CMS Delays Enforcement of the 5010 Electronic Transaction Standards

The Centers for Medicare and Medicaid Services (CMS) is delaying action against physicians who have not complied with the version 5010 transaction standards for transferring health information electronically. The new compliance deadline is June 30, 2012. This gives physicians a few more months to make preparations, such as installing software, testing the system, and training staff. The 5010 standards, which replace the 4010/4010A standards, were mandated by the Health Insurance Portability and Accountability Act. CMS reports that physicians and other affected entities are making steady progress, with more than 70 percent of all Part A claims and more than 90 percent of all Part B claims in the Medicare fee-for-service program being transferred using the 5010 standards. The Office of E-Health Standards and Services expects 98 percent compliance by the June 30 deadline. Medicare administrative contractors are available to work with physicians who need assistance with using the 5010 standards. For more information, visit http://www.aafp.org/news-now/practice-professional-issues/20120320transstdsdelay.html.

NRMP Reports a Small Increase in Match Rates for Family Medicine Residencies

The National Resident Matching Program (NRMP) has released preliminary results from the 2012 match. For the third straight year, more graduating medical students chose family medicine residencies, although this year's increase was less than that in the previous two years. This year, family medicine programs filled 94.5 percent of their residency positions, which is slightly up from last year's 94.4 percent fill rate. The number of U.S. graduating seniors who were matched to a family medicine residency program increased by 18 seniors. Although the increase is positive, small increases may not be enough to keep pace with the demand for family physicians in the United States. A report prepared by the American Academy of Family Physicians (AAFP) Division of Medical Education indicates that the earning power of physicians in primary care continues to be lower than that of physicians in other medical specialties. According to the AAFP report, key factors in sustaining the specialty include recruiting students into family medicine, training family medicine residents to provide health care within the patient-centered medical home (PCMH) model, and sustaining family physicians in practice. An annual census that is due to be released in July 2012 will provide a more complete picture of family medicine residency programs. For more information, visit http://www.aafp.org/news-now/education-professional-development/20120316matchresults.html and http://www.aafp.org/online/en/home/residents/match/summary.html.

Smoking Cessation Rates in Children and Young Adults Level Out After Gains

The rate of smoking cessation in children and young adults has slowed over the past decade, according to the U.S. Surgeon General report, Preventing Tobacco Use Among Youth and Young Adults. At a recent news conference to present the report, Surgeon General Regina Benjamin, MD, noted that 99 percent of smokers begin smoking before 25 years of age, and that nearly one in three young adults between 18 and 26 years of age smokes. Although the United States has made strides in decreasing smoking rates in young persons, these decreases have leveled off recently, according to Benjamin. She called on family physicians and other health care professionals to focus on prevention by educating young patients about the dangers of tobacco use. "We always need to talk to our patients about smoking and ways to quit smoking, particularly in the primary care arena where we are dealing with adolescents and this age group," Benjamin said. She encouraged continued efforts with tobacco cessation programs, mass media campaigns, higher tobacco prices, smoke-free laws and policies, and evidence-based school programs. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120320sgreporttteensmoking.html and http://www.surgeongeneral.gov/library/preventing-youth-tobacco-use/index.html.

PCMH Practices May Have Higher Morale and Job Satisfaction, Increased Burnout

Adopting the PCMH model of care in a physician practice leads to increased morale and job satisfaction, but implementing the change may increase physician burnout, according to a recent survey. The survey, PCMH Characteristics and Staff Morale in Safety Net Clinics, included physicians and staff in 65 safety net clinics participating in a five-year Commonwealth Fund project to help clinics transition to high-functioning PCMHs. The survey used five subscales to measure respondents' perception of PCMH characteristics: access to care and communication with patients, communication with other health

care professionals, tracking data, care management, and quality improvement. The communication with patients and quality improvement subscales were associated with increased morale and job satisfaction in both physicians and staff, and care management was associated with increased morale in staff. The survey also showed that about 30 percent of respondents had at least one symptom of burnout, such as exhaustion. The survey authors note that implementing the PCMH model is a transition that may increase workloads and change in staff rolls, leading to strain among physicians and staff members. For more information, visit http://www.aafp.org/news-now/practice-professional-issues/20120314pcmhmorale.html and http://archinte.ama-assn.org/cgi/content/full/172/1/23.

