



aafp NEWS NOW

May 2011 • Volume 7 • Number 5

the family physician's trusted source for news

AAFP Backs Legislation to Make Medicare Payment Process More Transparent, Accurate

The AAFP has thrown its support behind a House bill that is attempting to bring more accuracy and transparency to the process used to assign relative values to Medicare services.

Currently, the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, provides the only guidance on values for Medicare services, but the Medicare Physician Payment Transparency and Assessment Act, H.R. 1256, would require CMS to use alternative means of verifying values for medical services, as well.

"The mechanism for how (Medicare payment) codes are

evaluated has contributed to the devaluation of family medicine and primary care through the years,"

said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas. He added that it doesn't

seem likely the current RUC process will change this imbalance.

However, H.R. 1256, which was introduced by Rep. Jim McDermott, D-Wash., would require CMS to hire independent contractors to identify and analyze misvalued codes for medical services provided to Medicare beneficiaries and to conduct an annual review of these codes. This independent analysis would augment the work of the RUC and could result in greater accuracy and transparency, according to a March 30 press release from McDermott's office.

The AMA created the RUC
See AAFP Backs Legislation, page 2



AAFP, Chapters Create ACO Resources to Aid Family Physicians

By Sheri Porter

Accountable care organizations, or ACOs, represent a rising star in health care policy circles. That's why the Academy — in collaboration with six AAFP constituent chapters and with assistance from the North Carolina-based law firm of Smith Anderson — has created a set of resources to help FPs

understand the ACO model.

"Just about everybody is talking about ACOs," says Gail Jones, AAFP's manager of practice management. Jones served as program coordinator for the ACO resource project, which is called Practice Affiliation Options, and authored a number of the supporting documents.

"It's important for family physicians to become as knowledgeable as possible so they'll be able to ask — and answer — questions when a hospital wants to buy their practice or requests that they join an ACO," says Jones.

"It may not always be in a practice's best interest to do so," she adds.

"When family physicians understand their options, it puts them in a better position to assess their long-term strategic planning. These resources were written specifically for family physicians to equip them with the knowledge they need to make good business decisions."

See ACO Resources, page 2

MAY HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

MCAT Revisions. page 4
New recommendations for the Medical College Admission Test may result in an increase in family medicine students.

Data Repository. page 14
The AAFP is launching a clinical data repository pilot program designed to help improve practice revenue and quality.

SPECIAL REPORT

Getting Connected: EHRs
pages 6-9

AAFP Backs Legislation, *continued from page 1*

in 1991 to act as an expert panel in making recommendations to CMS on the relative values of CPT codes using the Resource-based Relative Value Scale mandated by Congress in 1989. According to McDermott, the RUC's recommendations are accepted by CMS and implemented more than 90 percent of the time.

The AAFP is not calling for the elimination of the RUC, said Goertz, but it has endorsed the McDermott bill as an alternative to the current process. He noted that the AAFP has for years asked the AMA to provide more primary care physician representation on the RUC and to provide greater transparency in terms of how the RUC's votes are taken. "But there does not appear to be movement in that direction," he said.

Currently, primary care physicians comprise only one-sixth to one-thirteenth of the RUC's 29 members, even though they provide about half of Medicare physician visits.

"Most people don't know this, but there is this small panel that decides behind closed doors what

the reimbursement rates will be for certain medical procedures," McDermott said in the news release. "For two decades now, this panel has been dominated by (sub)specialists who undervalue the essential and complex work of primary care providers and cognitive specialists, while often favoring unnecessarily complex, costly and excessive specialty medical services. The result of this is clear – there is a shortage of family doctors, patients don't necessarily get the services they need and medical costs are increasingly driven higher."

"Study after study has shown that primary medical care must be the foundation for a high quality, efficient health care system," said Goertz. "If we are to build up our primary care physician workforce to create this foundation, we need a system that recognizes and appropriately rewards the medical expertise and cognitive skills of primary care physicians. This legislation is an important step in that direction." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110405ruclegislation.html>.

ACO Resources, *continued from page 1*

The new ACO resources include two major pieces that were prepared and distributed by the AAFP

with considerable editorial and financial support from the California AFP, the Florida AFP, the Illinois AFP, the North Carolina AFP, the Ohio AFP and the Texas AFP.

One resource, titled "The Family Physician's Practice Affiliation Guide," notes that changes in health policy and reimbursement are making many private practice physicians consider affiliations with larger organizations.

The guide analyzes the reasons behind the trends, explores the pros and cons of various options, and gives a thorough analysis of the hospital employment model. According to the guide's introduction, "There are

compelling 'offensive' and 'defensive' reasons to consider integration and specific guideposts to assure a successful and sustainable partnership."

A second resource is packaged as "The Family Physician's ACO Blueprint for Success." Part one of the blueprint

walks readers through basic definitions, elements and benefits of an ACO. The second half provides readers with ACO strategies and analyses that specifically apply to family physicians and their practices.

"The development of the ACO model is a once-in-a decade opportunity for family physicians," says Gregory Griggs, M.P.A., EVP of the North Carolina AFP. "Primary care is not only at the center of the ACO model, it is the only specialty specifically required to make it work. Done

right, the ACO model can greatly benefit patients, family physicians and the entire health care system by improving health care quality and reducing cost."

Other materials on the website family physicians may find valuable include

- Resources for Employed Physicians,
- State Restrictions on Owning a Practice,
- Interested in ACOs? and
- Other Practice Affiliation Options.

According to Jones, the Academy will continue to assess and update the materials as ACO regulations take shape and members' needs are identified.

She urges members to check in with their local chapters for additional resources that are state-specific. "State laws vary when it comes to issues such as practice ownership," she says. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110401acoresources.html>.



The Family Physician's Trusted Source for News May 2011

Volume 7 • Number 5

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

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

Energy and Commerce Committee Seeks Academy's Input on Medicare Physician Payment Reform

As the effort to eliminate or reform the sustainable growth rate, or SGR, formula continues, the House Energy and Commerce Committee is asking the AAFP and other organizations to submit ideas and proposals for reforming the system. Specifically, the committee is asking the organizations for ideas on how to reform the Medicare physician payment system to reduce spending, pay physicians and other providers fairly, and provide a fair value for services.

The committee, which plans to hold a hearing on the issue in early May, sent a bipartisan letter to the AAFP and 50 other organizations asking them to submit ideas and suggestions that can be translated into legislative proposals.

"The current payment system for physician services in Medicare is a major threat to the integrity of the program and the ability of America's seniors to access quality health care," says the committee in the letter to the AAFP. The SGR has called for steep reductions in Medicare payment rates during the past several years, forcing Congress to intervene at the last minute to block the cuts. Without another congressional fix by the end of this year, physicians are facing a 29.5 percent reduction in payments on Jan. 1, 2012.

However, according to the letter, "The House Energy and Commerce Committee is determined to achieve a permanent, sustainable solution to the Medicare physician payment problem this year."

"The current payment system for physician services in Medicare is a major threat to the integrity of the program and the ability of America's seniors to access quality health care."

— House Energy and Commerce Committee

The letter adds, "The problems preventing reform of the payment system are twofold: a budgetary hole of \$300 billion and a lack of consensus among experts and stakeholders about what kind of payment system should replace the Medicare physician fee schedule. It is the latter question on which we invite your comment."

The committee stresses in its letter that, "Unless we begin the process of developing a long-term solution, we will once again be faced with the unwanted choice of extending a fundamentally broken payment system or jeopardizing access for Medicare beneficiaries."

"We cannot let either happen," says the letter.

According to AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, the committee's request for proposals demonstrates that it is "at least taking a positive step toward a longer-term, if not a permanent (payment) solution."

AAFP President Roland Goertz, M.D., of Waco, Texas, will testify on this issue during a May 5 hearing on Capitol Hill. AAFP principles support Medicare payment reform that, at the very least, recognizes and attempts to reduce the discrepancy in payment between primary care and nonprimary care physicians. It also supports a blended payment model to better support and reward care coordination and the patient-centered medical home. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110330committeeinput.html>.

