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AAFP to NBME: Cease Claims of Equivalence Between FPs and Advanced Practice Nurses

By Barbara Bein

The AAFP is vigorously objecting to some of the policies of the National Board of Medical Examiners, or NBME, related to health system reform. Specifically, the Academy is taking the NBME to task regarding its policies equating physicians with graduates of programs in clinical advanced practice nursing and graduates of physician assistant master's programs based on their scopes and depths of practice.

In a strongly worded letter from AAFP Board Chair Ted Epperly, M.D., of Boise, Idaho, to NBME President and CEO Donald Melnick, M.D., the Academy said it is "surprised and disappointed" by recommendations in the draft document "Policies of the National Board of Medical Examiners Regarding Health System Reform," which was approved in principle by the NBME membership in March.

The Academy strongly urges the NBME to "immediately reconsider" its recommendations and change its policies.

The Academy letter points to several sections of the NBME policies that indicate equivalency between primary care physicians and advanced practice nurses and notes that when AAFP leaders met with NBME representatives in September 2008, the NBME agreed to cease making such statements.

See AAFP to NBME, page 2



AAFP's Center for Health IT Evaluates Burden of 'Meaningful Use'

By Sheri Porter

The AAFP's Center for Health Information Technology has carefully analyzed the CMS final rule that defines "meaningful use" in terms of electronic health records, or EHRs, and has determined that the final rule contains changes that will benefit family physicians. However, the rule still will require

significant effort to implement, according to Steven Waldren, M.D., director of the AAFP's Center for Health IT.

One area of concern to the Academy was parity between Medicare and Medicaid regarding the incentive programs' first-year requirements. That type of parity was not in the final rule.

"Eligible professionals in the Medicare program must bear a heavier burden of full meaningful use compliance in their first payment year to receive the incentive payments," said Waldren. That gives Medicaid-participating physicians, who just have to commit to adopt, implement or upgrade a certified EHR, a "significant

advantage" the first year, he said.

In addition, according to Waldren, CMS' aggressive timeline for the implementation of meaningful use will be a "significant challenge."

Jason Mitchell, M.D., assistant director of the Academy's Center for Health IT, told AAFP

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SEPTEMBER HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

Health Care Reform page 4
The new health care reform law is expected to increase demand for preventive services and provide tax breaks.

Point/Counterpoint . . . pages 11-12
Two family physicians provide their perspectives on the ongoing threat of Medicare payment cuts for physicians.

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"At that time, you expressed regret and remorse for having made statements that both misled the public and permitted militant members of the nursing community to equate the 'certification' of a graduate from a doctor of nursing practice, or DNP, program with that of a primary care physician," says the letter. "The content of these policy statements, unfortunately, once again seems to suggest equivalence between primary care physicians and advanced practice nurses."

Epperly was more direct when he told *AAFP News Now*, "They absolutely renege on what they told us."

The Academy letter points to a guideline policy in the NBME document that states, "National standards should apply uniformly to all clinicians providing the same or similar services, without regard to professional or educational background." The letter then cites an example in the NBME document's supporting text that says "physicians, graduates of master's or doctoral programs in clinical advanced practice nursing, and graduates of physician assistant master's programs might share licensure assessment related to primary comprehensive care."

"In other words, you equate both the scope and depth of practice of primary care physicians with those of advanced practice nurses," says the Academy's letter.

Expanding on the equivalency issue, the AAFP

also objects to NBME statements alleging that physicians and nurse clinicians have "comparable scopes of practice" and suggesting that licensing authorities for both "should be required to create common means of assessing proficiency for entry to and continuation in practice."

"Here again, the NBME is suggesting equivalency between the services provided by a nurse with as few as 1,000 hours of clinical training and those provided by a primary care physician with several years and more than 14,000 hours of clinical training," the letter says. "We believe that this position by the NBME once more has the potential to endanger the health of the public."

In the letter, the Academy insists that the NBME "cease and desist this misguided effort to delude the American people" into thinking they receive the same breadth and depth of care from a nurse as they do from a physician.

"The NBME must clearly state that doctors of nursing practice are not equivalent to primary care physicians, that their scope of practice is substantially more narrow than that of physicians, and that they should, therefore, be assessed very differently than physicians," says the letter. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100811nbmeletter.html>.

Center for Health IT, *continued from page 1*

News Now that the lack of technical support topped the Academy's list of concerns.

He said many federally funded health IT regional extension centers would have trouble providing the level of support that practices need. "There isn't the right amount of expertise, and there isn't enough money to put the people with expertise on the ground to help practices along," said Mitchell. "Most regional extension centers are brand-new organizations, quickly assembled and with no track record for providing the proposed services."

The Academy, however,

is pleased with some of the changes CMS made to the original rule. For example, CMS

"Eligible professionals in the Medicare program must bear a heavier burden of full 'meaningful use' compliance in their first payment year to receive the incentive payments."

— Steven Waldren, M.D.,
Director, Center for Health IT

moved 10 of 25 measures into a "menu set" whereby physicians can select five measures to use.

Calling the change a "vast improvement," Waldren said it reduced the overall number of required measures from 25 to 20. "Though not truly a partial incentive ... this new flexibility intro-

duced in the requirements will allow practices some choices to match their capabilities and workflow processes," he said.

In the final rule, CMS also reduced the scope of computerized provider order entry to apply only to medication orders and reduced the compliance threshold from 80 percent to 30 percent of all medication orders.

Thresholds for several other utilization measures also were reduced in the final rule. In addition, CMS reduced the number of potential quality measures from 96 to 44. That means most physicians will need to submit only six quality measures; three of those will be core requirements, and the physician will choose three. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100812meaningfulusereview.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between July 22 and August 12, 2010.

