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# NEWS NOW

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## AAFP Commends CMS' Proposed 2010 Medicare Physician Fee Schedule

*Proposed Rule Recognizes Value of Primary Care Role*

By Sheri Porter

A proposed rule that would alter the 2010 Medicare physician fee schedule in favor of family physician services has resulted in commendation from the Academy. The AAFP is "grateful for the recognition of and support for the value of primary care represented by several key policy changes proposed in this rule," said AAFP Board Chair Jim King, M.D., of Selmer, Tenn., in an 18-page letter to CMS Acting Administrator Charlene Frizzera.

Such recognition "is an appropriate and long-overdue acknowledgement of the role primary care plays in our nation's health care

delivery system and the Medicare program in particular," said King in response to the CMS fee schedule, which was published in the July 13 *Federal Register*.

Of great interest to the AAFP is CMS' proposal to remove physician-administered drugs from the definition of "physicians' services." That definition is used to compute the sustainable growth rate, or SGR, formula, which determines physician fees. It also is used to calculate the levels of allowed expenditures and actual expenditures, said King.

**See 2010 Medicare Physician Fee Schedule, page 2**



## FTC Again Delays Enforcement of 'Red Flags' Rule — This Time Until Nov. 1

The Federal Trade Commission, or FTC, announced July 29 that it was once again delaying enforcement of a regulation known as the Identity Theft "Red Flags" Rule by pushing the deadline back to Nov. 1.

The rule is an antifraud regulation administered by the FTC that



requires financial institutions and creditors — including physician practices — to develop and implement written identity theft prevention programs as part of the Fair and Accurate Credit Trans-

actions Act of 2003.

Originally, physician practices and other entities covered under the rule were to come into compliance on Nov. 1, 2008; the FTC subsequently extended that deadline to May 1, 2009, and then to Aug. 1.

The FTC now says the new

Nov. 1 deadline will permit the agency to further increase efforts to educate businesses about the rule by providing more resources and compliance guidelines. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20090730red-flags-novdelay.html>.

### SEPTEMBER HIGHLIGHTS



**AAFP**  
STRONG MEDICINE FOR AMERICA

**Chilling Effect** . . . . . page 9

The AAFP is warning CMS that a proposed rule on residency training programs could have a 'chilling effect' on training family physicians.

**Grassroots Advocacy** . . . . . page 12

Two AAFP grassroots advocates tell the story of how they got involved with the political process as family physicians.

## 2010 Medicare Physician Fee Schedule,

*continued from page 1*

"From an AAFP perspective, drugs that are not paid for by the Medicare physician fee schedule do not belong in the formula to determine the fee schedule rates," noted King. He added, however, that although Medicare physicians would benefit from CMS' proposal, it would not fix the underlying problem created by using the SGR.

CMS has said that family physicians likely would see an 8 percent increase in Medicare-allowed charges in 2010 based on proposals in the rule. However, King pointed out that all Medicare physicians would see their payment rates drop by 21.5 percent — a net 13.5 percent decrease for FPs — unless Congress takes action to stop a negative update in the SGR formula.

King encouraged CMS to "continue to work with Congress to avert what would be a disastrous reduction in Medicare physician fees if the negative 21.5 percent update in the conversion factor were allowed to occur."

King praised CMS' proposal to eliminate use of all consultation codes, except G-codes related to consultation via telemedicine, as of Jan. 1. At the same time, CMS would increase the work relative value units, or RVUs, for new and established office visits and for initial hospital and nursing facility visits.

"AAFP supports the appropriate valuation of all services" paid under Medicare, said King. "As noted in the proposed rule, the distinction between con-

sultations and other E/M (evaluation and management) services has become increasingly blurry over time, leading to significant misuse of the consultation codes.

"We support CMS' proposal to eliminate the use of consultation codes and make budget neutral adjustments to shift the difference in RVUs to other E/M services done in the same setting."

The AAFP also supports a recommendation from the Medicare Payment Advisory Commission, or MedPAC, that CMS establish a group of experts separate from the AMA's Relative Value Scale Update Committee, or RUC, to help CMS review RVUs.

"We recommend that CMS examine in-depth and issue a report on the process by which RVUs are established, reviewed and adjusted under the Medicare physician fee schedule," said King.

MedPAC, the AMA and others "have observed that CMS routinely accepts 90 percent or more of the RUC's recommendations with respect to RVUs," said King. He added that CMS has never critically examined the process by which the RUC generates those recommendations.

"We believe that after 16 years of relying on the RUC process, CMS is overdue for an examination of the matter," said King. He also urged CMS to ask for transparency in the RUC voting process. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090812medicare-fee-schedule.html>.



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## 2009 AAFP Congress of Delegates to Meet in Boston

**T**he AAFP Congress of Delegates will meet Oct. 12-14 in the Grand Ballroom West of the Boston Convention & Exhibition Center. The Congress will convene in conjunction with the AAFP Scientific Assembly, which will meet Oct. 14-17.

During the Congress reference committee hearings on Oct. 12, AAFP members may share their views and help shape new Academy policies. The delegates will elect AAFP officers and members of the AAFP Board of Directors on Oct. 14.

Further information about the Congress is available at <http://www.aafp.org/online/en/home/aboutus/theaafp/congress.html>, including links to the delegates' schedules, the 2009 candidates' Web sites and resolutions. Information about Assembly activities also can be accessed at <http://www.aafp.org/online/en/home/cme/aafpcourses/conferences/assembly.html>. ■

**CONGRESS  
OF DELEGATES**  
American Academy of Family Physicians

# TransforMED Launches Interactive Physician Networking Site

By Sheri Porter

**T**ransforMED LLC, a wholly owned subsidiary of the American Academy of Family Physicians, has launched Delta-Exchange, a social networking site that primary care physicians can use to speed up their progress toward practice transformation and the patient-centered medical home.