As Affordable Care Act Turns a Year Old, AAFP Testifies About Benefits of Law, Improvements Needed

As the Patient Protection and Affordable Care Act reached its one-year anniversary, the AAFP reiterated its support for the health care reform law and vowed to continue working to improve the law for family physicians and their patients.

"The AAFP supported this legislation for many reasons, not the least of which is its goal of achieving health coverage for nearly everyone in this country," said the AAFP in written testimony to the Senate Finance Committee. "In addition, the (Affordable Care Act) implemented numerous strategies for improving health care delivery and making more available affordable, high-quality care."

The testimony, which was

produced for a March 16 hearing on lessons learned during the first year of the Affordable Care Act, pointed to the AAFP's 20 years of efforts to broaden health insurance coverage as part of its Health Care for All policy and noted that many of the provisions of that policy were included in the Affordable Care Act.

However, the AAFP emphasized, "Health insurance coverage alone cannot ensure access to care." Although the health care reform act includes provisions to modernize several federally funded health care programs, including Medicare, Medicaid and the Children's Health Insurance Program, payment levels in these programs must cover provider

costs, said the AAFP.

"The Medicare physician payment system, in particular, must be fundamentally reformed to eliminate the sustainable growth rate (SGR) formula that has required repeated Congressional interventions to prevent steep annual payment cuts that threaten access to services."

The Academy also expressed concerns that the Affordable Care Act "might not accommodate privately owned, small and medium-sized physician practices."

In addition, the AAFP testified that although the Affordable Care Act contains provisions that acknowledge and recognize the value of primary care, these provisions may not go far enough.

In summary, the AAFP tes-

timony noted that although the Affordable Care Act has made "important strides" toward ensuring insurance coverage for all Americans and encouraging better health care delivery models, the Academy has identified issues that it will continue to work on, including

- constructive health insurance reform for everyone in the United States;
- changes in health care delivery and payment systems that ensure high-quality, affordable care for patients; and
- medical education reform that will rebuild the primary care physician workforce. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110322acaturnsone.html>.

Proposed MCAT Revisions Give More Weight to Applicants' Social Sciences Knowledge, Personal Traits

Preliminary recommendations for a new version of the Medical College Admission Test, or MCAT, include key changes to the content and format of the current MCAT that can help medical schools select students who are more likely to go into family medicine and primary care, say AAFP medical educators.

According to a March 31 news release from the Association of American Medical Colleges, or AAMC, the proposed recommendations call for testing the behavioral and social sciences concepts that underlie students' capacity to learn about the human and social issues of medicine.

The revamped recommendations also propose revising the current verbal section of the MCAT to test the way examinees reason through passages in ethics and philosophy, cross-cultural studies, population health, and other subjects, thus communicating the need for students to read broadly in preparation for their medical education.

Moreover, the recommendations call for the AAMC to gather information about applicants' personal characteristics, such as integrity and a service commitment.

Perry Pugno, M.D., M.P.H., AAFP vice president for education, said a revised MCAT will be helpful to family medicine and primary care.

"The new framework to the MCAT will clearly give admissions

committees more information to help them identify those applicants whose personal characteristics forecast a greater likelihood of seeking careers in family medicine," he told *AAFP News Now*.

Wendy Biggs, assistant director of the AAFP Division of Medical Education, agreed.

"We know some demographic and educational factors that appear to predict whether a medical student will enter primary care, such as female gender, having a rural background or attending a publicly funded medical school," she told *AAFP News Now*.

"Research also has suggested that students choosing primary care are likely to be altruistic and possess a commitment to service," Biggs added. "The proposed changes in the MCAT may be advantageous for students with these values who will be more likely to choose family medicine as their future career."

According to the news release, the revised MCAT aims to balance the exam's focus on the natural sciences with testing applicants' critical analysis and reasoning skills. It also acknowledges the importance of behavioral and social sciences by, among other things, adding a specific test of these concepts. ■

For the complete story, visit <http://www.aafp.org/news-now/education-professional-development/20110411mcatrev.html>.

Physician Re-entry Programs Get Family Docs Back Into Practice

By Barbara Bein

After taking a break from family medicine for several years, family physicians Russell Brofer, D.O., of Arlington, Texas, and Liesa Harte, M.D., of Austin, Texas, decided to return to full-time practice. However, because they had let their medical licenses lapse, they found it wasn't simply a matter of hanging out an FP shingle. They both needed to complete a physician re-entry program. Fortunately, one such program was nearby.

For Brofer, the John Peter Smith, or JPS, Physician Re-entry Program in Fort Worth, Texas, allowed him to return immediately to a position with his former employer, CareNow. For Harte, the JPS program gave her the confidence to establish her own personalized medicine practice.

Although both Brofer and Harte made their transitions relatively easily, other physicians

don't have as smooth a road. In fact, the AMA recently announced the release of new recommendations designed to improve the re-entry process for physicians after an extended absence.

In its recommendations, the AMA defines physician re-entry as "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment."

There are a number of reasons why a physician might take a voluntary leave of absence from clinical practice, including family issues; personal health reasons; career dissatisfaction; or the pursuit of alternate careers, such as administration, military service and humanitarian leave.

For those physicians, the United States does not have a

comprehensive physician re-entry system, according to the AMA report, which lists several barriers to re-entry, including

- lack of information on the process of and requirements for re-entry,
- high monetary costs of participating in re-entry programs,
- lack of geographical access to the limited number of programs available, and
- lack of consistency in state medical licensing laws and regulations.

The AMA recommendations offer five principles intended to provide a coordinated approach to physician re-entry:

- Ensure that there is a comprehensive, transparent and feasible regulatory process for physicians to return to clinical practice.
- Develop policies that assure the quality of re-entry programs and the readiness of the programs'



graduates to resume practice.

- Create an evidence base that can be used to inform policymakers, re-entering physicians and re-entry program development.
- Develop means to ensure that a physician re-entry system is financially feasible.
- Ensure that all stakeholders participate in planning for a physician re-entry system. ■

For the complete story, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20110323docreentry.html>.

Academy Joins ACOG, Others in Blasting Price of Drug Used to Reduce Preterm Birth Risk

FDA Won't Stop Pharmacies From Compounding Cost-effective Equivalent

The AAFP and other health care organizations that focus on providing care for pregnant women and their children are applauding the FDA's decision to not prevent compounding pharmacies from continuing to produce 17-hydroxyprogesterone caproate, or 17P, for the prevention of preterm births.

In an April 1 joint statement developed by the American College of Obstetricians and Gynecologists, or ACOG, in conjunction with seven other organizations, including the Academy, the groups also criticize manufacturer KV Pharmaceutical Co. for its plan to charge \$690 per dose for Makena, its branded version of the medication.

"Although there are clear ben-

efits to having an FDA-approved version of 17P, there is no evidence that Makena is more effective or safer than the currently used compounded version," said the statement. "In fact, the evidence used to obtain FDA approval for Makena relied primarily on data obtained using the compounded product."

Compounding pharmacists produce 17P at a cost of \$10 to \$20 per dose, according to a March 17 letter from Sens. Amy Klobuchar, D-Minn., and Sherrod Brown, D-Ohio, to the Federal Trade Commission, or FTC. In their letter, the two senators asked the FTC to investigate "anticompetitive conduct" by KV Pharmaceutical.

In an accompanying news release, Brown referred to the

company's actions as "price-gouging" that "undermines public health and fleeces taxpayers," and Klobuchar called for the FTC to ensure that KV Pharmaceutical "isn't taking advantage of (the FDA's) orphan drug determination to monopolize the market and engage in price-gouging."