Financial, Technical Support Are Keys to Health IT Adoption by Small Physician Practices

By James Arvantes • Washington

The American Recovery and Reinvestment Act of 2009, or ARRA, will spur the adoption and use of health information technology, or health IT, among small physician practices by giving them much-needed financial and technical support to implement health IT systems. Without this kind of assistance, many small physician practices will find it difficult, if not impossible, to adopt health IT and electronic health records, or EHRs.

That was one of the main messages delivered by AAFP President-elect Roland Goertz, M.D., M.B.A., of Waco, Texas, and other witnesses who testified July 27 before the House Energy and Commerce Committee's Subcommittee on Health.

"H(health) IT is critical to improving quality and effectiveness of patient care," Goertz told committee members during the hearing. He added, however, "physicians in small, rural practices must receive technical support during implementation and use of (health) IT."

One portion of the ARRA, known as the Health Information Tech-



AAFP President-elect Roland Goertz, M.D., M.B.A., tells the House Energy and Commerce Committee's Health Subcommittee that solo and small rural practices, in particular, need assistance if they are to adopt health information technology.

James Arvantes/AAFP News Now

nology for Economic and Clinical Health, or HITECH, Act, focuses on promoting the adoption of health IT among hospitals, physicians and other health care providers. HITECH authorizes \$2 billion in grants for the creation of several programs to spur health IT use, including a beacon community program, a health IT workforce program and a health IT extension program.

"Solo, small practices, in particular, are short of time and dollars," said Goertz. "They are busy focusing on patient care and operating on small margins. Assisting them is critical to making (health) IT work in the U.S."

Therefore, Goertz said, "the HITECH grants are critical, as physicians make these transformative changes to their practices."

Among other witnesses who testified during the hearing was family physician Matthew Winkleman, M.D., of Harrisburg, Ill. In his testimony, Winkleman agreed that one of the obstacles many physicians face when trying to decide whether to deploy an EHR is the "initial upfront costs."

"Not only is the software, hardware and necessary infrastructure costly, but the process of seeing patients in the initial weeks of transitioning to use of an electronic record requires changes in workflow that will likely decrease efficiency and the number of patients seen daily," said Winkleman, who is one of the physician owners of the Primary Care Group in Harrisburg. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100729goertz-heslin-testify.html>.

MGMA Survey Tracks Medical Practice Trends

Operating Costs, Medicare Pay, EHRs Top 2010 'Challenges' List

By Sheri Porter

Keeping a U.S. medical practice afloat in 2010 is still a struggle, according to new survey data collected by the Medical Group Management Association, or MGMA. However, the specific day-to-day challenges of running a practice have shifted somewhat when compared with similar MGMA surveys conducted in 2008 and 2009.

The issue of dealing with rising operating costs topped the list of practice challenges in 2010, just as it did in 2009. Managing finances with the uncertainty of Medicare reimbursement rates ranked No. 2, and selecting and

implementing an electronic health record, or EHR, filled out the No. 3 spot on MGMA's challenge list.

Rounding out the top 10 challenges for 2010 (in descending order beginning with No. 4) are

- maintaining physician compensation levels;
- recruiting physicians;
- collecting from patients with self-pay, high-deductible health plans or health savings accounts;
- negotiating contracts with payers;
- managing teamwork and group dynamics among physicians;
- modifying physician compensation methodology; and

- participating in CMS' Physician Quality Reporting Initiative.

David Gans, M.S.H.A., vice president of innovation and research at MGMA, told *AAFP News Now* that comparing three years of survey results helps researchers see how health care is evolving.

For example, the challenge of implementing a patient-centered medical home model of care leapt from No. 22 in 2009 to No. 12 in 2010. That means an issue that didn't even make the survey in 2008 saw the largest gain in 2010.

Gans said the medical home also is gaining momentum with subspecialists, who now are rec-

ognizing that their practices interact differently with a patient who is part of a medical home compared with one who is part of a traditional primary care practice.

Gans also noted that a companion survey that ranked survey participants' responses to how their practices dealt with the effects of the economic recession, found that the top priority remained unchanged since 2009; namely, practices said they need to improve billing, collections and denial management processes. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100727mgmasurvey.html>.

Tax Credit Designed to Help Small Businesses Provide Health Insurance

As small-business owners, many family physicians who own solo or small practices struggle to provide health insurance for their employees. However, thanks to the recently enacted health care reform legislation, these physicians now may be eligible for a tax credit that they can use to help purchase this health insurance.

The Patient Protection and Affordable Care Act contains various provisions to help small businesses purchase health insurance for their workers, including a measure that offers a tax credit for small employers (i.e., businesses with fewer than 25 workers and average wages of less than \$50,000 per worker) who provide health insurance for their employees.

The tax credit provides as much as 35 percent of an employer's cost for employee coverage and as much as 25 percent of the cost of coverage for employees at nonprofit organizations. The smallest businesses with the lowest salaries (i.e., those that employ 10 or fewer employees who earn an average wage of less than \$25,000) are eligible for the full 35 percent tax credit – 25 percent for nonprofits. The tax credit, which takes effect this year and runs until 2016, phases out as the size of the business and its average per-worker wage increase.

The income of small-business owners is not calculated when determining the tax credit.

In addition, the value of the tax credit climbs to 50 percent from 2014-16 for small businesses that purchase employee health insurance through state-based health insurance exchanges established by the health care reform act. These insurance exchanges are required to be established by 2014.

To qualify for the tax credits, businesses have to cover at least 50 percent of a worker's health insurance premiums. Small employers are eligible for the tax credit even if they already receive assistance from their state to help them purchase coverage for their employees, according to a recent report issued by Families USA and the Small Business Majority.

"A Helping Hand for Small Businesses: Health Insurance Tax Credits" notes that the eligibility limits for employers with as many as 25 workers include the hours of part-time employees, who will be counted as full-time time equivalents. For example, two half-time workers count as one full-time worker for the purpose of calculating tax credit eligibility.