TransforMED created Delta-Exchange in the wake of its two-year national demonstration project, or NDP, which tested how to implement various components of the medical home model of care.

"We started ... assisting practices with 'boots-on-the-ground'

full facilitation in the NDP in 2006," said Terry McGeeney,



M.D., M.B.A., TransforMED's president and CEO. However, the company found that this type of facilitation was labor intensive and expensive; it has been tweaking and perfecting its educational outreach to physicians ever since. The result is Delta-Exchange.

"We listened to physicians across the country, and this is what they said they wanted — a solution that is cheap, doesn't require a long-term commitment and lets practices 'dip a toe in the water' to get a feel for practice transformation," said McGeeney.

He described Delta-Exchange as a "virtual, online learning community." The \$30-per-month Delta Exchange member fee includes access to a variety of tools including

- online discussions,
- interactive webinars,
- how-to articles on practice improvement topics,
- an expert panel of practice facilitators, and
- customizable forms that streamline policies and procedures.

Members can sign up for online discussions in separate

work zones, including in zones for physicians, clinical staff members, office staff members and residency programs. Users also can set up a notification system that will track specific discussions and topics.

Gregg Stefanek, D.O., of Alma, Mich., is one of 241 "test" members who have been putting the exchange through its paces. He has found the site helpful in his quest to become a medical home. "It's not a lack of information out there that's preventing me from being a full patient-centered medical home," said Stefanek. "It's the lack of time on my part ... (Delta-Exchange) is a resource that helps me focus my time. It's convenient and pertinent." ■

*For more information, visit <http://www.aafp.org/news-now/practice-management/20090811delta-exchange.html>.*

## CME Course Offered by Johns Hopkins, AAFP Designed to Help With PCMH Transformation

**T**he AAFP has launched a new, asynchronous online CME course designed to help family physicians and other primary care health professionals transform their practices into patient-centered medical homes, or PCMHs.

The nine-module course, Practice Leaders in Medical Homes, provides physicians and other practice leaders with information about the competencies that are needed to smooth the evolution of their practices into medical homes.

The Roger C. Lipitz Center for Integrated Health Care at Johns Hopkins University, Baltimore, designed the course in cooperation with the AAFP; the Academy's practice redesign affiliate, TransforMED; the American Board of Internal Medicine; the American College of Physicians, or ACP; and the American Geriatrics Society. The Center for Teaching and Learning with Technology at the Johns Hopkins Bloomberg School of Public Health is offering the course.

The CME program's nine modules are

- Assessing Readiness to Change Into a Medical Home;
- Leading Change in Medical Homes;
- Health Information Technology in Medical Homes;
- Interdisciplinary Teams in Medical Homes;

- Communicating With Patients of Medical Homes;
- Supporting Patient Self-Management Within Medical Homes;
- Care Management in Medical Homes;
- Continuity of Care for Patients of Medical Homes; and
- Managing the Medical Home.

Each module contains self-assessment questions, a short reading, a narrated presentation, a case study, a video vignette and a list of additional resources.

At the end of each module, learners answer multiple-choice questions related to the course objectives. For each completed module, family physicians receive a certificate and 1 Prescribed AAFP credit.

The course is available free to leaders of practices seeking recognition from the National Committee for Quality Assurance, or NCQA, and wishing to participate in the CMS Medicare Medical Home Demonstration project mandated under the Tax Relief and Health Care Act of 2006. For those not seeking NCQA recognition, the cost of the course is \$15 per module. ■

*For more information, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20090723lipitz-pcmh.html>.*

## Do You Qualify for a \$63,750 Medicaid EHR Bonus?

*Funding Comes Courtesy of Federal Stimulus Package*

**A** new report estimates that as many as 45,000 office-based physicians who participate in Medicaid and use electronic health records, or EHRs, could collect as much as \$63,750 paid out over a six-year period as part of the American Recovery and Reinvestment Act of 2009.



Notably, about 9,800 primary care physicians — defined by report authors as family physicians, internists and general practitioners — could qualify for the bonuses.

“Boosting Health Information Technology in Medicaid: The Potential Effect of the American Recovery and Reinvestment Act” was issued by the Geiger Gibson/RCHN Community Health Foundation Research Collaborative, an arm of George Washington University’s School of Public Health and Health Services in Washington.

To receive the Medicaid bonus, physicians must meet criteria beyond using a certified EHR. For example, to qualify for the full bonus, at least 30 percent of a physician’s patient panel must be enrolled in Medicaid.

Physicians who practice in federally qualified health centers or rural health clinics have less stringent criteria — they need only claim that 30 percent of their patients are “needy individuals.” As such, the patients must be covered by Medicaid, provided with free care or billed on a sliding-fee scale.

Also of note, eligible Medicaid physicians will be able to collect \$21,250 at the program’s start in 2011 to cover the cost of purchasing or upgrading health information technology, including training and other support services. Physicians who demonstrate “meaningful use” can earn an additional \$8,500 annually for the subsequent five years.

The definition of meaningful use is under discussion and should be finalized by year’s end. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090810medicaid-ehr-bonus.html>.

## AAFP Supports Health Care Reform Bill But Raises Concerns

**T**he AAFP has responded to a House health care reform bill, saying in a recent letter to the three committees responsible for drafting the legislation that it supports the bill — certain provisions in particular — but that it has concerns about various parts of the legislation.