The FDA approved Makena in February under its accelerated approval program and gave KV Pharmaceutical seven years of exclusivity under the Orphan Drug Act, which is intended to spur pharmaceutical firms to invest in producing drugs and biologics for rare conditions and diseases. Because 17P is a sterile injectable and there is a risk of contamination with compound-

ing such medications, the availability of an approved product is thought to provide greater assurance of patient safety.

However, the FDA said March 30 that it will not prevent compounding pharmacies from making 17P. The agency's statement followed an announcement that TherRx Corp., a subsidiary of KV Pharmaceutical, planned to charge \$1,500 per dose for Makena.

Also in its statement, the FDA flatly denied claims KV Pharmaceutical is purported to have made in letters to pharmacists — specifically, that the agency planned to enforce the manufacturer's exclusive rights to the drug. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20110404makenacost.html>.

In Brief *Health of the Public Digest*

Risk to Fetuses Prompts Citalopram, Finasteride Recall

Greenstone LLC is recalling two generic drugs because of potentially dangerous labeling errors made by a third-party manufacturer. The recall involves 100-count bottles of 10-mg citalopram tablets and 90-count bottles of 5-mg finasteride tablets. Both recalled products are labeled with lot number FI0510058-A. Greenstone, which is a subsidiary of Pfizer Inc., said in a March 26 news release that bottles labeled as the depression medication citalopram actually may contain finasteride, which is used to treat benign prostatic hypertrophy and male pattern baldness. According to the company, women who are or may become pregnant should not take or handle finasteride because of the possible risk of side effects, which may cause abnormalities to the external genitalia of a developing male fetus. <http://www.aafp.org/news-now/health-of-the-public/20110330greenstonerecall.html>

Risk Posed by Popular Teething Meds Prompts FDA Warning to Parents, Physicians

Family physicians and other health care professionals who provide care for infants may soon be fielding questions from parents about how best to soothe children who are teething. That's because the FDA issued a safety announcement on April 7 that warns parents and caregivers to not give OTC gel or liquid benzocaine products,

such as Anbesol and Orajel, to children younger than 2 years old unless directed to do so by a physician. The agency's action comes in response to nearly two dozen reports of methemoglobinemia, a rare but potentially fatal condition in which the amount of oxygen carried through the bloodstream is greatly reduced, stemming from use of these medications. <http://www.aafp.org/news-now/health-of-the-public/20110412benzocaine.html>

AAFP Joins ANA, Others in Urging Clinicians to Follow New Tdap Recommendations

The AAFP has signed on to a letter drafted by the American Nurses Association that supports recent recommendations from the CDC's Advisory Committee on Immunization Practices, or ACIP, for adolescent and adult pertussis vaccinations. The ACIP is recommending that children ages 7 through 10 years who did not complete the recommended childhood series of diphtheria and tetanus toxoids and acellular pertussis, or DTaP, vaccine receive a catch-up dose of tetanus, diphtheria and acellular pertussis, or Tdap. The ACIP also recommended that adults ages 65 and older who have close contact with infants receive a dose of Tdap. A dose also may be given to people in this age group who have not previously received Tdap. <http://www.aafp.org/news-now/clinical-care-research/20110328pertussisltr.html> ■

Health IT Can Make Good Family Medicine Practices Even Better

Two Family Physicians Give EHRs High Marks

By Sheri Porter • Platte City, Mo.; Spring Hill, Kan.

A national conversation on the value of health information technology, or health IT, and electronic health records, or EHRs, is taking place as the federal government continues to push physicians to adopt the technology via the American Recovery and Reinvestment Act and the Patient Protection and Affordable Care Act.

Talking about the benefits of health IT, however, is one thing. Seeing how family physicians actually use the technology in a busy family medicine practice is quite another, particularly as FPs are on the front lines of implementing EHRs.

That's why *AAFP News Now* wanted to spend time with family physicians who are actively engaged in using health IT. We wanted to see firsthand if EHR systems really could increase practice efficiencies and the quality of patient care family physicians deliver.

Missouri FP Uses Health IT to Engage Patients

"The computer is a window to the world. You have everything at your fingertips," says David Voran, M.D., of Platte City, Mo. "The minute you sit down and turn the screen to face the patient, you have the patient." Period.

AAFP News Now recently paid a visit to Heartland Clinic of Platte City, a physician-led clinic that includes family medicine, pediatrics, internal medicine and specialty clinics. Voran and his family physician partner, Ann Riggs, D.O., comprise the family medicine component of the clinic.

Voran is much more than a family physician who's a fan of EHRs. He's known as the "champion" of innovative technology at the clinic, and he uses all available resources to develop health care partnerships with his patients.

"I want patients to be in charge of their health," says Voran. He's standing in the middle of his private office surrounded by no less than seven computer screens of varying sizes. He's constantly testing and tweaking and experimenting to find what best serves his staff and his patients.

Every patient has a "patient portal," and Voran communicates often and effectively through this secure messaging system. He says he eliminates eight to 10 office visits a week because he can deal with so many patient questions — such as prescription refills — electronically.

Solo Kansas Doc Relishes EHR Efficiencies

About 25 miles south of Kansas City, Mo., Jerad Widman, M.D., of Spring Hill, Kan., is nearly six years into his solo practice and has used an EHR since the day his practice opened.

"While no solution is perfect, compared to the paper charts I used in residency, the positives I gain with my EHR ensure that I'll never go back to paper," says Widman.

Spring Hill Family Medicine has an active patient panel of more than 1,860 patients and boasts about its efficient EHR system. Widman sees about 95 patients a week and models his practice with patient-centered medical home concepts in mind. "It's hard to imagine how I would do this work without an EHR," he says.



David Voran, M.D., helps patient Melissa Smith understand her hip pain by showing her visuals of human anatomy.

Sheri Porter/AAFP News Now

For example, when a patient with diabetes is overdue for a hemoglobin A1c, the EHR "rules manager" alert system goes to work. As soon as the patient's electronic chart is opened — and often it's by the receptionist who has the patient on the phone making an appointment — an alert pops up. "Even if the patient is calling in because they have a cold, the receptionist is able to say 'Oh, by the way, you are overdue for your diabetes follow-up, as well,'" says Widman.

An EHR query also allows Widman to see which of his patients with chronic conditions, such as asthma or hypertension, need follow-up care. "Of course, with our ultimate goal of partnership in care, we prefer that they would have scheduled on their own," says Widman. "But we're able to contact them and get them back in the loop to optimize their care and promote their long-term health."

Ditto for wellness care. "We're able to identify patients who haven't had a physical in two years," says Widman. "We can make proactive contact with them and bring them back in for that physical. Typically, we identify one or two issues they didn't even realize needed to be addressed," he adds.

Tracking quality measures is also an uncomplicated task, and the EHR greatly simplifies the reporting requirements Widman needs to follow to qualify for incentives through CMS' Physician Quality Reporting System.

Widman says his practice is ranked in the top tier of hospital and insurance company quality reporting markers "on all measures for all conditions with very rare exceptions — no matter what the condition." He credits his staff, his patients and his EHR.

"Because of the efficiencies of the EHR, we're able to provide quality care — consistently," says Widman. ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401fpehrstories.html>.

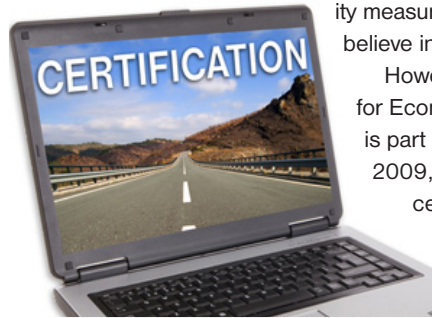
Certified EHRs Drive Incentive Payment Program

By Sheri Porter

One of the basic components of the federal government's incentive program for adopting health information technology is a funny little term: "meaningful use." To receive the incentives, physicians have to adopt a system that ensures they can apply meaningful use criteria to their use of an electronic health record, or EHR, system.