"This means that part-time workers, who are more likely to be uninsured than their full-time counterparts, may finally be able to obtain job-based health insurance with the help of the small business tax credits," says the report. ■

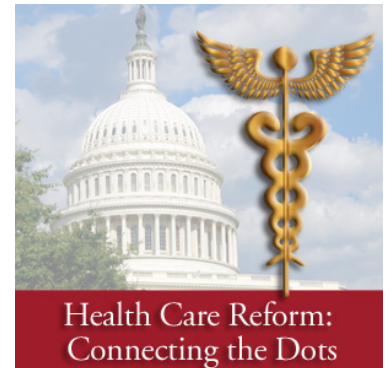
For more information, visit <http://www.aafp.org/news-now/practice-management/20100811insurancecredit.html>.

Health Care Reform Law Will Increase Demand for Preventive Services, Say Experts

By James Arvantes

The recently enacted health care reform legislation, which calls for eliminating financial barriers for many preventive services, likely will create a greater demand for these services and give physicians a better opportunity to provide preventive care, according to analysts interviewed by *AAFP News Now*.

The Patient Protection and Affordable Care Act will require new health plans (i.e., plans that are established on or after Sept. 23, 2010) to cover and eliminate copays, deductibles and coinsurance amounts for preventive services rated "A" or "B" by the U.S. Preventive Services Task Force. According to the law, new plans also will 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 such as HHS.

The same provisions will apply to the Medicaid and Medicare programs as of Jan. 1, 2011. Both programs will be required to eliminate copays, deductibles and coinsurance for the same recommended preventive services and vaccines. This requirement is expected to boost patient access to dozens of services, including cholesterol screening tests, routine vaccinations, many cancer screenings, prenatal care, and regular wellness visits for infants and children.

HHS has moved quickly to supply details regarding this part of the health care reform legislation. It issued interim final rules for the preventive services provisions on July 14. HHS estimates that the provisions will eliminate financial barriers for 41 million people within the next year. However, this likely will lead to a much greater demand for preventive services.

"There is very good evidence showing that when you eliminate cost-sharing and copays for evidence-based services, people are more likely to use them," said Ann O'Malley, M.D., M.P.H., senior researcher at the Center for Studying Health System Change.

The new law's provisions could lead to patients having a difficult time getting an appointment with an increasingly small pool of primary care physicians. But they also will mean that primary care physicians will be able to catch many chronic problems before they become acute.

With the new law, it will be easier for primary care physicians to provide the recommended services, said Herbert Young, M.D., director of the AAFP's Scientific Activities Division.

"It should alleviate the frustration that many physicians face when patients say they cannot afford the copay or other costs associated with preventive services," said Young. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100728hcreformprevent.html>.

Pair of Studies Link Vitamin D, Cognitive Ability in Seniors

Researcher Says Majority of Older Americans Deficient in Vital Nutrient

Two recent studies indicate that vitamin D intake can have a significant effect on the cognitive abilities of the elderly. Unfortunately, more than half of older Americans have insufficient levels of vitamin D, according to David Llewellyn, Ph.D., a researcher at the University of Exeter Peninsula Medical School, United Kingdom.

Llewellyn presented data on this topic from the Third National Health and Nutrition Examination Survey, or NHANES III, during the Alzheimer's Association International Conference on Alzheimer's Disease 2010, July 10-15 in Honolulu.

Researchers examined information from more than 3,000 adults ages 65 and older who participated in NHANES III. Vitamin D levels in blood samples were assessed in relation to par-

ticipants' performance on cognitive function tests for memory, orientation in time and space, and attention span.

According to Llewellyn, 8 percent of the subjects who had sufficient levels of vitamin D were cognitively impaired compared with 15 percent of subjects who were vitamin D-insufficient and who demonstrated cognitive impairment. Those who had significant vitamin D insufficiencies were four times more likely to be impaired.

Llewellyn said many older Americans aren't exposed to enough sunlight to produce adequate levels of vitamin D, and skin becomes less efficient at producing the vitamin as the body ages. He also said there are few dietary sources with high levels of naturally occurring vitamin D and noted that even foods that

are fortified with the vitamin still do not provide adequate levels.

According to Llewellyn, vitamin D may protect blood flow to the brain and also may clear toxins from the brain, including the amyloid proteins associated with Alzheimer's disease. But, he added, more research is needed to establish whether vitamin D supplementation has therapeutic potential for dementia.

Llewellyn also is the lead author of a similar study recently published in the *Archives of Internal Medicine*.

Researchers used data from more than 800 noninstitutionalized Italians ages 65 and older who were enrolled in the InCHIANTI (Invecchiare in Chianti, or "aging in the Chianti area") study. Blood test results were assessed in relation to the results of three cognitive evaluations – the Mini-



Mental State Examination and Trail Making Test Parts A and B.

Scores for all three tests were significantly lower in subjects who were vitamin D-deficient or severely deficient than in those who had sufficient levels, and more than half of participants with dementia were severely vitamin D-deficient. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100727vitamind-cognition.html>.

In Brief *Health of the Public*

NFID Initiative Aims to 'S.T.O.P. Meningitis!'