“We believe that the America’s Affordable Health Choices Act will make significant progress toward payment and delivery system reforms and contribute to building a primary care workforce for the future,” said AAFP Board Chair Jim King, M.D., of Selmer, Tenn., in a letter to the chairs of the House Energy and Commerce Committee, the House Education and Labor Committee, and the House Ways and Means Committee.

“The AAFP supports the bill’s proposals to reform the insurance industry so that coverage must include people who have pre-existing conditions or who develop an illness while insured,” said King. “Family medicine agrees with the bill’s assurance of parity in benefits for mental health and substance abuse disorders and the inclusion of genetic nondiscrimination laws.”

The bill also makes several key changes to how health care would be delivered, including via a greater reliance on primary care in the delivery system.

“The legislation frequently demonstrates recognition of the value of primary care as the foundation for health reform,” said King. “It is (the AAFP’s) strong contention that investment in primary care will yield better health for everyone, but also more efficiencies, less waste and less duplication.”

The bill also takes other steps to strengthen primary care. For example, it would increase Medicare payments by 5 percent for designated services provided by primary care physicians and would provide a 10 percent bonus for services provided in primary care physician shortages areas.

“However, the language in H.R. 3200 changes the definition of primary care services from the language in the draft bill in a way that might exclude many primary care physicians from being eligible for the bonus,” said King. “(The AAFP) recommends that the eligibility criteria be modified to ... incorporate the services typically provided by family physicians and other primary care physicians.”

The AAFP also is concerned about expansion of the definition of physicians considered to be primary care providers for the purposes of this bonus. King urged the committees to return to their original definition of primary care, saying that family medicine, internal medicine, and pediatrics — along with geriatrics — are the only specialties that prepare residents and physicians in the broad competencies necessary for primary care practice.

In addition, King noted that the 5 percent bonus for primary care physicians falls far short of the 10 percent increase called for by the AAFP, the American College of Physicians and the American Osteopathic Association.

“The goal of this bonus payment is to signal to medical students that an effective and efficient health care system depends on an adequate number of primary care physicians to provide the vast majority of health care services,” said King. “Primary care physicians believe that a 5 percent incentive is insufficient to send that signal.” ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090722house-bill-htr.html>.

**“It is (the AAFP’s) strong contention that investment in primary care will yield better health for everyone, but also more efficiencies, less waste and less duplication.”**

— Jim King, M.D.  
AAFP Board Chair

## CDC Points to ‘Full-out Recommendation’ on Seasonal Flu Vaccine for Children

*Annual Immunization Urged for Kids Ages 6 Months to 18 Years*

All individuals ages 6 months to 18 years should be vaccinated annually against seasonal influenza, the CDC said in a *Morbidity and Mortality Weekly Report* released today. Not only do these children and teens stand to benefit, say CDC officials, the entire population could remain healthier as a result.

The CDC’s Advisory Committee on Immunization Practices, or ACIP, has been moving toward a broad annual flu vaccination recommendation for children for years. The ACIP recommended in 2004 that children ages 6 months to 23 months be vaccinated, and the recommendation was expanded to include children ages 24 months to 59 months in 2006.

Last year, the ACIP – working in conjunction with the AAFP and the American Academy of Pediatrics – called for an expansion of annual influenza immunizations to include all children ages 6 months to 18 years beginning no later than the 2009-2010 flu season.

The phased-in approach was intended to give physicians time to plan for vaccinating a larger patient population.

“This past year’s recommendations encouraged vaccination, and the plan has been that this year this would be a full recommendation – no longer just an encouragement or ‘where feasible,’ but a full-out recommendation,” said Anne Schuchat, M.D., director of the CDC’s

National Center for Immunization and Respiratory Diseases, in a July 24 media briefing.

According to the CDC, children typically have the highest attack rates during influenza outbreaks and are a major source of transmission. Thus, widespread vaccination of children potentially could decrease the incidence of infection among their close contacts and, consequently, reduce overall transmission.

The CDC said children ages 6 months to 8 years who have not previously been vaccinated against the annual flu should receive two doses four or more weeks apart. The agency also said children in this age group who received only one dose the first time they were vaccinated should receive two doses the following year.

Children younger than age 6 months cannot be vaccinated, but their household members and other close contacts should be, the CDC said.

CDC officials have said the seasonal flu vaccine will be available in August or September – earlier than usual – to clear the way for vaccinations for the novel influenza A (H1N1) virus. That vaccine is expected to be available beginning in mid-October, pending FDA approval. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090724mmwr-ann-flu.html>.

## H1N1 Vaccine Production Lagging Behind Expectations

*Limited Initial Supply Means Priority Groups Go to Front of Line for Immunizations*

By David Mitchell

The CDC told its Advisory Committee on Immunization Practices, or ACIP, in late July that it hoped to have 120 million doses of vaccine for the novel influenza A (H1N1) virus available by October. Manufacturing issues, however, have slowed production of the new vaccine, and federal officials now expect only about 45 million doses to be available by mid-October.

According to HHS spokesman Bill Hall, 20 million more doses should be available each week thereafter.

“There’s no shortage,” Hall said in an Aug. 18 interview with *AAFP News Now*. “It’s simply a delay, which will push it back

about four weeks.”

The ACIP planned for such circumstances during its July meeting, recommending that several groups receive the vaccine



before others if supply is limited:

- pregnant women,
- people who live with or care for children younger than 6 months of age,
- health care and emergency services personnel who

have direct patient contact,

- children ages 6 months to 4 years, and
- children ages 5 to 18 years who have chronic medical conditions.

CDC officials have said the prioritized groups include about 42 million people.

“We believe we’ll have enough for the priority groups that have been identified,” Hall said. “People in those groups should talk with their doctor or health care provider about the vaccine.”