According to Farzad Mostashari, M.D., deputy national coordinator for programs and policy in the HHS Office of the National Coordinator for Health Information Technology, or ONC, physicians should view EHR product certification as a sort of "consumer protection" program. Certification can help assure EHR purchasers — mainly physicians and hospitals — "that the systems they purchase are capable of helping them achieve meaningful use," he said.

Product certification by one of the six currently ONC-authorized testing and certification bodies is "not a seal of approval," said Mostashari. And it does not mean that one EHR system is easier to use or better than another. "All it says is that there is a minimal assurance that if you are a motivated provider using this product, you will be able to achieve meaningful use. (The system) will have decision support; it will have registry functions; it will have quality measurement; it will have minimal assurances of interoperability and security."



Mostashari speaks from personal experience. He said that when he was shopping for his own EHR four years ago, "some of the largest EHR vendors in the country said to me 'We can't do quality measurement; we can't do a registry function; we don't believe in decision support.'"

However, passage of the Health Information Technology for Economic and Clinical Health, or HITECH, Act, which is part of the American Recovery and Reinvestment Act of 2009, was a crucial first step toward mandatory product certification, according to Mostashari.

Fast forward to July 28, 2010, when CMS issued a final rule that defined meaningful use criteria for EHRs with the understanding that physicians must demonstrate meaningful use of a certified EHR to qualify for incentive payments of as much as \$44,000 through Medicare or nearly \$64,000 through Medicaid.

At that point, said Mostashari, certification became necessary to ensure "that the systems (physicians) purchase are capable of helping them achieve meaningful use."

To date, "more than 400 products and modules are certified," under a temporary certification program, and the number is growing daily, said Mostashari. ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401certifiedehrs.html>.

Visit <http://www.aafp.org/news-now/ehr.html> to see the complete *AAFP News Now* special report on electronic health records.

EHRs Prompt Better Uptake of Preventive Services, Help Track Patients' Progress

By David Mitchell

When it comes down to it, the chief motivation behind the health care industry's move to adopt health information technology, or health IT, is really very simple: patients. Give them better, safer care that they can afford to access.

So when family physician V. Paula Messmore-Arn, M.D., decided to take the health IT plunge, patients were her central focus. Specifically, she wanted to improve the quality of care in her practice and "make a difference in patients' lives."

Messmore-Arn knew she was seeing as many as 100 patients with diabetes each month, but

until her Kansas City, Mo., practice implemented an electronic health record, or EHR, system in 2009, there was no easy method for tracking those patients.

"I had no way to pull that information and see who they were and who needed help," Messmore-Arn told *AAFP News Now*. "Now, my office manager is able to pull that, and we're able to get a report once a month to see where our progress is, or not, and target that."

In addition to hemoglobin A1c test results, Messmore-Arn's EHR allows her to track other clinical and preventive measures data, such as lipid profiles, blood

pressure readings and information about tobacco use.

"It has helped us with our quality of care," she said, "and we expect that we'll get even better because we can identify deficiencies. We can identify which patients are outliers, get them in and try to get them resources to get their diabetes under control if it's not."

Ed Bujold, M.D., is working to achieve patient-centered medical home recognition from the National Committee for Quality Assurance at his practice in Granite Falls, N.C. He told *AAFP News Now* that one of the results of that process has been improved

screening rates for health issues such as tobacco use.

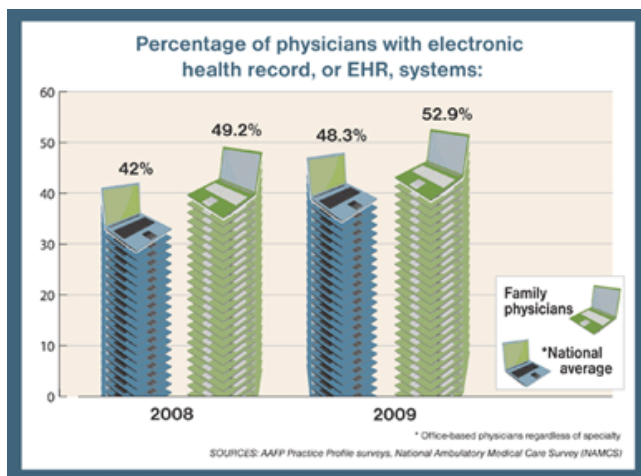
"There are a lot of things that are required in regard to those kinds of questions, which we hadn't been asking before, but we are now," said Bujold. "The EHR has helped with that. Every time a patient comes in, we ask about smoking status and if they're interested in quitting. We weren't doing it before we had an EHR because the question wasn't sitting there for the nurse to ask every time. It prompts you to ask the question." ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401ehrclinical.html>.

FPs Stack Up Well in Implementing EHRs *Managing Expectations Key to Reaping Incentive Payments*

As the medical community continues its trek into the age of health information technology — spurred, in no small part, by federal incentives to adopt electronic health record, or EHR, systems, along with the threat of financial reprisals for resisting — family physicians are further along the road than physicians in other specialties. And those federal incentives for adoption and comprehensive utilization could very well keep family docs on the cutting edge.

According to the National Ambulatory Medical Care Survey conducted in 2010 by the CDC's National Center for Health Statistics, 48.3 percent of all office-based physicians were using an EHR at some level in 2009. Meanwhile, use of EHRs among board-certified family physicians increased from 37 percent in 2006 to 55 percent in 2009, according to an article in the March/April 2011 *Journal of the American Board of Family Medicine*.



Also in 2009, 52.9 percent of members who responded to an AAFP survey indicated they were using an EHR in their practice.

"I would say the biggest reason (for the higher EHR adoption rate among FPs) is AAFP leadership around the issue," said Terry McGeeney, M.D., M.B.A., president and CEO of TransforMED, the AAFP's wholly owned subsidiary that specializes in practice redesign. "The AAFP had very consistent messaging early that EHRs are critically important to the future of the specialty."

In addition, said McGeeney, whereas many primary care physicians acquire practice management systems with their EHRs, subspecialists are more likely to outsource management of their billing and collections.

FPs can maximize their chances of success by exercising due diligence before buying an EHR system and planning extensively before implementing that system, McGeeney advised.

"It is critically important that the practice purchase an EHR that fits its needs and practice style," he said. "It is said that to use an EHR effectively, it should touch every aspect of a practice. Many physicians look at it only as a mechanism to electronically document the patient encounter and do not see the true value." ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401ehrstats.html>.

Research Network Seeks to Expand Its Data Collection Reach, QI Efforts *Joining DARTNet Can Benefit Patient Care, Bottom Line, Say Members*

By David Mitchell

The promise of reaping the rewards of data aggregation and analysis on a national scale is just one of the many factors behind the health information technology movement that continues to gain ground across the U.S. health care system. And the Distributed Ambulatory Research in Therapeutics Network, or DARTNet — of which the AAFP National Research Network, or AAFP NRN, is a founding partner — is on the verge of realizing that promise.

DARTNet — which collects data from multiple commercial electronic health records, or EHRs, for practice-based research and quality improvement — already can access, with appropriate permission from practices, data from 1,700 physicians in 345 practices who care for more than 4 million patients.

And now, DARTNet is looking to add even more physicians, practices and patients to its growing network.

"The bigger the sample size, the more questions we can answer," said Elias Brandt, research systems analyst for the AAFP NRN. "Diversity is always a big thing in any data pull. The wider selection of clinics that we can choose from, the more powerful our research will be."

DARTNet was founded in 2007 at the behest of the Agency for Healthcare Research and Quality. In addition to the AAFP NRN, DARTNet's partners are the University of Colorado Department of Family Medicine and School of Pharmacy; the Robert Graham Policy Center; the University of Utah's Center for High Performance Computing; and QED Clinical Inc. d.b.a. CINA.

