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Q&A With the President

New AAFP President Identifies Priorities, Objectives for Coming Year

By James Arvantes



Sheri Porter/AAFP News Now

The AAFP has emerged as a leading voice for primary care and family medicine during the past several years, staking out clear and unmistakable positions on health care reform, Medicare physician payment, the need for more family physicians and other issues that are essential for an effective health care system. New AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, CEO and executive director of the Heart of Texas Community Health Center in Waco, addressed these and other issues during a recent interview with *AAFP News Now*.

Q. What are the main concerns of AAFP members right now?

A. The main concern of members, particularly from what I have been able to learn going across the

country to chapter meetings and meeting members at various other venues and conferences, is a significant frustration with the current health care system — their position in it, their potential rewards in it and the frustration of what we are about. The family medicine model is not as valued by payers as it ought to be.

Q. And how will the AAFP change that?

A. Ultimately, members have to be involved in the political processes. We have progressively stepped up our political involvement during the past several years to make sure who we are is better understood. And to make sure that what we need and what we want and what we can do to help make a difference with patient care and patient care deliv-

See President Q&A, page 2

AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, says that during his year as AAFP president, he wants to concentrate on rebalancing the U.S. health care system more toward primary care and on ensuring members and others truly understand the patient-centered medical home model.

AAFP Takes Issue With IOM Report Calling for Greater Nursing Role

Failure to Ensure Patient Safety Is 'Major Drawback' of Report, Says AAFP President

A report on the future of nursing in the United States that was released by the Institute of Medicine, or IOM, on Oct. 5 has drawn criticism from the AAFP because it does not adequately address the training

and certification nurses will need to assume greater responsibilities in the health care system.

The report is woefully inadequate in the area of patient safety, according to AAFP President Roland Goertz, M.D., M.B.A.,

of Waco, Texas.

"I have not read anywhere in the report recommendations about standard training or standard certifications of competencies, which are embedded throughout physician training,"

he said in an interview with *AAFP News Now*.

"That is a major drawback of the report," said Goertz.

The IOM report, "The Future of Nursing: Leading Change,

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NOVEMBER HIGHLIGHTS



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Bonuses Taxedpage 4

The AAFP has learned that the federal bonus money for meaningful use of electronic health records is taxable.

Tort Reformpage 10

The lack of medical liability reform measures in the recently enacted health care reform law is a "missed opportunity."

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ery are continually heard by those who can vote — by those who can change the system. It can't be just what we do in Washington. The chapters have to be equally committed to what they do in their statehouses, and even members need to include advocacy for family physicians in their interactions with patients.

Q. Why did the Academy feel it was imperative to come out strongly in support of health care reform?

A. If you look at the findings of the Future of Family Medicine report, I think it was imperative that we responded to the challenges it presented our specialty. One of the three major recommendations was that we needed to work for system change. We needed to work for better and different payment models. We needed to work for better physician positioning of family medicine in the delivery of health care and to include preventive and wellness care along with sickness care. To me, if we just change ourselves without changing the system, we are just going to be frustrated. So, we had to exert our best effort to get some changes made to the health care delivery system.

Q. What would you say to AAFP members who do not support health care reform?

A. I would remind them of the position we would have been in if nothing happened at all. The AAFP Board and the various advisers to the Board are just like the members. We are members, and we do the

same things that members do. The major difference is we are given incredible amounts of information about things that are happening. We are extensively involved in the AAFP's advocacy efforts and that has opened up the floodgates of information about what we can accomplish to help our members live better as family physicians and take care of patients better.

So for members who do not support reform, I would say, "Bear with us." We made a decision based on whether there was enough in the health care reform bill to support the changes we needed in the system to have us be a better and more important part of the system in the future. The decision was that there were enough elements in the bill that will help family physicians to merit our support.

Q. What is the AAFP doing to make sure that the interests of family physicians are represented in the health care reform law as it is implemented?

A. We have largely entered the regulatory phase in terms of health care reform. We are making sure that our voice is heard and making sure our positions are made clear, especially when there are forums for input into federal decisions. We are advocating that there is enough flexibility within the rules to make sure family medicine is part and parcel of the positive changes that need to happen within the health care system. ■

For the complete interview, visit <http://www.aafp.org/news-now/inside-aafp/20101013goertzqa.html>.

IOM Report, *continued from page 1*

Advancing Health," calls for eliminating scope-of-practice barriers and allowing advanced practice nurses to practice to the full extent of their education and training. It also asks Congress to expand the Medicare program to include coverage of advanced practice nursing services "that are within the scope of practice under applicable state law, just as physician services are now covered."

In response to these recommendations, Goertz said, "Patient care is way too important to decide to do away with various recommendations and certifica-

tions and allow it to be done without some sort of standardization and competency measurements."

The AAFP agrees that nurses should practice to the fullest extent of their nurse training, said Goertz. However, he added, the basic educational preparation for the largest proportion of registered nurses is an associate's degree. Forty percent of nurses received their basic nursing education in an associate's degree program, he noted. About 30 percent attended diploma programs and 30 percent attended baccalaureate programs.

Among registered nurses who obtained their initial nursing education during the past five years, 55.4 percent graduated from an associate's degree program and 38 percent graduated from a baccalaureate program; 6 percent graduated from diploma programs.

"By comparison, primary care physicians have four years of postgraduate education in medical school and an additional three to four years of residency training," Goertz said. ■

For the complete story, visit <http://www.aafp.org/news-now/professional-issues/20101006iomnursingreport.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between September 27 and October 20, 2010.

AAFP Leaders Stress Importance of Family Medicine in Private Meeting With CMS Administrator

By James Arvantes

Provisions in the health care reform legislation that affect primary care, including accountable care organizations, or ACOs; primary care bonuses; and graduate medical education, or GME, funding, were topics on the table during a recent meeting between AAFP leaders and the new head of CMS.

During a Sept. 21 meeting with CMS Administrator Donald Berwick, M.D., (then) AAFP President Lori Heim, M.D., of Vass, N.C., and EVP Douglas Henley, M.D., emphasized the importance of primary care as a foundation for provisions in the Patient Protection and Affordable Care Act.