The National Foundation for Infectious Diseases, or NFID, is offering free resources for physicians via its S.T.O.P. (Share. Teach. Outreach. Protect.) Meningitis! initiative. The initiative's updated tools for health care professionals and patient education materials include a meningococcal disease fact sheet, tip sheets about vaccine delivery and reimbursement, posters, letters to parents, phone scripts, standing orders, a patient education video, and a video question and answer with vaccine experts. According to the NFID, the United States averages 1,500 cases of meningitis per year. The death rate is 11 percent in the general population and 14 percent in adolescents and young adults. In addition, as many as 19 percent of survivors face permanent damage, including hearing loss, brain damage and limb amputations. <http://www.aafp.org/news-now/health-of-the-public/20100722stopmeningitis.html>

FDA Warns Docs, Consumers About Unapproved IUDs

The FDA is warning physicians and consumers about risks associated with the use of unapproved intrauterine devices, or IUDs, and intrauterine systems, or IUSs. The agency said in a July 22 letter to physicians that the items in question include unapproved versions of FDA-approved products, such as Mirena (levonorgestrel IUS), Impla-

non (etonogestrel implant) and ParaGard (copper-T IUD), as well as products not approved for use in the United States, such as T-Safe. According to the FDA, such unapproved products could be unsafe and ineffective. The agency said the products may not have been manufactured, transported or stored under the stringent conditions required by the agency. <http://www.aafp.org/news-now/health-of-the-public/20100728unapprovediuds.html>

GAO Report Critical of Genetic Tests Marketed to Consumers

Direct-to-consumer genetic tests provide results that are misleading and of little or no practical use, according to a report from the U.S. Government Accountability Office, or GAO. In a study of 40 genetic tests from four different companies, investigators found 10 "egregious examples of deceptive marketing," including claims made by the four companies that a customer's DNA could be used to make personalized supplements capable of curing diseases. According to Jeff Shuren, M.D., J.D., director of the FDA's Center for Devices and Radiological Health, the FDA is working to regulate genetic tests to "give patients and doctors confidence in these tests and facilitate progress in personalized medicine." <http://www.aafp.org/news-now/health-of-the-public/20100811gaoreport-genetic.html> ■

Advisory Committees Reject FDA Plan for Controlling Opioid Use *Panel Wants Mandatory Training for Docs Included in Risk Management Plan*

FDA advisers have overwhelmingly rejected the agency's plan for reducing the inappropriate prescribing, misuse and abuse of extended-release opioids.

During a July 22-23 joint meeting of the FDA's Anesthetic and Life Support Drugs and Drug Safety and Risk Management advisory committees, committee members voted 25-10 against a proposed Risk Evaluation and Mitigation Strategy, or REMS, for extended-release and long-acting opioid analgesics after deeming the plan insufficient to stop abuse of the painkillers.

John Jenkins, M.D., director of the Office of New Drugs in the FDA's Center for Drug Evaluation and Research, explained during a July 23 press briefing that the agency's two-year effort to develop the REMS focused on the legitimate medical use of the drugs. The FDA, he said, was chiefly concerned about ensuring that physicians were selecting the right patients and the right drug dosages and making sure that patients were using the medications as directed.

However, Jenkins said, the committee members focused much of their discussion on nonmedical use of these opioids.

"We tried to help the committee understand that some of the other activities are beyond our REMS authority," he said. "But I don't think we helped them understand that enough. It didn't creep back into a lot of their concerns and recommendations."

The REMS called for physicians who prescribe opioids to complete

a voluntary training program, but Jenkins said many members of the committees wanted training to be mandatory.

According to Jenkins, FDA officials considered such an option but determined that mandatory training might place an undue burden on the health care system because more than 700,000 physicians are authorized by the DEA to prescribe extended-release opioids.

The FDA was concerned that some physicians would stop prescribing the drugs rather than complete the training, thereby decreasing access to care for the estimated 4 million patients who have a legitimate need for the medications each year, said Jenkins.

Although physicians must register with the DEA, Jenkins said it would require a legislative change by Congress to give the FDA the authority to require training as part of that registration.

The agency currently *does* have the authority to require drug manufacturers to provide mandatory training of this type, but Jenkins said that option was less than ideal.

The FDA also was concerned, he noted, about the sheer magnitude of a mandatory training program for opioids because it would be significantly larger than any similar program the agency has undertaken for other medications. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100803fdarejects.html>.

ACIP Recommends Against Use of Afluria in Children Ages 6 Months Through 8 Years

Vaccine Linked to Higher Fever Incidence, Febrile Seizure Risk

The CDC's Advisory Committee on Immunization Practices, or ACIP, has recommended that Afluria, the trivalent inactivated seasonal flu vaccine manufactured by the Australian company CSL Ltd. and distributed in the United States by Merck and Co. Inc., not be given routinely to children younger than 9 years old.

The ACIP, which made the recommendation during its Aug. 5 meeting, based its decision on data that indicate an increased risk of

febrile seizures in children ages 6 months through 4 years following vaccination with CSL's Fluvax and Fluvax Junior. The committee also looked at data that showed a higher incidence of reported fever in children ages 5 years through 8 years following Fluvax vaccination this year compared with the incidence seen after Fluvax vaccination during previous seasons and after immunization with other flu vaccines on the market this year.

A higher incidence of fever in children ages 5 years through 8 years also was reported during a

2009 U.S. trial of Afluria, which is antigenically similar to Fluvax and Fluvax Junior.

The ACIP recommended that other age-appropriate, licensed seasonal influenza vaccine formulations be used to prevent influenza in children ages 6 months through 8 years.

If no other age-appropriate, licensed flu vaccine is available for a child age 5 years through 8 years who has a medical condition that increases his or her risk for influenza complications, the committee said Afluria may be given. However, physicians should discuss the benefits and risks of vaccination with the child's parents or caregivers before administering Afluria.

Four other seasonal vaccines

are licensed for use in children in the United States:

- Sanofi Pasteur's trivalent inactivated vaccine, which is marketed as Fluzone, may be used in children ages 6 months and older;
- MedImmune's live, attenuated influenza vaccine, which is marketed as FluMist, may be used in children ages 2 years and older;
- GlaxoSmithKline's trivalent inactivated vaccine, which is marketed as Fluarix, may be used in children ages 3 years and older; and
- Novartis' trivalent inactivated vaccine, which is marketed as Fluvirin, may be used in children ages 4 years and older. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20100812afluria.html>.