When vaccine becomes more widely available, the ACIP has recommended that, in addition to the groups listed above, all health care and emergency services personnel receive the vaccine, as well as individuals 4-24 years of age and individuals 25-64

years of age who are at increased risk from novel H1N1 because of chronic health conditions or compromised immune systems.

All of the recommended groups together include about 159 million people, or more than half the nation’s population.

Hall said physicians interested in administering the new vaccine should be proactive in contacting their state or local health officials. The CDC offers an online resource at <http://www.cdc.gov/mmwr/international/rel-res.html> that can help physicians contact state and, in some cases, local health departments. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090819h1n1-update.html>.

## National Research Network New Subnetwork Seeks Evidence to Support Collaborative Care

**T**he AAFP's National Research Network, or NRN, is recruiting practices for its new subnetwork, the Collaborative Care Research Network, or CCRN. The new network is designed to investigate and evaluate the integration of mental health services in primary care settings.

A study published online in *Health Affairs* in April found that two-thirds of primary care physicians don't have access to mental health specialists because of numerous barriers, including lack of mental health professionals and insurance restrictions.

According to Rodger Kessler, Ph.D., a research assistant professor in the department of family medicine at the University of Vermont College of Medicine, Burlington, mental health is the most difficult specialty for family physicians to access.

"When a physician refers a patient out to mental health providers, only 20 percent to 40 percent (of those visits) result in care being initiated," said Kessler, who also is the research director of the CCRN. "It just doesn't happen." The CCRN, however, is studying a new treatment model for mental health services.

The new model, said Kessler, would involve in-house medical teams who would work together to plan treatments and execute a patient's care. The expectation is that combining mental health, substance abuse and physical health services in this kind of team structure will produce better outcomes than the old referral system.

The CCRN has recruited about 30 practices to date and hopes to add 50 practices a year during the next two years, according to Kessler. The eventual goal is to have 150 to 200 practices nationwide working together to make collaborative care more effective.

In addition to having a mental health professional on staff, primary care practices participating in the CCRN need to have an interest in practice-based research, a willingness to share data and an interest in addressing important research questions, said Kessler.

Practices interested in obtaining an enrollment packet should contact Mindy Spano with the AAFP's National Research Network at (800) 267-2237, Ext. 3178. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20090805ccrnlaunch.html>.

## Nation's Obesity Epidemic Carries Hefty Price Tag

*More Than One-Fourth of U.S. Adults Are Obese, Says CDC*

By David Mitchell

**T**he medical cost of treating the nation's obesity epidemic is growing rapidly — right along with Americans' waistlines. In fact, a recent study from the CDC and the Research Triangle Institute, Research Triangle Park, N.C., estimates that costs attributable to obesity could be as high as \$147 billion in 2008, up from \$78.5 billion in 1998. The study was released July 27 during the CDC's Weight of the Nation conference in Washington.

According to the study, Medicare beneficiaries who are obese cost the federal program \$600 a year more than normal-weight beneficiaries did in 2006. Across all payers, the difference was even greater, at \$1,429.

"The costs attributable to obesity are almost entirely a result of costs generated from treating the diseases that obesity promotes," such as diabetes, according to the study's authors.

"Obesity, and with it, diabetes are the only major health problems that are getting worse in this country, and they're getting worse rapidly," said CDC Director Thomas Frieden, M.D., M.P.H., in a July 27 media briefing during the Weight of the Nation conference. "Beyond the economic costs are the disability, the suffering and the early deaths caused by obesity."

According to family physician Michelle May, M.D., of Phoenix, physicians can help patients who are obese make important, long-lasting changes.

"We have decades of evidence to show that diets don't work for most people long term," said May, who is a member of the AAFP Commission on Health of the Public and Science. "Instead, physicians should focus on helping their patients identify small steps they are willing to take toward a healthier lifestyle."

"For example, by asking open-ended, supportive questions, a patient may decide to decrease his or her soda intake, take a walk around the building during work breaks, or manage stress better. A small change practiced on a consistent basis will be more effective than a huge, short-term overhaul."

It's also important, May said, for physicians to advise their adult patients to be good role models for their children. Recent CDC data indicate that the prevalence of obesity in low-income, preschool-aged children increased steadily from 12.4 percent in 1998 to 14.5 percent in 2003 before leveling off at 14.6 in 2008.

"Children learn many of their beliefs and behaviors from their parents," May told *AAFP News Now*. "When parents model healthy eating and a positive attitude about physical activity, their children are more likely to hold those same values. We can positively impact the entire family by encouraging family meal times, family activities like sports and bike riding, and getting rid of outdated messages like 'Clean your plate or you don't get dessert.'" ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20090810obesity.html>.



# FDA Analysis Finds Toxins, Carcinogens in Electronic Cigarettes

The idea that electronic cigarettes offer tobacco users a safer alternative than regular cigarettes seems to have gone up in smoke.

The FDA issued a warning about the so-called e-cigarettes on July 23, advising consumers about health risks associated with the products, which are battery-operated devices designed to look like and be used in the same manner as regular cigarettes. The devices turn nicotine and other chemicals into a vapor that is inhaled by the user. Manufacturers have touted the smokeless products as safer than conventional cigarettes.

However, after analyzing samples of e-cigarettes and components from two leading brands, the Division of Pharmaceutical Analysis in the FDA's Center for Drug Evaluation and Research said the samples showed detectable levels of known carcinogens

and toxic chemicals.

The FDA found specific issues, such as

- tobacco-specific nitrosamines, which are carcinogens, were detected in half of the samples tested;
- the tobacco-specific impurities anabasine, myosmine and beta-nicotyrine were detected in a majority of the samples;
- the vast majority of cartridges labeled as containing no nicotine did, in fact, contain low levels of nicotine;
- on testing three different cartridges with the same label, each cartridge emitted a different amount of nicotine.