“Dr. Berwick is certainly well aware of the need for care coordination and medical homes from his work in performance improvement and office redesign,” said Heim in an interview with *AAFP News Now* shortly after the meeting. “I think he understands very well how foundational pri-

mary care is to achieving care coordination.”

For example, the health care reform legislation encourages physicians and hospitals to form ACOs, but Heim and Henley stressed to Berwick that the ACO model should be based on a foundation of primary care and the patient-centered medical home.

“We know, and I think (Berwick) also understands, that in order for us to be successful with ACOs, they have to be primary care-based,” Heim said.

Heim said that she and Henley also expressed their concerns about various parts of other provisions in the health care reform legislation. For example, although the law provides a 10 percent Medicare bonus for physicians whose primary care services comprise 60 percent of their total

Medicare services, Heim and Henley informed Berwick that the threshold is too high.

“Dr. Berwick is certainly well aware of the need for care coordination and medical homes from his work in performance improvement and office redesign. I think he understands very well how foundational primary care is to achieving care coordination.”

— Lori Heim, M.D.

In the final analysis, a 60 percent threshold could prevent many primary care physicians from receiving the bonus. In particular, said Heim, in many rural and underserved parts of the country, primary care physicians are the only physicians around. Their remote location means they often are required to provide services that would not fall into the category of primary care. This makes it difficult, if not impossible, for primary care physicians

in these areas to meet the 60 percent threshold required for the primary care bonus.

According to Heim, the AAFP leaders also stressed that most primary care training takes place outside of the hospital setting, so it is important that GME funding go directly to residencies instead of to sponsoring hospitals or organizations.

She added that they also discussed with Berwick bringing Medicaid payments up to the level of Medicare payments in 2013 and 2014. Heim pointed out to him that many primary care physicians would have reservations about taking on more Medicaid patients if the enhanced payment rate expires at the end of 2014. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20100928berwickmeeting.html>.

AAFP Calls for Changes in Preventive Services Coverage Rule

Interim Final Rule Could Reduce Payments for Physicians

The AAFP has raised concerns about various parts of an interim final rule that addresses coverage of preventive services under the recently enacted health care reform law. In a letter to HHS Secretary Kathleen Sebelius, Labor Department Secretary Hilda Solis and Treasury Department Secretary Timothy Geithner, the Academy notes that the rule, as written, could have adverse cost implications for physicians who provide wellness services.

The Patient Protection and Affordable Care Act requires new health plans (i.e., those established on or after Sept. 23, 2010) to cover or eliminate copays, deductibles and coinsurance amounts for preventive services with an A or B rating from the U.S. Preventive Services Task Force. New plans also have to eliminate copays, deductibles and coinsurance for other preventive services and vaccines whose health benefits are strongly supported by scientific evidence and recommended by agencies within HHS.

But the interim rule may contain an “unforeseen cost ramification” for physicians who see patients in an office setting, said (then) AAFP Board Chair Ted Epperly, M.D., of Boise, Idaho, in the letter.

“If a patient comes in for a preventive service visit, also called a ‘well-

visit,’ typically, a copay will not be collected,” Epperly said. “If, however, during the visit, the patient brings up something else not related to a well-visit and the physician bills the insurance company, many times, the insurer/payer covers the preventive service at 100 percent, but the problem-oriented part at something less than the full cost.”

In fact, he noted, some patients may ask the physician for treatment beyond what is typically done at well-visits, knowing that they will avoid the copay. This could put a strain on the physician-patient relationship, according to Epperly.

The Academy estimates that the new law will result in an increase in the number of well-visits and a corresponding increase in the number of well-visits that include a request to provide other problem-oriented services that are not fully reimbursed. Thus, Epperly urged HHS to revise the final rule so that payers or issuers of plans that include preventive services are required to provide explicit descriptions of both a preventive visit and a problem-oriented service visit. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101005preventservltr.html>.

Changes to Physician Medicare Enrollment Process Aimed at Preventing Fraud, Abuse

At first glance, it may appear that an HHS proposed rule published in the Sept. 23 issue of the *Federal Register* imposes an application fee on the treatment of Medicare patients. However, a closer look indicates that the fee may be limited to types of health care suppliers other than physicians.

According to wording in the proposed rule, the proposed changes to Medicare, Medicaid and the Children's Health Insurance Program, or CHIP, should "enhance the provider and supplier enrollment process to improve the integrity of the programs to reduce fraud, waste and abuse in the programs."

If approved, the proposed rule would implement provisions contained in the recently enacted Patient Protection and Affordable Care Act, including those that deal with

- procedures under which screening is conducted for health care providers and suppliers in Medicare, Medicaid and CHIP;
- an application fee for certain providers and suppliers;
- a framework by which temporary moratoria would be imposed under certain circumstances to combat fraud, waste and abuse;
- guidance for states regarding the standing of health care providers enrolled in one of the three programs but terminated by another; and
- requirements for suspension of payments to health care providers and suppliers pending credible allegations of fraud in the Medicare and Medicaid programs.

According to Robert Bennett, the AAFP's federal regulatory manager, the proposal to charge an enrollment fee appears to be limited to hospitals; facilities; and suppliers of durable medical equipment, prosthetics, orthotics and supplies, or DMEPOS.

"At first glance, it appears that physicians in general are not subject to the \$500 application fee unless they also supply DMEPOS," said Bennett.

The AAFP is reviewing the proposed rule and will submit official comments on the rule to HHS before the department's deadline of Nov. 16 at 5 p.m. EST.

Family physicians are encouraged to offer HHS their personal comments on the rule; directions for submission of comments are available on page 58204 of the *Federal Register* announcement. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20100927medicarefee.html>.

CMS' EHR Meaningful Use Bonus Money Subject to Federal Taxes

By Sheri Porter

Are CMS incentive payments, which are available to physicians who invest in electronic health records, or EHRs, and use them in a meaningful way, taxable by the IRS? That question was asked during the recent AAFP Town Hall meeting in Denver.