2010 National Conference
Family Medicine Residents, Students Elect New Leaders

Delegates to the National Congress of Family Medicine Residents and the National Congress of Student Members chose new leaders on July 31 to represent them in the coming year. Here are the election results:

Resident and student members of the AAFP Board of Directors: Heidi Meyer, M.D., of Tucson, Ariz., and Kevin Bernstein, of Quakertown, Pa.

Chairs of the 2011 National Conference of Family Medicine Residents and Medical Students: Mellisa Pensa, M.D., of Portland, Ore., and Andrew Lutzkanin III, of Middletown, Pa.

Alternate delegates to the 2010 AAFP Congress of Delegates: Peter Rippey, M.D., of Daytona Beach Shores, Fla.; Meshia Todd, M.D., of Durham, N.C.; Jessica Johnson, of Newington, Conn.; and Courtney Huhn, of Lansing, Kan.

Resident representative to the Association of Family Medicine Residency Directors Board of Directors: Benjamin Schneider, M.D., of Portland, Ore.

Resident representative to the Society of Teachers of Family Medicine Board of Directors: Sarah Tully Marks, M.D., of Shorewood, Wis. Sebastian Tong, of Boston, is staying on as student representative.

Resident representative to the AAFP Foundation Board of Trustees: Brooke Sciuto, M.D., of Sacramento, Calif.

National Family Medicine Interest Group Coordinator: Alyson Lewis, of Ormond Beach, Fla. ■

2010 National Conference

Residents, Students Seek Action on Medical Education, Preventing Burnout

By Barbara Bein & Sheri Porter • Kansas City, Mo.

Future family physicians want the Academy's help in making changes to medical education, including proposals on residents' duty hours and preventing burnout among medical students and residents. During the 2010 National Conference of Family Medicine Residents and Medical Students here July 29-31, members of the National Congress of Family Medicine Residents and the National Congress of Student Members expressed similar concerns about burnout and student debt. Only the residents, however, engaged in spirited discussion about the latest draft proposals on resident duty hours from the Accreditation Council for Graduate Medical Education, or ACGME.

Resident Ben Marcum, M.D., of Pocatello, Idaho, introduced a resolution expressing his concern about recent ACGME proposals requiring direct supervision of first-year residents, limits on moonlighting and a maximum 16-hour shift for first-year residents. His resolution asked the AAFP to oppose these proposed changes.

The resolution objected to the proposed 16-hour shifts for first-year residents, in particular, because such shifts "do not provide adequate time for PGY1 (post-graduate, year one) residents to experience the full progression of inpatient care outcomes, nor do they provide adequate home time due to the increased number of shifts at odd hours necessary to successfully prepare the resident."

Furthermore, the resolution contended, such a change would not appreciably improve resident fatigue or the ability to care for patients.

In the end, residents asked the Academy to submit written comments to the ACGME regarding the pros and cons of the latest proposals. They also want the AAFP to share findings from a national survey of family medicine residency directors about the potential impact of some of the ACGME recommendations.

Both residents and students looked for remedies to burnout in graduate medical education and in medical school, asking the AAFP to consider offering sessions on student and resident wellness, balance and avoidance of burnout during future national conferences. Both congresses also want AAFP constituent chapters to encourage programs for students and residents on individual counseling, support groups, mindfulness and other mind-body experiential learning opportunities.

"The burnout issue is important, especially in primary care," Carlos Hernandez-Torres, M.D., of Las Cruces, N.M., testified before a reference committee. "It's not just students and residents, but when we get into our practices. A healthy doctor means healthy patients."

Both residents and students also were concerned about student debt and asked the AAFP to approach the National Health Service Corps, or NHSC, about its eligibility requirements.

In their resolution, students noted that a student's outstanding service obligations — such as state loan repayment programs, scholarship programs or conditions of medical school enrollment — could conflict with a student's eligibility for the NHSC loan repayment program. Specifically, the NHSC states that eligible applicants "must have no outstanding service obligation for health professional service to the federal government ... or other entity, unless the obligation would be completed prior to receipt of the NHSC (loan repayment program) award."

In its report, the reference committee that heard testimony on the issue said investigation of potential conflicts should be the responsibility of the individual applicant and recommended that the resolution not be adopted.

The students, however, overturned that recommendation and adopted the measure. ■



Ben Marcum, M.D., of Pocatello, Idaho, testifies in support of a resolution he introduced during the 2010 National Conference of Family Medicine Residents and Medical Students that asks the AAFP to oppose certain changes in residents' working conditions. The changes have been proposed by the Accreditation Council for Graduate Medical Education.

Barbara Bein/AAFP News Now

2010 Tar Wars Winner Trumps Brother's Achievement

Colorado Student First From State to Win National Poster Contest

By David Mitchell

Jared Gorthy wasn't the first member of his family to be selected a state winner in the Colorado AFP's annual Tar Wars poster contest. That honor went to his brother Derek, who won the state contest and finished seventh at the Tar Wars National Conference in 2007.

Jared, however, fared even better than his older brother and was named the winner of the AAFP initiative's 2010 national poster contest July 26 during the national conference in Washington, D.C.

The fifth-grader from Colorado Springs said he was motivated by his sibling's experience three years ago.

"I wanted to go to nationals, too," Gorthy told *AAFP News Now*. "I was trying for that. I was kind of surprised I came in first."



Courtesy of Senate Photography Studio

Tar Wars National Poster Contest winner Jared Gorthy, of Colorado Springs, center, accompanied by his older brother Derek, mother Cheryl and father Scott, poses with Sen. Mark Udall, D-Colo., right, after meeting with the senator and presenting him with a copy of his winning poster.

Family physicians and other health care workers across the country present Tar Wars tobacco-free education programs to fourth- and fifth-graders

in their local schools each year, discussing the toll tobacco takes on health, as well as the financial costs of tobacco use. More than 8 million children have heard the tobacco-free message since the program's inception more than two decades ago.