Furthermore, FDA officials said the test results "suggested that quality-control processes used to manufacture these prod-

ucts are inconsistent or non-existent." For example, diethylene glycol, a toxic ingredient used in



antifreeze, was detected in one cartridge.

"Electronic cigarettes are made overseas, mainly in China, and have not previously been tested for safety," said FP Tom Houston, M.D., of Dublin, Ohio. Houston is director of Ohio-Health's Nicotine Dependence Program and clinical professor in the family medicine department at Ohio State University, Columbus.

"As we now see, they may

contain more than just nicotine and flavorings," said Houston of the FDA's announcement. "It is also a concern that their novelty, the attractive flavoring, and marketing through the Internet may attract youth to the products."

E-cigarettes are sold without legal age restrictions and do not contain health warnings comparable to those found on FDA-approved nicotine replacement products or conventional cigarettes.

Houston, who is chairman of the AAAP Tobacco Cessation Advisory Committee, said electronic cigarettes aren't a safe substitute for conventional cigarettes and should not be used as a smoking cessation aid. He said people who want to stop smoking have proven methods available to them. ■

For more information, visit <http://www.aaafp.org/news-now/health-of-the-public/20090728e-cigarettes.html>.

## In Brief *Clinical Care & Research*

### Cigarette Packaging Still Misleading

A study in the *Journal of Public Health* reports that efforts to remove terms such as low tar, light, ultra light and mild from cigarette packaging may be insufficient to significantly reduce false consumer perceptions about the risks of different brands. The study found that words, such as "smooth"; color descriptors, such as "silver"; and tar numbers incorporated into brand names, such as Marlboro One, led consumers to erroneously believe that certain cigarette brands were less harmful than others. <http://www.aaafp.org/news-now/news-in-brief/20090812wkly-nws-brfs.html>

### Drug Trial Stopped Due to Adverse Events

The NIH's National Heart, Lung and Blood Institute, or NHLBI, has halted a clinical trial of a drug treatment for pulmonary hypertension in adults with sickle cell disease because of safety concerns. Researchers found that 38 percent of participants taking sildenafil, which is marketed as Revatio, had serious adverse effects compared to 8 percent of participants in a placebo group. The most common problem was sickle cell pain crises, which resulted in hospitalization. NHLBI director Elizabeth Nabel, M.D., said in a news

release that patients with sickle cell disease who are taking sildenafil for pulmonary hypertension should talk with their physician about the risks and benefits of the medication. <http://www.aaafp.org/news-now/news-in-brief/20090812wkly-nws-brfs.html>

### AHRQ Offers Guides on Osteoarthritis Treatments

The Agency for Healthcare Research and Quality, or AHRQ, has released guides for consumers and physicians that examine the effectiveness, safety and potential adverse effects of various treatments for osteoarthritis of the knee. The consumer guide defines the condition, answers basic questions and is intended to guide patients when they discuss treatment options with their physicians. The physician guide, includes additional clinical information, such as a confidence scale that rates the available evidence on management of the condition. Both guides summarize the results of a report from AHRQ that found no treatment benefit associated with the use of the dietary supplements glucosamine and chondroitin sulfate, viscosupplementation (i.e., intra-articular injection of hyaluronan), or arthroscopic surgery. <http://www.aaafp.org/news-now/news-in-brief/20090717news-brf-clinupd.html> ■

*2009 National Conference*

# Family Medicine Residents, Students Call for Wide Range of Changes to Specialty Training, Health Care System

By Barbara Bein and David Mitchell • Kansas City, Mo.

**F**uture family physicians want the AAFP to take “bold action” to help double the number of U.S. medical students entering family medicine residencies by 2020. They also want the AAFP to work on getting

tics, by 2020.” Members of the student congress, on the other hand, considered a virtually identical measure but ended up not adopting it amid concerns about the deadline.

In testimony before the resident reference committee considering the measure, Preston Hatlestad, M.D., of St. Paul, Minn., one of the resolution’s co-authors, said American medical schools are not turning out enough primary care physicians.

Robert Stenger, M.D., M.P.H., of Portland, Ore., agreed, but noted that instead of raw numbers, some percentage-based goal would be more appropriate.

For their part, student members considered a similar measure, actually amending it twice to try to address concerns about what many deemed overly specific language before, ultimately, rejecting it as already being addressed by the AAFP.

**Focus on GME Funding**

Resident and student members also asked the Academy to continue to promote increased federal funding for family medicine residencies and to advocate “meaningful health care reform” that supports debt-reduction programs for physicians who choose to practice primary care.

Resident members specifically want the Academy to encourage the National Health Service Corps, or NHSC, to award multiple loan repayment terms, including for periods longer than two years, and distribute those awards at the beginning of residents’ NHSC service.

Both the resident and student congresses sought to encourage

rural residency rotations by asking the Academy to advocate that GME funding follow residents to their residency training locations. GME funding policies now mandate that money for residency training go to hospitals, so there’s a disincentive for programs to allow rural or other training experiences that take residents away from their primary training sites, said resident members in reference committee testimony. That disincentive would be remedied if GME funds were paid to the programs directly.

**Health Care Reform**

The resident congress also adopted three resolutions related to health care reform legislation that could include a possible

public plan option.

Resident member Tamaan Osbourne-Roberts, M.D., of Denver, said that the public plan option may entail “substantial risk,” but, he said, the greater imperfection would be maintaining the current broken system.