The simple answer is "yes." According to Steven Waldren, M.D., director of the AAFP's Center for Health IT, all health IT incentive payments received as a part of the American Recovery and Reinvestment Act of 2009 and the accompanying Health Information Technology for Economic and Clinical Health, or HITECH, Act are viewed by the IRS as taxable income.

Physicians who meet the incentive payment criteria are eligible to earn as much as \$44,000 from Medicare, or they can choose to earn Medicaid incentives of as much as \$63,750.

Waldren, who consulted with the Office of the National Coordinator for Health IT, noted that family physicians should consult their tax accountants for recommendations on how to manage the tax burden.

Mark Estroff, C.P.A., a principal at Gates Moore and Co., an Atlanta-based health care consulting and accounting firm, explained how the government is viewing the incentive program.

"The way I look at it, this is just enhanced reimbursement from the federal program," he told *AAFP News Now*. "They're just going to give you a little more money because you're utilizing the proper technology in your practice, and it is taxable just like any other practice gross receipts that you're going to receive."

Estroff added that there are some tax advantages for medical practices. For example, when physicians buy equipment — whether it's hardware or most software — the IRS allows them to write off as much as 100 percent of the cost of that equipment. However, that write-off is subject to the limitations of the optional expensing rules of Internal Revenue Code Section 179, Estroff added.

"Depending on how you go about it — the tax law limitations, the size of your practice and a lot of other factors — you may be able to write it all off in the year that you acquire it," he said, although in other situations, it may take five years to recover the investment through tax benefits.

Estroff also advised physicians to comb their state tax laws to see if there are additional tax incentives — as is the case in Georgia — for upgrading their practice technology or for training staff to use a health IT system.

Estroff makes sure that his physician and health care professional clients are aware that the HITECH incentive offer is a once-in-a-lifetime chance to boost their income.

"If they do not implement (an EHR) and take advantage of this extra money that's being offered, eventually they're going to be penalized," said Estroff. The federal program offers several years of bonus payments, but in 2015, CMS will begin penalizing physicians who aren't using EHRs by reducing their Medicare payments. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101020ehrtaxes.html>.



FDA Warns Docs, Patients of Femoral Fracture Risk Linked to Some Bisphosphonates

Long-term Use Suggests Need for Periodic Bone Density Reassessment

Physicians should be aware of the risk of atypical fractures of the femur in patients taking bisphosphonates, the FDA said in a safety announcement released Oct. 13.

The agency said information regarding the risk of atypical subtrochanteric and diaphyseal femoral fractures will be added to the warnings and precautions section of the labels of all bisphosphonate drugs approved for the prevention or treatment of osteoporosis.

The following products are affected by the labeling update:

- alendronate sodium, which is marketed as Fosamax;
- Fosamax Plus D;
- risedronate sodium, which is marketed as Actonel;
- Actonel with Calcium;
- ibandronate, which is mar-

keted as Boniva;

- risedronate sodium delayed release, which is marketed as Atelvia; and

- zoledronic acid, which is marketed as Reclast.

Generic versions of the products also are affected. The update does not affect bisphosphonates that are used only to treat Paget's disease or cancer-induced high blood calcium levels.

The FDA announced in March that it was conducting a safety review of oral bisphosphonates. That review included data from a report recently published in the *Journal of Bone and Mineral Research* that reviewed more than 300 cases of atypical femoral fractures. More than 90 percent of those patients had taken bisphosphonates for five years or more,

and 25 percent of the patients had fractures in both legs.

Theresa Kehoe, M.D., a medical officer in the Office of New Drugs in the FDA's Center for Drug Evaluation and Research, or CDER, said during an Oct. 13 news conference that bone density can normalize in patients taking bisphosphonates, and physicians should consider periodic reevaluation of patients' need for continued therapy, particularly in those who have been treated for more than five years.

The FDA said a limitation-of-use statement will be included in the drugs' updated labels, describing the uncertainty of the optimal duration of use of bisphosphonates for the treatment of osteoporosis.

Although the FDA's March

announcement of a safety review focused specifically on oral bisphosphonates, Sandra Kweder, M.D., deputy director of the CDER's Office of New Drugs, said during the news conference that injectable bisphosphonates also had been linked to atypical fractures of the femur.

However, said Kweder, bisphosphonates are effective in preventing common fractures, and atypical femoral fractures are rare, accounting for less than 1 percent of all hip and femur fractures. The FDA emphasized that patients should continue to take their bisphosphonate medications unless advised to stop by their physicians. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20101018bisphosphonatelabel.html>.

In Brief *Public Health*

Abbott Withdraws Sibutramine From U.S. Market

Physicians should stop prescribing sibutramine and contact patients who are taking the weight-loss drug — which is marketed as Meridia — following the FDA's recent decision to ask the drug's manufacturer Abbott Laboratories to voluntarily withdraw the product from the market. The agency made the decision after reviewing findings from the Sibutramine Cardiovascular Outcomes, or SCOUT, trial. According to John Jenkins, M.D., director of the Office of New Drugs in the FDA's Center for Drug Evaluation and Research, the SCOUT trial indicated patients treated with sibutramine experienced a 16 percent higher rate of cardiovascular events. <http://www.aafp.org/news-now/clinical-care-research/20101012meridiawithdrawn.html>

Most Toddler Vaccination Rates Near National Goals

The nation's toddlers are being immunized at or near Healthy People 2010 goals of 90 percent for longer-standing recommended vaccines, according to the results of the 2009 National Immunization Survey. However, one top CDC official says that sporadic disease outbreaks in some areas that are associated with lower rates of coverage for certain vaccines confirm the importance of working with parents to ensure they have their children immunized appropriately.