The program, which is supported by the AAFP Foundation, culminates each year with a national poster contest made up of submissions from state-level poster contest winners.

In addition to Gorthy, a number of other state-level poster contest winners were recognized

during the awards ceremony:

- Gianni Chiodo, of Des Moines, Iowa, placed second in the national poster contest;
- Krysti Maines, of Sparta, N.C., placed third;
- Macy Willis, of LaGrange, Ga., placed fourth;
- Lakyn Ogle, of Pleasant City, Ohio, placed fifth;
- Rachel Majors, of Tipton, Ind., placed sixth;
- Bryce Allen Martin, of Hinton, W.Va., placed seventh;
- Erynn Novak, of Novi, Mich., placed eighth;
- Ashton Curtis, of Madison, Miss., placed ninth; and
- Claire Lin, of St. Louis, placed 10th. ■

For more information, visit <http://www.aafp.org/news-now/inside-aafp/20100729tarwars-gorthy.html>.

AAFP's METRIC Videos Designed to Increase Program's Efficiency

The Academy's online performance improvement program, known as METRIC, or Measuring, Evaluating and Translating Research Into Care, has entered a new phase with the launch of three new videos. The resources were created to highlight the value of the METRIC program and to help physicians use the program more efficiently.

"Performance improvement CME, or PI-CME, is nontraditional CME and not always understood by the learners," said Susan Richart, the AAFP's manager of performance assessment and improvement.

"The videos are a direct result of user feedback," said Richart. "As physicians worked through the various METRIC modules, we discovered that a few kinks in the program were keeping some people from making progress."

The new "10 tips" video includes hands-on advice on how to successfully complete a METRIC module. Most of the players in the video are practicing physicians who have chalked up a METRIC completion or two themselves and are eager to help their colleagues avoid mistakes that may derail progress.

A second video offers a primer on the METRIC program. The video explains how METRIC can help physicians earn CME credit, fulfill their Maintenance of Certification for Family Physicians Part IV (performance-in-practice) requirement, and use METRIC in residency programs, as well as how it can help practices achieve recognition as patient-centered medical homes.

The third video, titled "Model for Improvement," offers an overview of the value of practice improvement. Physicians can use this video as a guide as they develop improvement projects, said Richart. ■

For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20100806metricvideos.html>.

STFM, AAFP Offer Online HIPAA Resources for Students, Preceptors

The Society of Teachers of Family Medicine, or STFM, in collaboration with the AAFP, has developed resource materials on Health Insurance Portability and Accountability Act, or HIPAA, rules for medical and premedical students and others who are invited to shadow family physicians in their offices.

The resources, which have been uploaded to the Family Medicine Digital Resources Library, consist of a PowerPoint presentation on HIPAA regulations and student agreement and patient release of information forms.

"Having materials that have been created and endorsed by STFM and the AAFP should help preceptors feel more comfortable bringing premedical and medical students into their offices and exposing them to a positive experience with a family medicine practice," said STFM Executive Director Stacy Brungardt, C.A.E. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100723stfmhipaatools.html>.

Expanded Tax Relief on State Loan Repayment, Forgiveness Programs Benefits Physicians, Medically Underserved Individuals

By Barbara Bein

Physicians who have received student loan forgiveness as an incentive to practice in medically underserved areas of their states may be eligible for some relief from federal income taxes on those loan amounts.

Under Section 10908 of the new Patient Protection and Affordable Care Act, an existing tax exclusion has been expanded to include health professionals in 16 states who are enrolled in these types of state loan repayment or loan forgiveness programs. Moreover, the exclusion is being applied retroactively to 2009, which means that program participants in these states may be eligible for a tax refund.

According to a press release from the Internal Revenue Service, or IRS, the exclusion was expanded as part of efforts to strengthen the health care workforce.

"Doctors and nurses who choose to practice in underserved areas make a great contribution to their local communities," said IRS Commissioner Doug Shulman in the press release. "By expanding the tax exclusion for student loan forgiveness, the (Patient Protection and Affordable Care Act provides an even greater incentive to practice

medicine in areas that need it most."

Individuals who think they may qualify for the refunds should consult their state loan program offices to determine if the program is covered by the new law, according to the press release.

Health care professionals who have not yet filed taxes for 2009 — for example, because they filed for extensions — do not have to report eligible loan repayment or forgiveness amounts when they file. Those who already have filed may exclude eligible amounts by filing an amended U.S. Individual Income Tax Form.

In addition, the IRS says that individuals whose employers withheld and paid taxes under the Federal Insurance Contributions Act, or FICA — which funds the Social Security and Medicare programs — on payments covered under the new exclusion may request that the employers seek refunds of withheld FICA tax amounts on behalf of their employees.

Because employers also pay a portion of the FICA tax, they also may be entitled to a refund, according to the IRS. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100727hcreformseries-taxrelief.html>.

Health Care Reform Legislation Will Drive Adoption of Medical Home Projects

By James Arvantes • Washington

Recent enactment of health care reform legislation will accelerate the adoption of the patient-centered medical home, or PCMH, in the public and private sectors by making key investments in the nation's primary care infrastructure while also giving CMS greater latitude in launching and sustaining innovative models, which then may be implemented by the private sector. That's according to two keynote speakers who addressed the Patient-Centered Primary Care Collaborative, or PCPC, stakeholders' meeting here on July 22.

The Patient Protection and Affordable Care Act has "expanded the portfolio investment in CMS in terms of Medicare and Medicaid innovation," which will give that agency much more latitude in developing payment and service delivery models that reduce costs and improve

quality, said Anthony Rodgers, M.S.P.H., deputy administrator for the Center for Strategic Planning and Initiatives at CMS and one of two keynote speakers to address the conference.

At the same time, the legislation substantially increased funding for the National Health Service Corps and community health centers for the next few years. It also provides funds to expand the number of primary care residency slots in community settings in an effort to train 500 additional primary care physicians by 2015.

