respectful. In addition, students should be taught how to do Web searches on themselves to see what is on the Internet for public consumption — including by residency program directors, future employers and future patients.

In addition, for those students and residents who choose to misuse these networks, medical schools need to have policies in place to address the incidents with appropriate consequences. ■

George Harris, M.D., M.S., of Lee's Summit, Mo., is the assistant dean for year 1 and 2 medicine at the University of Missouri-Kansas City School of Medicine and professor of medicine in the UMKC Department of Community and Family Medicine.

For more information, visit <http://www.aafp.org/news-now/opinion/20100407socialnetworkingimpact.html>.

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