Electronic Access to Results Does Not Decrease Use of Diagnostic Tests

A study published in *Health Affairs* shows that physicians with electronic access to diagnostic test results are 40 to 70 percent more likely to order these tests. This challenges the common theory that electronic access to test results will lead to a reduction in diagnostic testing and subsequent cost savings. The study evaluated data from the 2008 National Ambulatory Medical Care Survey of 28,741 patient visits to 1,187 office-based physicians. About one-half of the physicians had electronic access to test results. Access to the electronic health record itself did not affect how many tests physicians ordered, but the specific access to test results did. The authors conclude that the ease of electronic access to test results may indirectly encourage physicians to order the tests. For more information, visit http://www.aafp.org/news-now/practice-professional-issues/20120307imagingteststudy.html and http://content.healthaffairs.org/content/31/3/488.full.

Campaign Lists Top Five Activities in Family Medicine That Should Be Questioned

In response to decades of increased health care spending, the National Physicians Alliance has initiated the Choosing Wisely Campaign to help improve treatment decisions. The goals of the campaign, which is made up of a partnership of medical groups, including the AAFP, are to help physicians and patients choose evidence-based care and testing that are not duplicative, that will not be harmful, and that are truly necessary. The campaign has developed top five lists of activities that should not be performed in family medicine, internal medicine, and pediatrics, which were published in the *Archives of Internal Medicine*. The top five list in family medicine follows: (1) do not perform imaging for low back pain within the first six weeks unless red flags (e.g., severe or progressive neurologic deficits, suspected serious underlying conditions) are present; (2) do not routinely prescribe antibiotics for acute mild to moderate sinusitis unless symptoms (which must include purulent nasal secretions and maxillary pain or facial or dental tenderness to percussion) last for at least seven days or symptoms worsen after clinical improvement; (3) do not order annual electrocardiography or any other cardiac screening for asymptomatic, low-risk patients; (4) do not perform Papanicolaou smears in patients younger than 21 years or in women who have had a hysterectomy for benign disease; and (5) do not use dual energy x-ray absorptiometry screening for osteoporosis in women younger than 65 years or in men younger than 70 years with no risk factors (e.g., fractures after 50 years of age, prolonged exposure to corticosteroids, calcium or vitamin D deficiency, cigarette smoking, alcoholism, thin and small build). For more information, visit http://archinte.ama-assn.org/cgi/content/full/171/15/1385 and http://www.choosingwisely.org.

Survey Shows That Physicians Often Misinterpret Cancer Screening Statistics

A recent survey indicates that most primary care physicians do not know which screening statistics provide reliable evidence about the effectiveness of cancer screening. The survey, published in the *Annals of Internal Medicine*, introduced more than 400 primary care physicians to data from two hypothetical cancer screening tests. The results of one test were expressed in terms of five-year survival, and the other test was expressed in terms of decreased mortality and incidence. Although 76 percent of physicians indicated that survival data prove that screening saves lives, and about one-half of physicians indicated that improved cancer detection with screening proves that screening saves lives, the National Cancer Institute says that mortality is the only statistic reliable enough to prove the benefit of screening. This is because survival and early detection rates are susceptible to lead-time and overdiagnosis biases. According to the researchers, physicians are most likely interpreting survival in screening the same way they would interpret survival in a treatment trial. The term "survival" takes on a different meaning in screening data because the calculation has a different starting point for screened and unscreened patients. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20120309cancerscreenstats.html and http://www.annals.org/content/156/5/340.abstract.

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