These types of investments represent support and an underlying commitment to primary care and the PCMH, said Mary Wakefield, R.N., Ph.D., administrator at the Health Resources and Services Administration, or HRSA, and the other keynote speaker to address the conference.

The Patient Protection and Affordable Care Act calls for the

establishment of a Center for Medicare and Medicaid Innovation, or CMI, on Jan. 1, 2011. The legislation gives the CMI the authority to launch pilot projects without first demonstrating that projects will achieve budget neutrality.

The health care reform act also eliminates a stipulation that required many demonstration projects to last five years. This makes it possible for CMS to shorten the time for a demonstration and, thus, to "test models at different levels," said Rodgers.

"We don't have to have large demonstrations," he noted. "We can test at a prototype level. That is going to allow us to take existing models, optimize them (and) test what it takes to bring them to full maturity to derive that information into our policy settings and into how we reimburse in the future."

During her comments, Wakefield noted that the combination of the health care reform legislation



During the July 22 Patient-Centered Primary Care Collaborative stakeholder's conference, Mary Wakefield, R.N., Ph.D., administrator of the Health Resources and Services Administration, calls for a primary care workforce that is "adequate in number, adequate in distribution and adequate in competencies."

and the American Recovery and Reinvestment Act of 2009, represents the most significant expansion of primary care in recent memory from HRSA's perspective. ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100805pcpcstakeholders.html>.

U.S. Student Loans to Those Attending Foreign Medical Schools Important But Require More Oversight

A recently released U.S. Government Accountability Office, or GAO, report investigates the performance of international medical graduates, or IMGs – which the GAO defines as both U.S. citizens and foreign nationals enrolled in foreign medical schools – and urges better monitoring of foreign medical schools that participate in the federal student loan program.

The GAO's report to Congress, titled "Foreign Medical Schools: Education Should Improve Monitoring of Schools That Participate in the Federal Student Loan Program," makes

several recommendations to the U.S. Department of Education about the lack of consumer data on foreign medical schools and the department's oversight of pass rates at foreign medical schools whose students take the U.S. Medical Licensing Examination, or USMLE.

"Little is known about IMGs with respect to how much they borrow overall or the outcome of their medical studies, leading some policymakers to question the return on investment in IMGs," the report says.

The federal government, through the Federal Family Edu-

cation Loan program administered by the Education Department, loaned U.S. students enrolled at foreign free-standing medical schools \$1.5 billion between 1998 and 2008, according to the report.

Although that amount represents less than 1 percent of all federal student loans made during the same period, borrowing has grown by more than 300 percent because of increases in tuition, student enrollments and the availability of other loan funds.

Foreign medical schools that participate in the loan program have to meet certain statutory

requirements. One requirement has been that 60 percent of their students who take the USMLE must pass the test. Beginning in July, however, Congress increased that must-pass percentage to 75 percent of students.

Although most foreign medical schools have met the 60 percent pass rate requirement, only 11 percent would likely meet the new 75 percent pass rate, the GAO estimates.

The report recommends that the Education Department

- collect consumer information, such as student debt levels and graduation rates, from foreign medical schools that participate in the loan program and make that information available publicly;
- require foreign medical schools to submit their institutional pass rate data to the department annually;
- verify data submitted by the schools by, for example, entering into a data-sharing agreement with the testing organizations; and
- evaluate the potential impact of the higher pass rate requirement on school participation in the federal student loan program.

According to the report, the Education Department has not been able to fully enforce the institutional pass rate requirement on foreign medical schools.

That may change, however, because two organizations have been negotiating with schools for the release of aggregate student performance data. As a result, Education Department officials already have been planning to require pass rate data every year. ■

For more information, visit <http://www.aaFP.org/news-now/resident-student-focus/20100809gao-loans.html>.

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AS WE SEE IT

Voices From the AAFP

Point/Counterpoint

Why I'll Keep Accepting Medicare Patients

By Linda Stewart, M.D., Baton Rouge, La.

Like every other family physician with Medicare patients, I was horrified when Congress failed to stop the 21.3 percent Medicare payment cut that took effect June 1. A few weeks later, I sighed with relief when Congress finally rescinded the cut and passed a 2.2 percent payment increase. But that modest increase is only until Nov. 30. After that, who knows what will happen?

Furthermore, who knows when Congress will finally fix the sustainable growth rate, or SGR, formula for Medicare pay? I certainly don't.

In spite of the uncertainty and the inadequate pay, I have decided to continue accepting Medicare patients in my solo practice. Why? It's more a matter of philosophy than of economics. It's about my purpose and my aim in being in family medicine and this practice.

Serving Others

For me, being in practice is about much more than just earning a living. I went into family medicine to be of service to others. After residency, I opened my practice to serve the people in this community. I've practiced in the same location for nearly 35 years, and my practice has grown up and grown older with me.

I'm also aware that my medical education wasn't paid for just by me. I covered my own tuition, thanks to student loans, but taxpayers put a lot of dollars into my education, too. I have my career thanks, in part, to the American public, and I owe them for it.

In addition, Medicare is a positive thing for my older patients, including Part D, which is so helpful regarding their medications. Before Medicare, people who didn't have cash or insurance were often too embarrassed to ask for care. Or they got the care and paid what they could, if anything. Doctors weren't going to turn away families they'd seen for 20 years, so they wrote off an astronomical amount of bad debt.

Sometimes the only reward the doctor received was the patient's goodwill – the fellowship and handshakes at church. Those doctors gave their service and hoped for some payment to keep going. Now, with Medicare, we may be underpaid compared to what our expenses are, but at least we are guaranteed that we're going to get something. It's much better than it was 50 years ago.



Linda Stewart, M.D.