Meanwhile, members of the student congress adopted a proposal supporting the AAFP’s qualified endorsement of a public plan option, another calling for reciprocity and portability under such a plan, and a third that pointed to a single-payer model “as a viable method of health care reform.” ■

For more information, visit <http://www.aaafp.org/news-now/resident-student-focus/20090805nat-conf-resols.html>.

Barbara Bein/AAFP



**AAFP resident member Tamaan Osbourne-Roberts, M.D., of Denver, testifies before a reference committee during the National Conference of Family Medicine Residents and Medical Students that the nation needs “excellent, affordable care for all people.”**

more federal funding for family medicine residencies; more debt-reduction options for residents; and graduate medical education, or GME, financing that sticks with residents as a way to encourage training in rural areas.

These were some of the medical education and financing issues raised in resolutions that resident and student members considered during the 2009 National Conference of Family Medicine Residents and Medical Students here July 30-Aug. 1.

**Number of FP Graduates**

Members of the resident congress adopted a resolution that asked the Academy to “support the establishment of a national priority to double the number of U.S. medical school graduates entering family medicine residencies, based on 2009 statis-

*2009 National Conference*

# Family Medicine Residents, Medical Students Elect New Leaders

**D**elegates to the National Congress of Family Medicine Residents and the National Congress of Student Members chose new leaders here Aug. 1 to represent them in the coming year. Here are the election results:

*Resident and student members of the AAFP Board of Directors:* Robert Stenger, M.D., M.P.H., of Portland, Ore., and Brooke Sciuto, of Bethesda, Md.

*Chairs of the 2010 National Conference of Family Medicine Residents and Medical Students:* Shannon Brodersen, M.D., of Fort Walton Beach, Fla., and Tanya Anim, of Daytona Beach, Fla.

*Alternate delegates to the 2009 AAFP Congress of Delegates:* Lindsay Botsford, M.D., of Houston; Heidi Meyer, M.D., of Tucson, Ariz.; Chinyere Ogbonna, of Pittsburgh; and Kevin Bernstein, of Effort, Pa.

*Resident representative to the Association of Family Medicine Residency Directors Board of Directors:* Djing Lindsay, M.D., M.P.H., of Washington, D.C.

*Resident and student representatives to the Society of Teachers of Family Medicine Board of Directors:* Sabesan Karuppiah, M.D., of Hollidaysburg, Pa., and Sebastian Tong, of Boston

*National family medicine interest group coordinator:* Andrew Lutzkanin III, of Middletown, Pa. ■

## CMS Proposal Would Have ‘Chilling Effect’ on FP Training, Say AAFP, Other Family Medicine Groups

The AAFP is warning CMS that a proposed rule regarding new residency training programs will have a “chilling effect” on the training of primary care physicians at a time when primary care is expected to be a centerpiece of health care reform.

In a detailed June 30 letter to CMS Acting Administrator Charlene Frizzera, the Academy, the Society of Teachers of Family Medicine, the Association of Family Medicine Residency Directors, the Association of Departments of Family Medicine and the North American Primary Care Research Group said that the proposed rule, if enacted, would lead to more closings of family medicine residencies and more losses of first-year family medicine residency slots.

“Family medicine has been, and continues to be, the only specialty that is fully primary care at all levels. Now is not the time to reduce the ability of family medicine programs to establish themselves and provide critical training for primary care physician production,” said the letter.

At issue is CMS’ 1997 reclassification of the Stanislaus Family Medicine Residency Program in Modesto, Calif., as a “new” program after it moved from a hospital that closed to Doctors Medical Center of Modesto. In 2007, CMS re-evaluated the residency — applying rules that weren’t written in 1997 — which led to the decision to end Medicare support for graduate medical education, or GME, at the residency and to demand that \$19 million be paid back.

Now, say Academy leaders, CMS’ proposed rule would endanger any residency program that leaves one sponsoring hospital and goes to another.

### FAMILY PHYSICIAN TRAINING

“Essentially,” the groups said in their June 30 letter, “the proposal states that if a program closes (no matter the reason behind the closure), and a university, medical school, hospital or other entity applies ... to get approval for a ‘new’ program at a different hospital (that has never had residents before), CMS will no longer guarantee the counting of those residents for GME reimbursement purposes.”

According to the June 30 letter, the proposed rule also would require hospitals to use “ambiguous” criteria to decide whether a residency is deemed a new program, based on such factors as whether the program has a new director or teaching staff members and whether only new residents are training in the program at the new site.

Programs might not know for several years if they have passed the “newness” test. “This ambiguity will have a chilling effect on the ability of any new programs to be established,” said the letter. Residency programs also would be reluctant to hire experienced directors and faculty coming from another facility’s program.

“We are very concerned that CMS is promoting new regulations without an assessment of the impact of such a proposal,” the groups said in their letter. “We are extremely concerned that primary care programs in general and family medicine (programs) in specific will be disproportionately affected.

“The loss of primary care resident positions, at a time when our nation needs a larger production of primary care physicians, is not the direction federal policy should take.” ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20090729cms-gme-proprule.html>.

## CMS Medical Home Project Still Lacks Final Approval

### *Pilot Implementation Delayed*

By James Arvantes

CMS still has not received final approval to conduct a medical home demonstration project within the Medicare program, which means the project will not be fully underway for at least another year, according to Jim Coan, the CMS project officer in charge of the demonstration project.

“We are just in a holding pattern,” said Coan. “My feeling is eventually we will have a demonstration in the field, hopefully soon, but I can’t say when.”

Congress created the three-year medical home demonstra-

tion project as part of the Tax Relief and Health Care Act of 2006. According to the provisions of that act, the project will take place in eight states; CMS will announce the names of the states when the project receives final clearance.