According to the survey, coverage for poliovirus (92.8 percent); measles, mumps, and rubella, or MMR, (90 percent); hepatitis B (92.4 percent); and varicella (89.6) vaccines remained at or near the 90 percent goals established by HHS' Healthy People 2010 initiative for each of these vaccines. <http://www.aafp.org/news-now/clinical-care-research/20100927toddlervaccs.html>

Unusual Odor Leads to Lipitor Recall

Pfizer Inc. is recalling more than 190,000 bottles of its cholesterol-lowering drug atorvastatin, which is marketed as Lipitor, following reports of an uncharacteristic odor related to the bottles in which the medication is packaged. The FDA said in an Oct. 6 enforcement report that the source of the odor has been identified as 2,4,6-tribromoanisole, which is a degradant of 2,4,6-tribromophenol, a pesticide and flame retardant used to treat wooden pallets. The same contaminant and odor problem was responsible for a massive recall of OTC products by McNeil Consumer Healthcare earlier this year. The Pfizer recall of 191,000 bottles affects 40-mg Lipitor tablets packed in 90-count bottles. <http://www.aafp.org/news-now/health-of-the-public/20101013lipitorrecall.html> ■

AAP Publishes New Recommendations for Iron Intake Among Infants, Toddlers

Report Also Offers Guidance on Screening, Supplementation

Nine percent of U.S. toddlers (i.e., children ages 12 months to 35 months) are iron-deficient, putting them at risk for adverse neurodevelopmental effects, according to a report from the American Academy of Pediatrics, or AAP. The report includes new guidelines for the diagnosis and prevention of iron deficiency and iron-deficiency anemia.

One of the report's co-authors, Robert Baker, M.D., Ph.D., said in a news release that feeding older infants and toddlers foods such as meat, shellfish, beans, iron-rich fruits and vegetables and iron-fortified cereals can help prevent iron deficiency and iron-deficiency anemia. Fruits high in vitamin C, which helps iron absorption, also are beneficial.

However, some children still will need liquid supplements or chewable vitamins to achieve adequate iron intake, Baker said.

The guidelines — which were published online Oct. 5 and appear in the November issue of the journal *Pediatrics* — include the following age-specific recommendations for iron intake.

- Healthy infants born at term have sufficient iron for their first four months. However, breastfed infants should receive 1 mg/kg of an oral iron supplement per day beginning at age 4 months and continuing until iron-rich complementary foods are introduced.
- Formula-fed infants will receive adequate iron from formula and complementary foods. Whole milk should not be given before age 12 months.
- Infants ages 6 months to 12 months need 11 mg of iron per day. When infants are given complementary foods, red meat and vegetables with high iron content should be introduced. If iron needs are not met

by formula and complementary foods, liquid supplements can be used.

- Children ages 1 year to 3 years need 7 mg of iron per day, preferably from foods. Liquid supplements and chewable multivitamins also can be used.
- In their first 12 months, preterm infants should have at least 2 mg/kg of iron per day, which is the amount of iron in fortified formulas. Breastfed preterm infants should receive an iron supplement of 2 mg/kg per day by 1 month of age, and this should be continued until the infant is weaned to iron-fortified formula or begins eating complementary foods.

According to the report, between 6.6 percent and 15.1 percent of U.S. toddlers are iron-deficient, depending on ethnicity and socioeconomic status. Iron-deficiency anemia affects 1 percent to 4.4 percent of children in the same age group.

Roughly 20 percent of children will have some form of anemia during their childhood. The AAP recommends universal screening for anemia at 12 months, including an assessment of risk factors associated with iron deficiency and iron-deficiency anemia, which accounts for 40 percent of anemia in toddlers. Risk factors include premature birth, low birth weight, lead exposure and exclusive breastfeeding after age 4 months.

This recommendation contrasts with AAFP and U.S. Preventive Services Task Force recommendations that say evidence is insufficient to recommend for or against routine screening for iron-deficiency anemia in asymptomatic children ages 6 months to 12 months. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20101020aapironrpt.html>.

CMS Updates Vaccine, Medication Payment Files Retroactive to July 2009

Onus Is on Physicians to Recoup Money Owed Them

By Sheri Porter

The AAFP has learned that CMS is making it the responsibility of individual physicians to ensure that billing adjustments arising from new pricing for vaccines and other medications are made.

Earlier this year, CMS released new pricing files for vaccines and medications covered under Medicare Part B; those changes were effective on July 1, 2010, and were retroactive to July 2009. However, it appears that CMS is requiring physicians to point out any necessary billing adjustments to their Medicare carriers to ensure proper payment.

In comment number 6805.2 of its written instructions to Medi-



care contractors, CMS specifically states, "Contractors shall not search and adjust claims that have already been processed unless brought to their attention."

CMS did not respond to AAFP *News Now's* questions regarding whether this is standard proce-

dures when prices are adjusted.

Cynthia Hughes, C.P.C., an AAFP coding and compliance specialist, recommends that physicians review their billing records to compare how much Medicare paid them for vaccines and other medications during the time period in question to the rates in CMS' revised pricing files.

"Unfortunately, CMS replaced the old average sales price, or ASP, files with the updated version, so there's not an easier way for physicians to compare the old and new rates for vaccines and medications they provided in the practices," said Hughes.

Vaccines that may be affected by the new pricing include

- pneumococcal polysaccharide,
- seasonal influenza,
- hepatitis B,
- a tetanus booster when indicated due to injury, and
- rabies, although this is rare.

Physicians who discover they are owed money should contact their Medicare contractors for instructions on how to get those claims reprocessed, said Hughes. She cautioned against refiling claims without prior contractor instructions, however, because the claims could be rejected as "duplicate" claims. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20100927vaccpayment.html>.

Duty Hour Limits Could Hurt Small, Rural Family Medicine Programs, Say Directors

By Barbara Bein

After the Accreditation Council for Graduate Medical Education, or ACGME, approved new resident duty hour limits that especially affect first-year residents, Academy leaders and family medicine program directors are concerned that upper-level residents and faculty will shoulder too much of the workload and associated added expenses will force the closing of small programs.

Perry Pugno, M.D., M.P.H., director of the AAFP Division of Medical Education, told *AAFP News Now* that the new duty hour requirements disproportionately affect family medicine residencies at a time when the nation's need for more primary care physicians could not be more extensive.

The new duty hour limits “put our currently financially stressed programs at risk,” Pugno said. “It will boil down to a need for more resources to meet the new requirements.”