Family physicians who are members of DARTNet told *AAFP News Now* that joining the network has allowed them to participate in research that benefits the specialty while improving the quality of care they provide in their practices and yielding financial benefits. Moreover, some DARTNet members say, participation in the network has permitted them to connect with colleagues in ways they never could before.

"It is a painless way to participate in practice-based research," said Robert Eidus, M.D., of Cranford, N.J. "The projects actually improve care. You get to benchmark your performance to other (physicians' performance)."

How painless?

"Some of the studies involve a point-of-care aspect," Brandt said, "but some are straight data pulls, so the physicians don't have to do anything."

Cynthia Croy, M.D., of Joplin, Mo., said her private practice, which includes one other physician and a nurse practitioner, has received \$1,000 to \$2,000 for each of the half a dozen studies in which the practice has participated during the past two years.

"It adds a little bit of margin to the finances," she said.

According to Brandt, some DARTNet studies pay practices even more in direct stipends and also cover costs associated with clinical decision support. ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401ehrdartnet.html>.

Federal Government Employs Carrot-Stick Approach to EHR Adoption

By James Arvantes

In February 2009, Congress enacted the Health Information Technology for Clinical Health, or HITECH, Act as part of the American Recovery and Reinvestment Act, or ARRA. The HITECH Act called for a \$19 billion investment in health IT, as well as programs and procedures to spur health IT adoption among physicians and other health care providers.

Among those programs is an incentive program that will allow physicians, hospitals and other health care professionals to qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to meet criteria — commonly known as meaningful use — set in place by CMS.

The federal government is rolling out the meaningful use

incentive program in a three-stage process, requiring physicians and other providers to meet core requirements for each stage at various times during the next five years.

“Stage one is really about creating a foundation and getting physicians online and just kind of getting the basics in place to start capturing information,” says Jennifer Covich, CEO of eHealth Initiative. “Stage two is really about exchanging information, sharing it between different points in the health care system — a health information exchange. Stage three is supposed to be about outcomes, using all of that to actually improve — being able to measure that you have actually improved patient care as a result of (adopting an EHR system).”

Medicare physicians who meet the core requirements of stage one of meaningful use in 2011 and 2012 are considered early adopters and will be eligible to collect \$18,000 this year and \$12,000 next year. “But if you start in 2013, you will get less money the first year and less money during the next two years because the program only runs until the end of 2015,” says David Kibbe, M.D., M.B.A., senior adviser to the AAFP’s Center for Health IT.

“Physicians can get the full \$44,000 in incentive payments under Medicare by starting in 2012,” he says. And for physicians with Medicaid patients, the incentive payments are even higher.

The drawback of the ARRA, however, is that in addition to incentives for EHR adoption, it also

lays out penalties for Medicare and Medicaid physicians who do not adopt EHRs and use them appropriately. The government will start penalizing Medicare physicians for not meeting meaningful use criteria in 2015. The penalties will be 1 percent of Medicare allowed charges in 2015, 2 percent in 2016 and 3 percent in 2017.

According to Kibbe, HHS can continue to penalize Medicare nonadopters in 2018, but their payments cannot be reduced by more than 5 percent.

Not surprisingly, the penalty phase of the program has raised concerns about solo and small physician practices, which may lack the resources to adopt health IT. ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401carrotstick.html>.

Government Investment in Health IT Spurs Innovation in EHR Equipment

Family Physicians Confront Evolving EHR Market

Kay Lee, M.D., a solo FP in Houston, discovered in 2010 that the manufacturer of her electronic health record, or EHR, system was discontinuing the product line in 2011, putting an end to updates and technical support.

Fortunately, she was able to lease an EHR system that had greater capabilities than her previous system.

According to David Kibbe, M.D., M.B.A., senior adviser to the AAFP’s Center for Health IT, Lee’s experience is indicative of the changes, challenges and opportunities that are occurring as a result of an evolving EHR market. Two years ago, he notes, the nation’s EHR market essentially was frozen, slowed by inefficiencies, expensive products and a general lack of innovation.

But when Congress enacted the Health Information Technology for Economic and Clinical Health, or HITECH, Act in February 2009 as part of the American Recovery and Reinvestment Act, it invested \$19 billion in health information technology, including \$17 billion in incentives to encourage Medicare and Medicaid physicians and other health care providers to adopt health IT. Another \$2 billion was set aside as direct funding for the nation’s health IT infrastructure.

That had an effect on the market’s stagnation. “Any

time the federal government puts nearly \$20 billion in a market or industry, new products are bound to arise,” says Kibbe.

The cumulative effect of the HITECH Act has been dramatic. In just the past several months, the number of EHRs on the market jumped from about 90 to more than 400. And, nearly 65 percent of these products are produced by companies with fewer than 50 employees.

“Ultimately, what this means is that the products and services physicians will be able to buy for their EHRs are going to become less expensive,” says Kibbe. “They are going to be easier to implement and use, and a greater number of those product offerings will be Web-based applications in the cloud, so there will be less cost associated with their ownership and maintenance.”

This, in turn, should spur health IT adoption, creating a critical mass of physicians and other providers who are using the technology within the next several years.

“We will be a country of physicians, hospitals and patients using EHRs as a routine matter of getting care,” says Kibbe. “It is beginning now, and will happen more over the next five to 10 years. I would bet that in five years, 80 percent of doctors in this country will be using EHRs.” ■

For the complete story, visit <http://www.aafp.org/news-now/ehr/20110401ehrinnovation.html>.



AAFP, CMSS Weigh In on Sunshine Act

Regulations on Physician/Industry Interaction Must Include Clarification, Context, Consistency

The AAFP has joined with other members of the Council of Medical Specialty Societies, or CMSS, to urge CMS to ensure that regulations for the Physician Payments Sunshine Act, or PPSA, which was enacted as part of the Patient Protection and Affordable Care Act last year, are clear, contextual and consistent.

“CMS should attend to *clarifying* the direct financial relationships between physicians and industry for purposes of reporting, requiring companies to describe the *context* of relation-

ships so that consumers understand them, and requiring companies to *consistently* collect and report data in a standardized and uniform fashion,” said CMSS in comments to CMS. “Following these ‘three C’s’ will meet the intent of the PPSA without adding to the burden of the system, detracting from the ability of physicians to enhance the quality of care they provide to patients.”

The PPSA requires that, in 2012, companies start recording any payments, cash equivalents, in-kind items or services, or other value transfers to physicians

of more than \$10. Such items include stock options, research grants, knickknacks, consulting fees and travel to medical conferences.

Although CMSS, which represents more than 700,000 physicians nationwide, agreed that “direct payments and transfers of value,” including cash, stock options, ownership interests, dividends, consulting fees, gifts, food and travel, from companies should be disclosed, “it is unclear what Congress intended as it relates to other potential relationships.”

In addition, CMSS pointed out that the term “education” usually isn’t used to reflect a direct financial relationship between a physician and a company. CME is governed by the Accreditation Council for Continuing Medical Education’s Standards for Commercial Support: Standards to Ensure the Independence of CME Activities. The entire medical profession adheres to these standards, said CMSS.

According to the standards, “In the context of certified CME, direct payments to physicians (either in the role of faculty or attendees) by companies are prohibited, cannot occur and, therefore, would be irrelevant when it comes to disclosure under the PPSA.”

CMSS also called on CMS to provide additional information about financial relationships between physicians and companies for consumers, noting that, “It is not likely that the public will understand the nature of many disclosed relationships, not all of which are equivalent.

Consistency in how data in the program are collected also should be addressed, according to the letter. “We urge CMS to require a standardized set of data to be collected and reported by companies,” said CMSS. This would decrease the burden and “hassle factor” on physicians.

As marketplace competitors, many companies legally may not be able to collectively determine standardized reporting data, so it is important that CMS establish standardized categories and data elements in the regulations. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110413sunshineprovisions.html>.