The design of the demonstration will involve up to 400 practices, 2,000 physicians and 400,000 Medicare beneficiaries, according to CMS. Officials expected to launch the project in early 2010, but there have been delays in obtaining final clearance that have pushed the time-

table back.

Even if the project were approved tomorrow, it still would take about a year to become fully functional, said Coan. “If you add up all the time — from the announcement of the project to the recruitment to the application to the qualification process — it is approximately 12 months,” he noted, acknowledging that “everyone is anxious to begin.”

“We have been at this for two years, and a lot of work has gone into this from behind the scenes from a lot of different people,” said Coan. “I feel their pain ...

they would have liked to have been underway by now.”

If the demonstration project is approved, CMS will invite primary care practices in the eight chosen states to apply to participate. The agency then will decide on final participants and will ask those practices to obtain recognition as patient-centered medical homes through the National Committee for Quality Assurance, Coan said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090810cms-pilot-project.html>.

# Primary Care the ‘Fundamental Building Block’ for Health Care Reform

By James Arvantes • *Washington*

**C**ongress and the Obama administration have reached the same conclusion about health care reform — successful reform will not happen without a focus on primary care and the patient-centered medical home, or PCMH. That was one of the main messages delivered by a variety of federal officials during a Patient-Centered Primary Care Collaborative, or PCPCC, stakeholders meeting here on July 16

Edwina Rogers, J.D., executive director of the PCPCC, noted that House and Senate committees have introduced bills that call for payment increases for

primary care services and that make provisions for the PCMH. The House bill provides \$350 million for Medicare PCMH pilot projects and includes \$1.2 billion for a five-year Medicaid medical home pilot project.

On the Senate side, the Health, Education, Labor and Pensions, or HELP, Committee has introduced legislation that would authorize grants for new education and training programs in medical schools and residency programs that support the PCMH.

If Congress passes health care reform, medical home provisions are likely to be “fairly broad,” leaving a great deal of

flexibility in terms of implementation, said Carolyn Clancy, M.D., director of the Agency for Healthcare Research and Quality, or AHRQ, and one of several speakers from the federal government who addressed stakeholders during the July 16 meeting.

The PCMH is likely to look different in urban areas, such as Miami, than in rural or frontier areas, she said. “You don’t want legislation that goes on for pages and pages that defines details to the (last) degree. What you do want is legislation that focuses on primary care.”

Andrew Webber, president and CEO of the National Busi-

ness Coalition on Health seemed to agree with Clancy’s statement, saying, “genuine reform really happens in local communities at the ground level.” He added that the current health care system emphasizes acute care treatment and treatment for illnesses at the expense of prevention, wellness, primary care and chronic care management.

“Primary care really does need to be the spinal cord of any health care delivery system,” said Webber. “We need to work with our health care partners in setting expectations, including expectations that health care plans should be using their resources to move toward medical home, medical neighborhood concepts.”

Increasingly, policymakers are focusing on the ongoing crisis in primary care, the lack of adequate payment for primary care physicians and the shortage of primary care health professionals. But the crisis in primary care is symptomatic of a larger issue — the current way health care is delivered and paid for, said Steve Wojcik, vice president of public policy for the National Business Group on Health.

“In the end that is what really matters,” said Wojcik. “It is not what kind of mandates we have or what kind of public plan we have. If that is all we are focusing on and that is all we are doing, we are not going to get the kind of health care reform that we in the collaborative and we in the business community believe in.” ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20090722pcpc-clancy.html>.



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## Epocrates Users Can Download Free OTC Drug Database for Smartphones

**M**any studies in recent years have clearly demonstrated the potential adverse effects associated with polypharmacy, and research in this area is ongoing, especially among older patients with multiple comorbidities. Now, family physicians concerned about drug interactions in their patients who take numerous prescription and OTC medications can get help with a new drug reference tool for their smartphones.

Physicians already using mobile software made by Epocrates Inc. can access the latest information for hundreds of brand-name OTC drugs from their iPhone or iPodtouch, BlackBerry, Palm or Windows Mobile devices.

The OTC drug reference tool provides information on drug interactions, proper dosing, formulations, flavors and alternatives.

In addition to alerting physicians to possible drug interactions, the software also can be used to identify safe products for pregnant women and sugar-free products for patients with diabetes; products covered by health plans by state, as well as those covered by Medicare Part D; and medications by class, such as analgesics.

The drug database can be downloaded free with a subscription to any Epocrates premium product. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20090729epocrates-otc.html>.

## HASC Report: Reduce Pervasive Administrative Complexity in Health Care System

*\$500 Billion Saved Would Be Better Spent on Patient Care*

**T**he United States could save billions of dollars in its cash-strapped health care system by cutting through the administrative red tape that entangles physicians, hospitals and patients every day, according to a new report released by the Healthcare Administrative Simplification Coalition, or HASC.

Founded in 2005 by the AAFP, the American Health Information Management Association and the Medical Group Management Association, or MGMA, HASC is a partnership of organizations committed to reducing the administrative costs and complexity of health care.

The coalition's report, "Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Health-care System," says that about 25 percent of the nation's health care costs — estimated at more than \$2 trillion in 2007 — go toward administrative functions, such as billing and payment tasks.

That's money being diverted away from hands-on patient care, according to MGMA President and CEO William Jessee, M.D.

"Every dollar spent on a convoluted, redundant or unnecessary administrative process is a dollar poorly spent," Jessee said in a July 20 news release announcing the report. "We spend more on health care than any nation in the world, but we're getting far less than full value for our investment, partly because of unnecessarily complex administrative processes."

"These wasted health care dollars could be much better spent on ensuring that all Americans have access to high-quality health care," said AAFP EVP Douglas Henley, M.D., in an interview with *AAFP News Now*. "If we don't work toward reducing administrative complexity in our health care system, we'll continue to waste both time and money."