Joseph Gravel, M.D., of Lawrence, Mass., president of the Association of Family Medicine Residency Directors, agreed. “If there were a clear cause-and-effect (relationship), and these new requirements would improve patient safety, program directors would be in full support of all the rules. But the concern is that they would decrease resident training time, and we risk graduating less well-trained physicians. And this could hurt patient safety rather than improve it.”

Gravel said his biggest concerns are the 16-hour per day work limit for first-year residents and how it will affect his program's ability to ensure adequate graded responsibility and adequate supervision at the same time.

As a result of the changes, upper-level residents and faculty members in his residency may need to shoulder more of the work responsibilities, Gravel said. That, in turn, could mean additional faculty would need to be hired, increasing program costs without additional resources from Medicare.

“Some of the provisions will most likely have the unintended consequence of closing some programs,” he said. ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101006newdutyhours.html>.

Many Factors – Not Just Long Hours – Can Topple Residents' Work-Life Balance

Limiting resident physicians' duty hours alone won't necessarily lower their risk for fatigue or ease their difficulties in maintaining work-life balance. Women residents, especially, say they don't get enough sleep and rarely wake up feeling refreshed. Both men and women want a better work-life balance, especially if they are parents.

These findings from a study published in the September *Academic Medicine* may sound familiar to the ears of U.S. residency directors and resident physicians. But the conclusions actually are drawn from a survey of “junior doctors” conducted in New Zealand. Since 1985, these health care professionals – the equivalent of U.S. residents – have had a contractual duty limit of 72 hours per week.

According to the study, simply limiting work hours has not kept New Zealand's junior doctors from experiencing fatigue and having problems balancing work with other daily activities.

“Multiple aspects of work patterns, not just long working hours, are associated with problems of work-life balance,” said researchers from the Sleep/Wake Research Centre of Massey University in Wellington, New Zealand.

More than 1,400 junior doctors in hospital-based clinical training positions completed questionnaires on work patterns, sleep habits, fatigue-related errors in clinical practice and social support. Each received a fatigue risk score based on his or her answers.

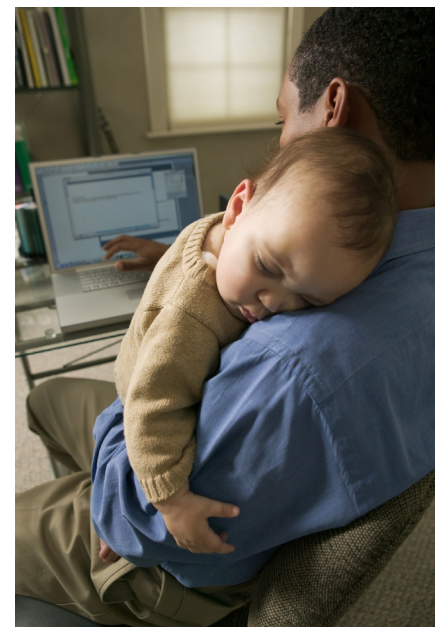
The researchers found that the higher the fatigue risk score a junior doctor received, the greater the work-life imbalance that individual reported. And although the fatigue risk scores of men and women did not differ significantly, women were more likely than men to report inadequate sleep and excessive sleepiness.

The study's main takeaway, said the researchers, is that “limiting work to 72 hours per week has not prevented many junior doctors in hospital-based clinical training positions from experiencing fatigue and problems with work-life balance.”

They said that multiple aspects of work patterns aside from longer total duty hours are independently associated with these difficulties, including increased amounts of night duty and schedule changes. Other variables that upset the balance are commuting times, living with children, studying more than 20 hours a week and inadequate supervision at work.

Solutions are elusive. Only a small proportion – about 15 percent – of the junior doctors reported ever having received training or guidance on personal strategies for coping with shift work and extended duty hours, the study said.

The researchers said the study's findings – particularly the finding of a disproportionate impact of the demands of medical training on women – could have significant policy fallout, in light of a growing number of women physicians worldwide, the current competitive global market for medical graduates, and the projected increases in demand for medical practitioners in industrialized countries due to aging populations and efforts to reduce working hours. ■



For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101019workhoursstudy.html>.

Academy Answers Member Inquiries on Flu Vaccine Coding, Billing

By Sheri Porter

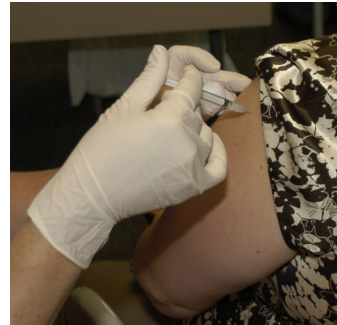
Influenza season has arrived, and that means family physicians are ramping up their vaccination efforts as the AAFP fields member questions about influenza vaccine protocols for the 2010-2011 flu season.

Cindy Hughes, C.P.C., an AAFP coding specialist, has answered several calls from family physicians in recent days. Based on the nature of those calls, she offered these timely reminders to AAFP members about flu vaccinations.

- There is no separate and specific code for the novel influenza A (H1N1) vaccine this year because the 2010-2011 seasonal influenza vaccine includes the H1N1 strain.
- Physicians should report two codes to bill for influenza vaccination services: the appropriate

CPT code for the flu vaccine given and the appropriate CPT code for vaccine administration. A complete list of CPT codes pertinent to the 2010-2011 influenza season is included in *Family Practice Management's* "Getting Paid" blog entry Organize to Immunize - Flu Season Is Coming, which posted on Aug. 26.

- This is the first year that the CDC's Advisory Committee on Immunization Practices has recommended that influenza vaccinations be given to all people ages 6 months and older in whom the vaccine is not contraindicated.
- Physicians should use CPT code 90662 when billing for Fluzone High-Dose, a new flu vaccine approved in December 2009 for use in people ages 65 and older.
- Seasonal flu vaccination is



David Mitchell/AAFP News Now

an annual benefit for Medicare beneficiaries; however, a beneficiary could conceivably receive a seasonal influenza vaccination twice in one calendar year for two different flu seasons. In that situation, physicians can bill – and will be paid – for both vaccine services.