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Community-focused Colorado Health Care System Touted as National Model

Physician-created Health Plan Boosts Care Quality, Lowers Costs

By David Mitchell

During the past few years, a highly integrated, community-focused health care system unique to Grand Junction, Colo., has been held up as a model to the rest of the country by sources ranging from medical journals to mainstream media, and from public policy think tanks to President Obama and other health care reform advocates.

According to Grand Junction family physician David West, M.D., who wrote about his hometown last year in the *New England Journal of Medicine*, or *NEJM*, such regionally run, regionally financed health care systems represent the sole pathway to achieving the twin goals of providing high-quality health care and holding down costs.

"We will never solve health problems comprehensively until we somehow escape profit centers and the current reimbursement system," he said.

With those goals in mind, a group of primary care physicians and subspecialists in Grand Junction got together nearly 40 years ago and started the independent benefits provider Rocky Mountain Health Plans, known locally as "Rocky," and Mesa County Physicians Independent Practice Association, or MCPIPA. Both are nonprofit organizations, as are both local hospitals, two mental health centers, a hospice and a handful of other vital health care entities.

"I can't stress enough the importance of a health plan that's community-oriented," said Grand Junction family physician Michael Pramenko, M.D. "I don't think this would have happened in Grand Junction without Rocky. Physicians made their own health plan and made it a nonprofit."

How Does the Model Work?

Specifically created to accept Medicare and Medicaid patients, as well as those who are privately insured, Rocky and MCPIPA work together to keep costs low. The organizations withhold 15 percent of physician fees in a risk pool. If health care costs are kept low, physicians receive the withheld funds at year's end.

The two organizations also are part of a consortium that subsidizes a health program for pregnant women and their infants, providing them access to insurance. The program actually lowers health care costs for the community by improving outcomes and reducing the need for intensive care services for newborns, Pramenko said.

And at the other end of the life spectrum, primary care physicians in the area encourage patients to have advance directives, thus decreasing costs by allowing patients to avoid unwanted procedures at the end of life.

The upshot of these and other cost-containment measures is that when Medicare ranked more than 300 cities for quality of health care



Family physician Michael Pramenko, M.D., evaluates a patient in his Grand Junction office. According to Medicare data, the Colorado town had the sixth-lowest health care costs out of more than 300 U.S. cities evaluated in 2005 while ranking 31st in quality of care.

Christopher Tomlinson/AAFP News Now

in 2005, Grand Junction ranked 31st. At the same time, the town had the sixth-lowest costs.

Can the Model Work Elsewhere?

In their *NEJM* article, West and his co-author — Thomas Bodenheimer, M.D., M.P.H., co-director of the Center for Excellence in Primary Care at the University of California-San Francisco — pointed out seven features of the city's health care system that *could* be replicated elsewhere:

- leadership by the primary care community;
- a payment system that involves risk-sharing by physicians;
- equalization of physician payment for the care of Medicare, Medicaid and privately insured patients;
- regionalization of services into an orderly system of primary, secondary and tertiary care;
- limits on the supply of expensive resources;
- payment of primary care physicians for hospital visits; and
- robust end-of-life care.

West, who is vice president of medical affairs for Hospice and Palliative Care of Western Colorado, told *AAFP News Now* that effective hospice care might be one of the least difficult measures to duplicate in another setting.

Conversely, he added, the most difficult is changing the payment system.

Although Grand Junction's successful system has been around for decades, it hasn't been duplicated. Pramenko said the Health Maintenance Organization Act of 1973 led to the creation of new health plans, but, in time, many were sold to for-profit insurance companies or larger nonprofit insurers.

"That didn't happen with Rocky," he said. "It stayed focused on the community."

Pramenko hopes more nonprofit insurers will result from a provision of the Patient Protection and Affordable Care Act that calls for \$6 billion in loans to start nonprofit, consumer-oriented, privately run, local insurance plans.

"The only reason it hasn't happened before is people haven't had the start-up money to cover the risk," said Pramenko, who is a member of an advisory board that is writing guidelines for HHS regarding the application process for such loans. "If you want to start your own health plan, the best opportunity in a lifetime is in Section 1322 (of the Affordable Care Act)." ■

For the complete story, visit <http://www.aafp.org/news-now/chapter-of-the-month/20110330coloradochapter.html>.

PCPCC Stakeholders Meeting

Former AAFP President Touts Challenges, Opportunities Created by ACOs

By James Arvantes • Washington

When the Future of Family Medicine report was released in 2004, it noted that the delivery model for health care in the United States had to change if family medicine was going to continue to exist. Now, according to former AAFP President Ted Epperly, M.D., of Boise, Idaho, the emergence of accountable care organizations, or ACOs, that are based on the patient-centered medical home, or PCMH, could give family medicine an opportunity to realign the health care system.

Epperly delivered his message during a March 30 Patient Centered Primary Care Collaborative, or PCPCC, stakeholders meeting here that preceded the release of CMS' proposed regulations for ACOs by just one day.

"The Future of Family Medicine report called for two things to change if this specialty was going to be in existence in 15-20 years," said Epperly, who is one of four co-chairs of the PCPCC's newly created Center for Accountable Care. "Number one, the larger health systems need to change, and second, the delivery model of care has to change."

The report has driven the AAFP's focus on making the PCMH the foundation of health care in the United States, and now, as the ACO model is gaining prominence, Epperly noted that the PCMH model has to be the basis for ACOs. Hospitals and other entities within prospective ACOs cannot be allowed to trump medical homes, said Epperly. "We cannot and must not lose

primary care as the bedrock for (the health care) system. If we do, we have lost an opportunity."

Epperly acknowledged that there is skepticism in the physician community that ACOs can deliver on the promise of better care for individuals, better health for populations and lower growth in health care expenditures. Many in the primary care trenches may be feeling beaten down by all the changes in the system, said Epperly, but he is gratified to see what has happened during the past three years to change the health care system. "Now we must deliver on that change," he said.

Epperly also called for a realignment of payment for family physicians. "I am a big fan of getting away from fee-for-service — see one, do one, bill one," he said.

A bundled or global payment that captures an episode of care makes more sense, Epperly added. ■

For the complete story, visit <http://www.aafp.org/news-now/professional-issues/20110406pcpccacos.html>



James Arvantes/AAFP News Now

Former AAFP President Ted Epperly, M.D., stresses the importance of the patient-centered medical home within the context of accountable care organizations during a March 30 stakeholders meeting of the Patient-Centered Primary Care Collaborative.

In Brief *Inside AAFP Digest*

New AAFP Connection Communities Offer Members a Voice

The AAFP has launched two new specialized communities on its AAFP Connection social networking site that give members a place to offer input on the work of the AAFP and to reach out to members interested in electronic health records, or EHRs, and other health information technology. The AAFP designed the marketing research online community to provide a place for members to share their thoughts about the work of the Academy. Community members are encouraged to voice their opinions and provide feedback about CME, health care reform and other important topics. The EHR and health IT community is a place for AAFP members interested in EHRs and health IT to reach out to one another. Community members have access to a variety of discussions on health technology topics. <http://www.aafp.org/news-now/inside-aafp/20110323newcommunities.html>

AAFP Foundation Offers Members Estate Planning, Giving Tools

The AAFP Foundation has updated its website to help family physicians combine their philanthropic goals with their long-term financial and estate plans. Specifically, the Foundation has introduced an enhanced section devoted to estate planning and planned giv-

ing. New features of the website include a will planner; presentations on estate planning topics; information about different types of gifts; and a gift calculator, which helps determine income and tax benefits associated with charitable remainder unitrusts, charitable remainder annuity trusts, charitable gift annuities and deferred charitable gift annuities. <http://www.aafp.org/news-now/inside-aafp/20110323fdntnplantools.html>