Although I'll continue to accept Medicare patients, I don't take Medicaid, and I'm not in the Women, Infants and Children Program. Both are simply not cost-effective, and the billing is extremely complicated. But other physicians in my community do participate in those programs, so people have access without my participation.

That's not necessarily the case with Medicare. If I were to stop accepting Medicare patients, some of the people I would turn away might not be able to access care somewhere else. How could I deny those people the care they need?

Staying Afloat

So I'll continue to look for ways to shave expenses and keep my practice afloat. In the past, I've reduced staff from five people to three, and I've discontinued procedures that weren't cost-effective, although I felt personally fulfilled doing them. I'm fortunate to own my own building, so I don't have to worry about the rent. But I have put off purchases, such as an electronic health record system. I just can't justify that expense while reimbursement shrinks faster than dry ice in the desert!

One change I might consider is to stretch out the interval between health maintenance visits for Medicare patients with chronic diseases, such as diabetes, because the cost of each office visit is greater than the payment Medicare provides. I'll do it only if I can find research showing that patients can be kept on track with less frequent visits than my patients get now, but I won't do it if it could cause harm. Of course, any patient who gets sick will be seen as soon as possible.

What the Future May Bring

Will the situation ever get so bad that I change my mind and stop accepting new Medicare patients, or get out of Medicare? I honestly don't know. I hope not.

But when I feel anxious about such questions, my worries quiet as I consider what my true objective in medicine really is. And it's not all about the money. ■

Linda Stewart, M.D., is a practicing family physician in Baton Rouge, La.

For more information, visit <http://www.aafp.org/news-now/opinion/20100804ptcncptstewart.html>.

For the other side on this issue, see page 12.

AS WE SEE IT

Voices From the AAFP

Point/Counterpoint

We're Leaving Medicare to Save Our Practice

By Lee Gross, M.D., North Port, Fla.

Some family doctors say they're staying in Medicare and accepting new Medicare patients because, philosophically, it's the right thing to do. But after participating in Medicare for several years, I've developed a different perspective. I think keeping my practice open is the right thing to do — for my community, as well as for me. Unfortunately, my practice may fold if we stay in Medicare.



Lee Gross, M.D.

I practice in Florida with another family physician. We're exactly what most family physicians used to be — small-business owners in an independent practice.

We stopped accepting new Medicare patients this past January, a gut-wrenching but necessary step. We plan to stop participating in Medicare by the end of this year or the next, and we're likely to opt out of Medicare altogether.

Health Reform and Russian Roulette

Although the AAFP threw its support behind the recently passed health reform bill, I think the bill was ill-conceived in many ways. The biggest tragedy is that the bill didn't eliminate Medicare's sustainable growth rate, or SGR, formula and institute a new formula to create payment stability.

Physicians have been playing Russian roulette with the SGR for years. Before this year, Congress always stepped in to stop SGR-dictated cuts before they started. Even so, Medicare payments became increasingly inadequate, making it hard to keep a practice solvent, much less to make changes to become a patient-centered medical home.

This year has been even worse. Congress allowed the disastrous 21.3 percent pay cut to go into effect June 1, finally rescinding it a few weeks later and giving us a 2.2 percent increase — but only until Nov. 30.

If Congress lets the 21.3 percent pay cut return after Nov. 30, it will be the death knell for many practices. The typical primary care practice has 60 percent overhead, so there's 40 cents on the dollar to take home at the end of the day. The 21.3 percent pay cut would take away about 20 cents of those 40 cents. I don't know any doctor who can absorb a 50 percent decrease in income and not face some unanswerable repercussions.

Congress might instead continue the 2.2 percent increase after Nov. 30, but Medicare pay still would be inadequate.

Some help will come from the new health reform law, which provides a 10 percent primary care bonus beginning in 2011. Unfortunately, the bonus is only for those who meet certain requirements, only for certain types of claims and only for five years. Furthermore, a 10 percent bonus on top of the possible 21.3 percent pay cut would still equal a disaster, just not of such epic proportions.

Unilateral Changes, Unending Hassles

Medicare's penchant for making unilateral changes — and not for the better — is another reason why we're getting out of Medicare as soon as we can.

Here's a perfect example. A few years ago, we decided to offer stress tests to detect heart disease. Since we didn't have all the equipment, we and several other doctors rented space in an existing facility and went there once a week to perform the tests.

But Medicare changed the rules so that this violated the Stark laws. Instead, the facility had to buy mobile equipment, and the technicians had to lug it to our office once a week.

Last January, Medicare changed its rules again. Since the technicians weren't our full-time employees, Medicare decreed that their costs had to be passed through with no profit to us — and we couldn't charge for office space or other costs. We would lose money on every single test. Therefore, the most profitable thing we did with our treadmill in recent months was to sell it. Unfortunately, all of the technicians were out of a job.

There are many other frustrating aspects of Medicare involvement, ranging from the silly bullet points we need in our charts to keep from being audited to the numerous pages of regulations we must wade through to learn how to qualify for "meaningful use" incentives. I can't wait to be done with it all!

Beyond Leaving Medicare

As we reduce our Medicare involvement, we are working to shore up our practice with more commercial payers. We hope to get Medicare to a low enough percentage of our patient base that we won't go out of business if we stop taking Medicare entirely.

However, since all insurers eventually follow Medicare, the problems with Medicare will still haunt us. The only sure way to get out of Medicare's shadow is to stop relying on third-party payers altogether. I frankly think that might be necessary for family medicine to survive.

Millions of formerly uninsured people will need access to family physicians as the provisions of the health reform law go into effect. What will America do if most of our practices go broke and close in the face of this need? I hope other family physicians will consider getting out from under Medicare as we are. If our practice in Florida can do it and survive, maybe your practice can, too. ■

Lee Gross, M.D., is a practicing family physician in North Port, Fla.

For more information, visit <http://www.aafp.org/news-now/opinion/20100804ptctprt-gross.html>.

For the other side on this issue, see page 11.