Additional resources that Medicare physicians might find handy during the 2010-2011 influenza season are available from

CMS via a recent issue of the agency's online provider publication, *MLN Matters*. CMS urges physicians and other Medicare fee-for-service providers to keep the issue for reference throughout the current flu season.

CMS also reminds physicians about some common-sense influenza strategies, such as

- use each office visit as an opportunity to encourage patients to get a flu shot;
- provide the seasonal flu shot as long as vaccine is available, even after the new year; and
- ensure that every physician and staff person in the office gets a flu shot. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101013fluvaccoding.html>.

In Brief *Practice Management*

'Partial' Freeze for ICD-9, ICD-10 Code Updates Planned to Ease Transition

As part of the process of transitioning to the ICD-10 code set for outpatient diagnosis coding, the committee responsible for maintaining the ICD-10 and the current ICD-9 code sets in the United States announced it is putting a partial freeze on the codes before implementing ICD-10 on Oct. 1, 2013. The ICD-9-CM Coordination and Maintenance Committee announced on Sept. 15 that it was suspending regular updates to the ICD code sets to ease the industry's transition to ICD-10. Regular updates to ICD-10 will resume on Oct. 1, 2014. <http://www.aafp.org/news-now/practice-management/20100928icd10freeze.html>

TransforMED Offers AAFP Members Discount on Delta-Exchange Service

The Academy's wholly owned subsidiary, TransforMED, is offering AAFP members a discount on a one-year membership in its Delta-Exchange practice transformation learning network. The AAFP member price of \$164.89 represents a 56 percent discount off the \$360 yearly rate Delta-Exchange users currently pay. Delta-Exchange offers participants access to patient-centered medical home

resources, including information on best practices, interactive and on-demand webinars, expert panels of practice facilitators and experienced patient-centered medical home peers, and customizable forms and practice templates to help streamline office processes.

<http://www.aafp.org/news-now/practice-management/20101006deltaexchangediscount.html>

AAFP Resources Guide Members in Coding, Getting Paid for Tobacco Cessation Counseling

The AAFP has created resources to help family physicians navigate Medicare coding for smoking cessation counseling. The online document, Tobacco Cessation Counseling Benefits 2010-2011, provides an overview of Medicare's new smoking cessation counseling benefits. It notes that from Aug. 25 to Dec. 31, 2010, tobacco cessation counseling for asymptomatic patients should be reported with the unlisted CPT code 99199 and on or after Jan. 1, 2011, tobacco cessation counseling services provided to asymptomatic patients should be reported with G-codes G0436 (tobacco-use counsel three to 10 minutes) and G0437 (tobacco-use counsel greater than 10 minutes). <http://www.aafp.org/news-now/practice-management/20101012tobaccocoding.html> ■

'Beyond the Walls of the Teaching Hospital'

GME Provides Multiple Benefits to Institutions, Communities, Say Educators

By Barbara Bein

At a time when more hospitals are being forced to consider closing their primary care residency programs for financial reasons — and many already have — the full economic impact of graduate medical education, or GME, programs has not been appreciated, says one family medicine educator. GME programs provide numerous direct, indirect and intangible benefits to physician-trainees themselves, their sponsoring institutions, university sponsors, and local and wider communities.



In a commentary in the June *Journal of Graduate Medical Education*, Perry Pugno, M.D., M.P.H., director of the AAFP Division of Medical Education, said the best elements of GME programs go beyond hospital-generated profit and loss statements.

"The community benefits of GME programs extend far beyond the walls of the teaching hospital," Pugno and his co-authors say in the commentary. "Through service to individuals and the community at large, these programs contribute positively in ways far beyond what may be found on the typical hospital revenue and expense report."

Yet hospital administrators don't always recognize these contribu-

tions, say the authors. The result? Since 1998, fiscal pressures, including major reductions in federal support, have contributed to the closing of 40 family medicine residency programs and 25 general internal medicine residencies.

This is despite the fact that a residency's teaching clinic often has a "multiplier effect" on its sponsoring hospital. For example, one study showed that for every \$1 billed by one such clinic's family physician faculty and residents, \$6.40 was billed by local consultants and hospital diagnostic and therapeutic services.

"The absence of having this information is why many programs have closed when their programs are challenged to show 'benefit,'" Pugno told *AAFP News Now*. "This information is widely known by primary care program directors, but appreciated by few others."

According to the commentary, GME programs affect five target levels: the residents themselves, the sponsoring institutions, the local community, the affiliated academic health center or university sponsor, and the greater community and nation.

Although many of these benefits are not widely recognized, Pugno said he remains optimistic about the future of GME programs — especially in the health care reform environment that now is unfolding.

"I believe an appreciation of these benefits by the community members themselves is growing, and that's why health care reform and primary care's role in reform have expanded so quickly," he said. ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20100824gmebenefits.html>.

No 'Magic Bullet' to Prevent Medical Errors

Residents, GME Programs Key to Boosting Patient Safety, Say Academic Leaders

There is no single "magic bullet" to prevent medical errors in U.S. hospitals and other clinical settings, according to the authors of a recent article in the journal *Health Affairs*. There are, however, a handful of factors that can help the nation's medical schools, teaching hospitals and health systems make the transformation from the "old culture of autonomy and independence to the new world of shared accountability, interdependence and teamwork" in which a culture of patient safety can be built.

Darrell Kirch, M.D., president and CEO of the Association of American Medical Colleges, and

Philip Boysen, M.D., executive associate dean of graduate medical education at the University of North Carolina, or UNC, at Chapel Hill School of Medicine, say in the article that residents are the ideal change agents.

Residents "are in a unique position, as learners gaining knowledge from faculty physicians through observation and targeted questioning, and as teachers modeling behaviors and techniques for health professions students," they note.

"As such, residents can bring issues of patient safety to the forefront of care delivery, affecting the practices of their more senior and junior colleagues alike. They can

serve as change agents by both mentoring students and 'reverse mentoring' faculty."