AAFP Resource Provides Clarification on CMS' E-Prescribing Incentive Program

The AAFP has created new resources to help family physicians understand how they can earn an e-prescribing incentive payment and avoid a penalty. The three-page guide is front-loaded with charts that clearly lay out four specific steps physicians can take to keep from getting hit with a penalty fee. That information is paired with three specific actions that will help ensure physicians get a bonus payment. The physician guide also provides need-to-know answers to questions such as: What is code G8553, and when do I report it? What are the denominator codes? What is a qualified electronic prescribing system? Does the penalty apply to all physicians and nonphysician professionals? <http://www.aafp.org/news-now/practice-management/20110404e-rxresources.html> ■

AAFP Member Defends Title VII Funding in Face of Possible Cuts

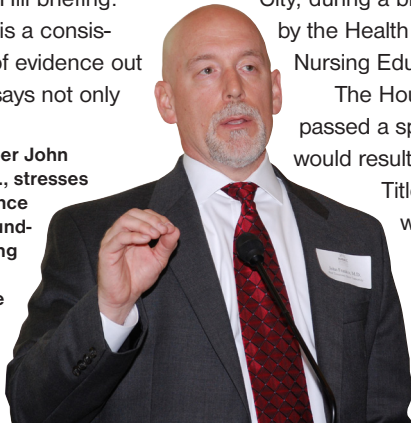
Title VII Vital to Building Nation's Primary Care Workforce

By James Arvantes • Washington

As Congress debates future funding levels for Title VII of the Public Health Service Act, AAFP member John Franko, M.D., arrived on Capitol Hill to defend the program against possible cuts, explaining its importance in sustaining and strengthening the nation's primary care workforce during a March 23 Capitol Hill briefing.

"There is a consistent body of evidence out there that says not only

AAFP member John Franko, M.D., stresses the importance of Title VII funding in building the nation's primary care workforce during a March 23 Capitol Hill briefing.



James Arvantes/AAFP News Now

does Title VII improve and increase the primary care workforce, (the program) puts that primary care workforce into play in medically underserved areas," said Franko, who is professor and chair of the department of family medicine in the Quillen College of Medicine at East Tennessee State University in Johnson City, during a briefing sponsored by the Health Professions and Nursing Education Coalition.

The House recently passed a spending bill that would result in deep cuts in Title VII programs, which added urgency to Franko's call for increased Title VII funding. Franko pointed out that

the number of medical students choosing a career in primary care started to decline as funding for Title VII dropped during the late 1990s and early 2000s. Section 747 of Title VII is the only federal program that provides funds specifically to academic departments and programs to increase the number of primary care health professionals.

"I am not suggesting a cause-and-effect relationship," said Franko, who appeared as part of a two-member panel along with Juliann Sebastian, Ph.D., R.N., professor and dean of the University of Missouri College of Nursing. "But it is certainly curious that as Title VII funding has significantly declined in adjusted 1984 dollars, the number of U.S. medical students choosing primary care is also declining."

Franko cited research that

found exposing medical students to primary care fields increases the likelihood that they will pursue careers in primary care, and that Title VII funds were vital to providing services for underserved and vulnerable populations.

Title VII funding has had specific effects at East Tennessee State University, Franko said. He noted that the university has been a consistent recipient of Title VII funds since establishing family medicine and primary care residency programs in 1978. Title VII funds have allowed the university to establish medical school and residency curriculum programs, as well as administration and faculty development programs, according to Franko. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110406frankotitlevii.html>.

Targeted Training, Education Can Help FPs Stay on Top of Testing for, Managing HIV/AIDS

By Barbara Bein

Primary care physicians, including family physicians, are among the relatively small number of clinicians who not only regularly perform HIV screening, they also provide the majority of care for people with HIV/AIDS, says a new report from the Institute of Medicine, or IOM. And, since 2006, when the CDC recommended that HIV screening be expanded to include all people ages 13-64 who are seen in health care settings, the U.S. health care system's ability to provide those additional screenings — let alone care for the resulting increased number of HIV-infected patients — has become critically strained.

Because future and existing providers' training and experience in HIV care often is limited, the report — *HIV Screening and Access to Care: Health Care System Capacity for Increased HIV Testing and Provision of Care* — calls for augmenting medical students' and residents' exposure to outpatient HIV care and providing practicing physicians more and better CME to help them address the complex health care needs of these patients.

"Greater exposure of medical students and residents to HIV patients in outpatient settings will help them develop an increased level of comfort and cultural competence in interacting with HIV-positive

individuals, as well as a greater appreciation for the complexity of care such patients may require," says the IOM report.

The report recommends that starting in medical school and continuing through residency, physicians-in-training should learn the importance of taking a thorough sexual history and performing routine HIV testing.

To help boost practicing physicians' knowledge, skills and confidence in screening for, diagnosing and managing HIV infection, the report suggests that HIV/AIDS-related CME opportunities could include such activities as

- satellite learning and consultation via HIV/AIDS-related teleconferences and Web-based programs,
- mini-sabbatical training sessions,
- independent CME programs,
- HIV certification after residency, and
- HIV fellowships. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20110420iomhiv-aids.html>.

Federal Budget Proposals Must Invest in Primary Care, FP Workforce, Says AAFP President

The AAFP is calling on federal lawmakers to enact budget proposals that make sound investments in the nation's primary care infrastructure, saying that this is the only sure way to improve health care quality while reducing health care costs.

"If any budget proposal is to restrain the growth in health care spending successfully, it must support programs that build the family physician and primary care workforce, that pay for the quality and outcomes of medical care and that ensure all Americans have access to that care," said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, in a prepared statement.

Goertz's statement comes as both the White House and House Republicans have put forth fiscal year 2012 budget proposals that aim to address the nation's long-term fiscal problems. Each proposal would effectively cut billions from the Medicare and Medicaid programs during the next several years, a prospect Goertz denounced in his statement.

"Arbitrarily cutting the portion of funds the federal government pays will only push the cost of care onto patients, states or other sectors of the economy," he said. "This is not savings, nor is it a true solution to identified problems."

According to Goertz, it's important to remember that how money is spent for health care is equally as important — if not more important — than focusing solely on what is spent.

"Over the decades, study after study has shown that patients get high-quality care at less cost when their health care system is based on primary medical care," said Goertz. For that reason, he noted, the AAFP has consistently called for a health care system — and the fiscal policies to support it — that has, at its core, primary care and access to that care for everyone.

"Budget proposals must fund programs that focus on making our current system more efficient, that improve the balance between primary care and nonprimary care services, and that value the results of such a system," Goertz said.

"Such a model can expand patient access to care and enhance quality within the current level of overall spending, but it must rebalance our health care system on primary medical care and invest in and build the primary care physician workforce." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110414goertzbudget.html>.

Newly Launched AAFP Clinical Data Repository Pilot Aims to Enhance Revenue, Boost Quality

By Sheri Porter

After many months of preparation, the AAFP's Center for Health IT recently launched the Academy's long-awaited clinical data repository, or CDR, pilot project. According to Steven Waldren, M.D., director of the Center for Health IT, the 12-month pilot is closely tied to long-term Academy strategies aimed at helping family physicians improve practice revenue and enhance the quality of care delivered to patients.

The pilot also fulfills a directive from the 2008 Congress of Delegates, which adopted a resolution that asked the AAFP to explore the creation and ownership of a secure clinical data repository. The resolution stated that family physicians should be able to both submit and retrieve clinical data from an AAFP-operated CDR, and that doing so would help members qualify for revenue boosters such as pay-for-performance bonuses and patient-centered medical home recognition programs.

The CDR pilot represents a partnership between the AAFP and Emdeon, the nation's largest health care claims processing company.

Emdeon's data management and distribution resources — coupled with the Academy's clinical and health informatics expertise — should provide a powerful engine to drive the pilot to a successful completion, said Waldren. The AAFP will be the data steward and will "own" the data in the CDR, he added.

"This is more than a 'data dump,'" said Waldren. "Our CDR will generate reports and provide benchmark data that will help members compare their practice data against that of their peers."