In its report, the organization outlines recommendations for how physician practices, hospitals, insurance payers, benefits managers and others can

- simplify the practitioner credentialing process,
- streamline the health care insurance eligibility process,
- standardize patient identification cards, and
- improve coordination of prior authorization processes for radiology and pharmacy services.

HASC recommends that all health plans and hospitals that require credentialing use the Universal Provider Datasource, a tool launched by the Council for Affordable Quality Healthcare, or CAQH, that allows physicians and other health care professionals to electronically enter their credentialing information into a single, uniform online system.

The coalition also recommends that health plans, clearinghouse and practice management systems voluntarily adopt operating rules from CAQH's Committee on Operating Rules for Information Exchange. Current rules cover patient eligibility and benefit information; future additions likely will include guidance on claim status inquiries, prior authorizations and more.

In addition, the report recommends using standardized, machine-readable patient identification cards, and it supports, to the extent possible, standardization of prior authorization processes among health plans and pharmacy benefits plans. The coalition also backs electronic prescribing national networks, such as Surescripts and other entities, that are working to achieve real-time, patient-specific formulary access. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20090804hasc-rpt.html>.



# AS WE SEE IT

Voices From the AAFP

## Editorial

### Grassroots Advocates' Push for Reform Pays Dividends for Family Medicine

**H**ealth care reform is on a roll, but many naysayers are trying to narrow its scope or slow the process down. Although no one can foresee the outcome of the debate, the good news is that bills drafted thus far contain many provisions favorable to family physicians and their patients.

When you think about such favorable provisions, think also about the family physicians who have stepped forward as grassroots advocates for their specialty — and then consider joining their ranks. Their efforts have paid dividends in rallying support for reform and getting primary care-friendly provisions in the bills, but the voices of even more family physicians are urgently needed.

How much difference can a family physician make by becoming a grassroots advocate? Consider the following two examples.

#### Frustration Leads to Advocacy

Solo family physician Heidi Foley, M.D., of Phillipston, Mass., didn't consider herself a political person — she was just sick and tired of insurers making it impossible for her to care for her patients. To vent her frustration, she became a grassroots advocate, first in her state and then in Washington after attending the AAFP's 2008 Family Medicine Congressional Conference.

"I went to that meeting with a list of questions and fired them at the deputy staff director for health of the Health, Education, Labor and Pensions (HELP) Committee chaired by Sen. Ted Kennedy, and she must have found them compelling," Foley says. "She and I exchanged e-mails that summer. When I reached the end of my rope again with difficulties in my practice, I e-mailed her to ask what I should do."

To Foley's surprise, that congressional staff member invited her to be part of a new health reform "brain trust" — six physicians and two practice managers — established to advise the HELP Committee. "There I was, the lone primary care physician on a panel with some big names," Foley recalls. "At first I was shaking in my boots, but I learned I could serve as the 'No way in hell will that work — *this* is what my patients really need' person. The horror stories I've shared from my practice have gone all over Capitol Hill."

Foley also reached out to other primary care doctors so she could share their opinions during advisory group discussions.

The advisory group has held weekly telephone discussions with congressional staff members and also has met in Washington three times. The group wrote a 30-page compendium of its recommendations, some of which appear in the Affordable Health Choices Act, Foley says.

She also has good relationships with her other federal legislators and their staff members. Her congressman, Rep. John Olver, senior whip of the Democratic caucus, recently spoke on the House floor about the need for health reform.

Foley hopes that health care reform will happen in spite of those trying to squelch it and that it will be based on primary care. "The AMA is not our voice — people who think that are fooling themselves," she says. "If we let the AMA and the politicians decide for us, we won't get what we and our patients need."

"You hear politicians saying this bill or that bill will kill America — but what's going on now is killing America!"

#### 'Noisy Mosquito' Pays Off

Dennis Salisbury, M.D., who practices in a multispecialty group in Butte, Mont., confesses that he was a noisy mosquito in the ear of Sen. Max Baucus, D-Mont., for some time before the chair of the Senate Finance Committee finally appointed him to a health care stakeholders panel. The finance committee is playing a prominent role in health care reform, although it hasn't introduced a specific bill yet.

After getting active in the Montana AFP and the AAFP, "I became convinced that doctors on the front lines need to speak to the people who are making policy," Salisbury says of his entry into grassroots advocacy. He set about establishing relationships with his federal legislators — especially Baucus, because the senator is so involved with health care. He wrote to Baucus several times about health care issues and spoke to the senator's staff members. He also attended a benefit for Baucus.

"Finally, my persistence got me on his radar screen" and on the stakeholders panel, says Salisbury, who is the only family physician on the panel's six-member physician subgroup.

When Baucus asked whether any panel members would help moderate meetings in the state about health care reform, Salisbury volunteered. "It was a very vocal crowd," he recalls of the meeting he helped moderate. "About a third of them were loud and angry because legislators were not looking at a single-payer system!"

Salisbury played a role in getting participants to listen to one another. He says that's a good example of how the skills family physicians use every day come in handy during advocacy work.

"In our practices, we're always trying to get people to stop, listen and engage in a discussion, not just stamp their feet and insist on one thing," he says. "I think FPs are naturally gifted at lobbying because the skills we use to educate and care for patients are the same skills we need in Washington. We can get the people who are writing legislation to listen and understand the issues from our perspective."

The consequences are huge if those people don't hear a family medicine perspective, he adds. "There are a lot of loud and well-heeled specialty groups giving their opinions, and those groups outnumber us, so it's critical for family doctors to get involved." ■