The authors say that patient safety training should be part of learning experiences integrated throughout the medical education continuum — from medical school through residency and into CME — culminating with the modeling of best practices in the clinical

setting. To achieve this, medical schools and clinical practices must collaborate closely.

"It has become clear that resident education can be a key driver of culture change, which, in turn, corresponds to improvements in quality and safety," the authors say. "With its long history of advancing the science behind health care, academic medicine is uniquely positioned to advance the culture of patient safety." ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101013kirch-patsafety.html>.

Health Care Reform Law Fails to Provide Remedies for Medical Malpractice

By James Arvantes

An area of primary concern for family physicians that was not addressed in the Patient Protection and Affordable Care Act is medical liability reform. Many physicians see this as a missed opportunity because, according to analysts interviewed by *AAFP News Now*, the current system has never really delivered on its promise of deterring medical errors and improving patient care. It is costly, inefficient and ineffective and fails to provide justice for either patients or physicians.

"We are spending an enormous amount of money to maintain a system that serves very few

people very efficiently, and it has a lot of bad side effects," said Michelle Mello, Ph.D., professor of law and public health at the department of health policy and management at Harvard University. "We spend about 55 cents out of every malpractice premium dollar on the overhead costs of the system. About 2 or 3 percent of the patients who are injured by negligence file a claim, and only a third to a half of those receive compensation, even if there was evidence of negligence.

"We also know that (medical malpractice) has substantial effects on physicians' level of fear and willingness to practice

good medicine."

Yet, the Patient Protection and Affordable Care Act does little to change the current liability system, making medical liability reform one of the biggest missed opportunities of the entire health care reform legislation, according to analysts.

The health care reform legislation addresses medical liability in two ways. First, it extends federal malpractice protections to nonmedical personnel working in free clinics. Second, it authorizes \$50 million for the next five years for HHS to award demonstration project grants to states to develop, implement, institute and evaluate alternatives to the

current tort litigation system for resolving disputes about injuries caused by physicians and other health care providers.

In a sense, these demonstration projects are an attempt to build on seven existing medical liability projects proposed by the Obama administration last year and funded in June of this year by the Patient Safety and Medical Liability Initiative.

Unlike these projects, however, Congress has not yet appropriated funding for the new demonstration projects. Without funding, the net effect of the projects will be nil, said Mello.

According to AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, fixing the medical liability system from a national perspective is not an easy task. He noted that tort reform typically is a state issue, not a federal one, and states don't agree on how to address it. As a result, medical liability laws have been applied unevenly across the states, creating added frustrations for family physicians.

"There are some states that have very lawyer-friendly laws pertaining to torts and, particularly, medical liability," said Goertz in an interview with *AAFP News Now*. "There are other states, like Texas, that have tighter medical liability tort law."

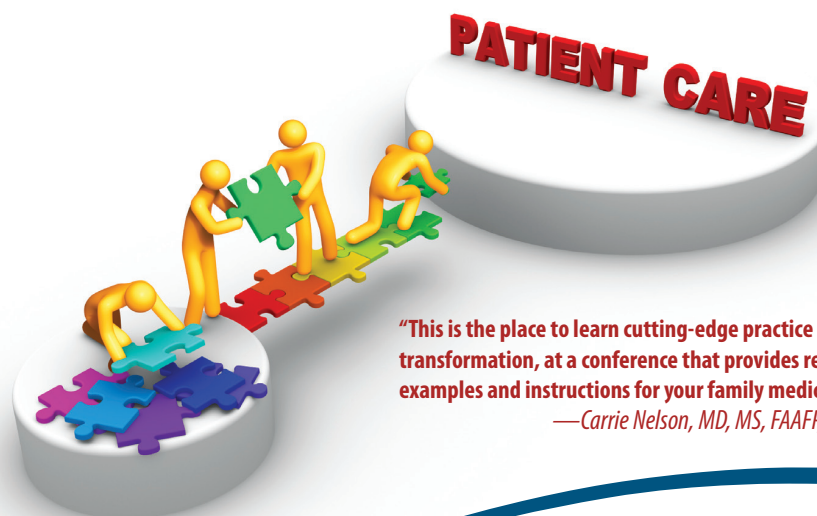
The AAFP has long pushed for a medical liability system that protects both physicians and patients. "It needs to be fair to the patient," said Goertz. "It needs to be fair to the physician, and ... it needs to be based on fact." In addition, when awarded, compensation needs to go predominantly to the patient. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101020tortreform.html>.

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HRSA Administrator Describes Role of Family Physicians in Health Care System

By James Arvantes

The Health Resources and Services Administration, or HRSA, serves as the home for primary care services in the United States. The agency, a \$7.5 billion concern, administers such programs as community health centers and the National Health Service Corps, and in its current capacity, it provides care to 24 million medically underserved and uninsured people.

In February 2009, President Obama named Mary Wakefield, R.N., Ph.D., to the post of HRSA administrator. *AAFP News Now* recently interviewed Wakefield about the role of family physicians in the evolving health care system; the future of the patient-centered medical home, and workforce issues, among other topics.



Photo courtesy of Health Services and Resources Administration

Mary Wakefield, R.N., Ph.D., is administrator of the Health Resources and Services Administration.

Q. What role do you see for family physicians in the U.S. health care system?

A. Family physicians are critically important, of course. As you know, the (Patient Protection and) Affordable Care Act emphasizes quite strongly a focus on illness prevention, promoting health, and management of chronic conditions. All of these areas are core, from my perspective, to the work of family physicians. Family medicine makes major contributions in these areas.

As provisions in the Affordable Care Act are implemented and as we go forward, there is a very clear role and a need for the expertise that family medicine brings to the table.

Q. What are your impressions of the recent Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*?

A. Of course, we are aware of the IOM's report, and we take all their recommendations seriously. I have asked my staff to review the report in detail. That being said, it is clear that nurses and nurse practitioners have essential roles in the delivery of high-quality, coordinated care. Care coordination is dependent on engaging an array of disciplines as part of care teams and is core to achieving high quality. There is no better illustration of this than (HHS) Secretary (Kathleen) Sebelius' recent announcement of more than \$167 million for primary care residency expansion, as well as more than \$30 million for physician assistant training and \$31 million for advanced nurse education expansion. The secretary said it best when she said, "Investing in our primary care workforce will strengthen the role that wellness and prevention play in our health care system."