In addition, Waldren said better data — such as the charting of dollars paid by private insurers for particular procedures and evaluation and management codes — would help physicians make better decisions when it comes time to negotiate payer contracts.

"Electronic health records, as good as they are, often lack the tools to do this kind of work and then pull all that data into reports that are useful to a busy family physician," said Waldren.

The pilot's timeline is divided into three segments:

- practice selection — 10 to 12 practices are needed for the pilot — is under way right now and will be completed within the first three months;
- active data collection is scheduled for the following six months; and
- formal analysis of the pilot is set for the final three months of the one-year project.

"The pilot will help us learn more about how the CDR works in the real world," said Waldren. "We'll take some time to make any revisions necessary based on what we learn from the pilot experience," he added. After the CDR is deemed a success, "we'll roll it out to all members." ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110330cdrlaunch.html>.

Interested in Participating?

Steven Waldren, M.D., director of the AAFP's Center for Health IT, is encouraging family physicians who are interested in the AAFP's clinical data repository to sign up to learn more about how to participate and to receive periodic updates on the pilot's progress.

The center is looking for family medicine practices with a high percentage of clinical data, FPs that do electronic prescribing, and practices that have lab connectivity as part of their electronic health record systems. But, according to Waldren, "It's equally important for us to hear from members who are enthused about the CDR project."

Learn more at <http://www.centerforhealthit.org/online/chit/home/project-ctr/cdrinfo.html>. ■

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

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

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



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

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

According to the report, in 2009, the office-based physician indus-

try supported:

- \$1.4 trillion in total economic output, with each physician supporting an average of \$2.2 million in output;
- 4 million jobs, with each office-based physician supporting 6.2 jobs, including his or her own; and
- \$833 billion in wages and benefits, with each physician supporting \$1.3 million in those areas.

In 2007, the AAFP's Robert Graham Center did a similar study that measured the economic impact of a single family physician and the cumulative effect of FPs in each of the 50 states and the District of Columbia.

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

Andrew Bazemore, M.D., M.P.H., the center's assistant director, told *AAFP News Now* that both the Graham Center and the AMA used Impact Analysis for Planning, or IMPLAN, data to generate their reports. IMPLAN is an economic analysis system that allows users to create regional models.

According to the Graham Center data, which Bazemore notes are both conservative and nearly 5 years old, California FPs topped the list as economic drivers, with an economic impact of nearly \$986,000 per family physician per year. The total annual impact of family physicians in the state was more than \$8.2 billion in 2007. ■

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

AAFP Calls for 'Robust Investment' in Primary Care Physician Workforce

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

"We recognize the difficult decisions (that) our nation's budgetary pressures present," said the AAFP. However, the Academy urged the House Appropriations Subcommittee on Labor, Health and Human Services, and Education "to make a robust fiscal year 2012 investment in our nation's primary care physician workforce ... to ensure that it is adequate to provide efficient, effective health care delivery addressing access, quality and value."

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

- \$140 million for primary care training and enhancement as authorized by Title VII, Section 747 of the Public Health Service Act;
- \$10 million for development grants for teaching health centers; and
- \$4 million for rural physician training grants.

Failure to provide adequate funding for Title VII programs "would

destabilize ongoing efforts to increase education and training support for family physicians, exacerbating primary care shortages and further straining the nation's health care system," said the AAFP.

"We urge the committee to increase the level of federal funding for primary care training to reinvigorate medical education (and) residency programs, as well as academic and faculty development in primary care to prepare physicians to support the patient-centered medical home."

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

In addition, the Academy continues to call for reforms to graduate medical education programs that encourage training of primary care residents in nonhospital settings, which is where most primary care is delivered.

The Academy also addressed rural health needs in its testimony. For example, the Rural Physician Training Grants Program helps medical schools recruit students who are more likely to practice medicine in rural communities. "This modest program ... will help provide rural-focused training and experience and increase the number of recent medical school graduates who practice in underserved rural communities," the AAFP said. ■

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

AS WE SEE IT

Voices From the AAFP

From the President

Match Shows Med Students Believe in Specialty's Future

By Roland Goertz, M.D., M.B.A.

Great news abounded for family medicine in this year's National Resident Matching Program, with a record-breaking 94.4 percent of our residency positions filled. More than 100 additional medical students chose family medicine this year compared with last, and the percentage of U.S. seniors who chose the specialty rose as well.

We had similar good news in last year's Match, with a then-record 91.4 percent fill rate. However, as we all know, a single year does not a trend make. With this year's results, ladies and gentlemen, we do have a trend — and the trend is *up*.

The media have been all over this story. In many of the media calls I fielded after this year's Match, reporters wanted to know if the Patient Protection and Affordable Care Act had anything to do with our rising Match numbers. *"Of course it did,"* I told them.

There continues to be intense political disagreement about aspects of the Affordable Care Act, but I think everyone would agree that the debate laid everything on the table for all the world to see, including the care-enhancing, cost-saving benefits of the patient-centered medical home, or PCMH, and the critical need for more family physicians.

Our Match results show that medical students have been paying attention to the debate in Washington. This is reinforced for me every time I meet with medical students, because I'm always impressed with how astute and well-informed they are.

They're aware of the present state of payment for FPs, and they know they could make more money in the short term by becoming "Botox specialists." But they also know that the system is in the throes of change and that the only substantial proposal under consideration to actually change the process of care is our proposal for moving the system to a primary care base with the PCMH and paying appropriately for care within that model.

Many of these students are doing what hockey great Wayne Gretzky described when he said, "I skate to where the puck is going to be, not where it has been." They're choosing a career in family medicine with their eyes fixed firmly on the reformed system of the future, not on the dysfunctional, economically unsustainable one we have today. I salute them for their foresight.

This heartening trend in the Match, along with last year's surge in AAFP student membership and resident conversion to active membership, tell us we must be doing something right. But after a brief moment of celebration, it's back to work. So much remains to be done.



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

For example, we must keep pushing to make primary care the bedrock of a reformed system, and to convince Congress to give us appropriate payment so that FPs can thrive in practice, and not just scrape by.

In addition, we must press ahead on family medicine workforce development. We have to convince Congress to support a significant increase in our residency positions. This year's Match fill rate was great, but we had only 2,730 positions to fill. That's a drop in the bucket when you consider that the Council on Graduate Medical Education projects that 63,000 more primary care physicians are needed to meet the nation's health care needs. If health reform boosts the number of insured individuals, that number may grow even bigger.

We also must communicate as effectively as possible with students about our specialty's promising future to attract enough of them to fill the residency positions we hope to create. The AAFP uses a multi-pronged, evidence-based approach to student interest. First, we work hard to get the right young people into medical school. After they are medical students, we try to ensure a good educational experience and good family medicine role models. And we support student membership coordinators and family medicine interest groups, or FMIGS, in the schools. We stay in touch with students to help them keep family medicine top of mind.

Our website for students, the Virtual FMIG, plays a key role in this effort. It offers a wealth of information about the specialty, the premed years, medical school, residency selection and the Match. It also links to the latest news about the Academy's advocacy efforts in Washington.

We also must continue to foster collaborative relationships to amplify our efforts on many fronts. For example, we have a tighter working relationship than ever before with the other family medicine organizations as we collaborate on workforce development. We also participate in the Partnership for Primary Care Workforce, which includes medical groups outside the specialty and other interested organizations.

The Academy's regional Stakeholder Collaboration Workshops offer another good example. These exciting events, held in 2010 and 2011, bring together representatives from all the groups interested in family medicine workforce development, including students, academic family medicine, premedical advisers, AAFP chapters, practicing FPs and local communities. The objective is to improve communication and develop infrastructure to facilitate local collaboration focused on student interest.

Our ultimate goal for all of these efforts is to create a primary care-based system that provides appropriate reimbursement for us as AAFP members, as well as the comprehensive, coordinated care that all Americans deserve. That's a worthy goal, indeed. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20110413matchpm.html>.