Q. The health care reform law contains \$1.5 billion in capital projects funding for the National Health Service Corps. What are your plans for deploying those funds?

A. I have to say I am really excited about that investment in the National Health Service Corps. The National Health Service Corps is a sig-

nature program when you think about ensuring that health care providers are placed in locations that need them the most, which includes family physicians and other primary care clinicians, as well.

The great news there is we project that by the end of 2011, we will have more than 8,500 clinicians across the National Health Service Corps. That nearly doubles the number of National Health Service Corps clinicians between 2008 and the end of 2011. We are almost doubling the number of clinicians if you use 2008 as a base year. That means 9 million people served in those underserved communities.

Q. The health care reform law also creates teaching health centers to establish new or expanded primary care residency programs to help train primary care physicians. How do you envision those teaching health centers working?

A. The teaching health centers will establish new primary care residency programs in family medicine and a number of other specialties, as well. The resources also can be used to expand existing accredited primary care residency programs.

An important feature of this teaching health center program is the emphasis on community-based training, which is important and quite consistent with a renewed focus on illness prevention and health promotion. Data show that if you educate folks in community settings, there is an increased likelihood that individuals will practice in community-based settings. It is important to give people exposure, not just in acute care facilities, but also to facilities that are community-based.

Q. What would you say to a medical school student who is considering a career in family medicine? What would be your advice?

A. Many of the investments that we are making right now mean nothing but opportunities for students who might choose family medicine as a specialty. This administration is focusing like a laser on promoting health, preventing illness and supporting innovation in health care delivery. I think that is family medicine. Family medicine is about engaging and leading new models of care, and family medicine also is about managing people with chronic illnesses, working as part of a team and coordinating care.

From HRSA's vantage point, given the investments we are making in community health centers, for example, the next generation of family physicians will have a lot more places to practice. I think it is a very exciting career specialty. ■

For the complete interview, visit <http://www.aafp.org/news-now/government-medicine/20101020wakefieldinterview.html>.

AS WE SEE IT

Voices From the AAFP

From the President

We're Taking the AAFP to the Next Level to Serve You Better

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

Academy leaders are always on the lookout for ways to improve the AAFP so it can better serve you and your patients. But recently, we decided it's time to do something more than search for improvements ourselves. It's time to bring in a consultant to take a fresh look at the AAFP from the outside in, from top to bottom, to find new and improved ways to function — ways that those of us on the inside may overlook.

To get that fresh perspective, we've hired the global consulting firm Accenture to perform a comprehensive organizational effectiveness review of the AAFP. We've asked Accenture to recommend ways to maximize the efficiency of the Academy's structure and operations, to suggest new and innovative revenue streams, and to enhance the effectiveness of the Academy's communications with members.

As you read this, Accenture is delving into everything that is our Academy, from our big-picture strategic objectives to the gritty details of how we operate day to day. They're getting input from all of the AAFP's key stakeholder groups, including members, constituent chapter leaders and their staff members, and AAFP leaders and staff. They're reaching out to other family medicine organizations, as well.

Accenture has a wealth of experience with for-profit as well as non-profit organizations, so we'll be compared with both types. I'm sure Accenture's recommendations will include ideas for improvement that we never would have imagined ourselves.

Why Now?

Why is the time ripe for such an assessment now? For one thing, this type of review is something that consistently successful organizations do on a regular basis. Since our last assessment was in the 1990s, we're due for one.

I also want to make it clear that the AAFP is *not* an organization in crisis. Instead, the Academy is working hard to be a far-sighted, visionary organization that sees the need to improve to succeed in an environment that has changed significantly and that will continue to change.

For example, mergers and acquisitions in the pharmaceutical industry, coupled with new rules regarding pharma funding for associations, have caused the AAFP's topline revenues to drop during the past few years, and we expect this trend to continue. Yet members tell us we should keep up many of our activities, especially our advocacy for payment reform. But these activities require revenue to support them.

The Academy's Consumer Alliance Program is one step we've



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

taken to counter the drop in pharma revenue, but we want to find other innovative revenue streams, as well as operational efficiencies that save money, so we can keep doing our most important work — and so we can keep pressure off member dues, our other key revenue source.

Another catalyst for action is the small dip in members' overall satisfaction with the Academy that was revealed on the most recent member satisfaction survey. We take this decline very seriously and want to maximize the value of your Academy membership.

The advent of new communications methods is another force behind our decision for the assessment. Just think of the changes we've seen; a few years ago, the phrase *social media* wasn't in anyone's lexicon! We need to make sure that we communicate with you the way you want us to and that we frame our messages in a way that makes you want to read them.

I'm excited that the AAFP's assessment is taking place while I'm president because I'm a strong believer in being far-sighted and asking for help when you need it. Years ago, I saw firsthand what happens when an organization doesn't reach out for the help it needs. I began practicing family medicine in a small Texas community with a 30-bed hospital right after Medicare changed to the diagnosis-related group, or DRG, payment method. Our little hospital should have sought help to learn how to cope with DRGs, but it didn't. Eighteen months later, it closed.

The Board expects Accenture to present its recommendations early next year — and then the real fun begins, as we decide which ones to implement and when. Some recommendations may be implemented quickly, but others may take up to two years to bring online. We'll keep you apprised as the process unfolds.

On the Right Road

I'd like to close by sharing a couple of observations with you, one from an American president and the other from an entertainer who's very funny but also very astute.

"Neither a wise man nor a brave man lies down on the tracks of history to wait for the train of the future to run over him," Dwight D. Eisenhower once said. I hope you're proud to belong to a visionary organization that isn't huddled on the tracks, dreading the roar of the future overhead.

Finally, comedian Lily Tomlin once observed, "The road to success is always under construction." I'm sure this organizational assessment will help the Academy of the future remain foursquare on that road. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20101102accentureassess.html>.