The Roadrunner

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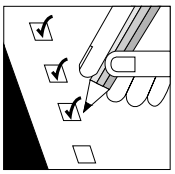
# NMAFP Conducts Survey to Consider New Programs and Services

*By Michael Joe Dupont*

Upgrade our website. Provide financial planning assistance. Strengthen our links to medical students. Become less Albuquerque-centric. Heighten our political presence. Create scholarships for working physicians. Develop our telecommunication abilities.



Those are just a sampling of the suggestions offered by New Mexico AAFP members during the recently completed first phase of a survey by our chapter to determine how we can deliver more and better service to our doctors.

Over the past several months, a cross-section of 23 family physicians from every corner of the state was contacted and asked a series of questions about what new programs or services our chapter should consider investigating to re-invigorate our membership.

NMAFP President-Elect Dion Gallant and Foundation President Dan Derksen initiated the survey last August after reviewing the chapter's finances. They drafted survey questions and selected the rural and urban physicians to be interviewed.

The financial review and subsequent survey were envisioned as an opportunity to free up funding to re-energize our chapter with new activities identified as most desired by our membership.

The information obtained in the member interviews was then supplemented by contacting six other regional or similarly sized AAFP chapters—Arizona, Colorado, Mississippi, North Carolina, Texas and Wyoming—to find out what additional services they deliver.

The feedback from both our members and the other chapters seemed to settle around six central issues: Communication and contact, practice management services, rural outreach, pipeline to medical students, lobbying and advertising, and education.

In the communication area, NMAFP members said the chapter needs to create more opportunities for information exchange, possibly by reconfiguring the website, changing newsletter content or setting up a circuit-riding position.

On the rural outreach issue, many members requested more regional meetings outside Albuquerque, including roving board get-togethers or half-day CME sessions.

Several respondents discussed increasing the chapter's political visibility. More participation in medical committees and Email updates about lobbying events were proposed.

All of the information gathered in the survey was compiled into an 18-page report that was presented and discussed at the quarterly NMAFP Board Meeting in Albuquerque on January 21.

At that meeting, board members volunteered to conduct a detailed review of the member and chapter feedback related to each of the six central issues identified in the survey. Those volunteers will then make recommendations about action steps at the next quarterly board meeting on April 16. ■

## Winter Refresher – A Huge Success

On Saturday, January 22, 2005, the New Mexico Academy of Family Physicians held the 23rd Annual Winter Refresher at the Wyndham Airport Hotel in Albuquerque. The scientific session was preceded by a Past-President's Breakfast that was attended by 15 of our former chief executives. Plaques were presented to all attendees honoring them for their selfless service to the Academy and recognizing their past achievements.

Over 130 physicians from New Mexico and several surrounding states then participated in the general session. Dr. Robert Galagan addressed the assembly on the recognition and treatment of thyroid disorders. He was followed by Dr. Will Richardson speaking about the complexities of wound healing – from the simple to the more serious. Practical examination and treatment of knee and shoulder disorders was the topic of Dr. Dan Junick. The final morning speaker was Dr. Bruce Miller, who shared much current information and advice regarding the

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President's Column

# The Era of Quality Improvement

*By Dion Gallant, MD*

If you haven't participated in Quality Improvement, you will. If you haven't measured quality outcomes yet in your practice, you will. If quality measures haven't affected your bottom line yet, they will. My employer has initiated a quality bonus this year which will provide a bonus based on quality measures – some of which I can control – some of which are systemic and out of my individual control.

It's becoming increasingly clear that, for organized medicine in the United States, this is the era of quality improvement. A brief look at the CMS quality website (www.cms.hhs.gov/quality) gives just a brief hint of what's to come. At the request of CMS, the National Quality Forum has initiated a project to endorse national standards for ambulatory care. These broad standards cover a wide variety of ambulatory measures including assessment and treatment of asthma, URI, pharyngitis, depression, osteoporosis, osteoarthritis, diabetes, CAD, CHF, HTN, prenatal care, cancer screening, tobacco and alcohol screening, and the list goes on. See www.cms.hhs.gov/quality/AmbulatoryMeasures.pdf for details. Big brother will soon be watching, and your reimbursement from Medicare may depend on your "quality" scores. In fact CMS has already chosen 10 physician groups to participate in a demonstration project that offers financial incentives (pay-for-performance) for "improved quality and coordination." The question one has to ask is whether "quality care" simply means converting practice guidelines into quality measures and quantifying adherence, or does "quality care" have a more complex meaning?

What do I make of all of this? As a believer in evidence based medicine, I think encouraging physicians to practice evidence based treatments will improve the health of our patients. On the other hand, I see many complicating factors that need to be considered. The first is the data itself. Take mammography for example. There is little consensus about what the data has shown. Do mammograms save lives? (See for instance the ongoing debate about the Cochrane evaluation that showed no overall decrease in mortality.) If mammography is worthwhile, should we start at age 40 or age 50? Should it be done annually or biannually? What about patient choice? I have a 92- year-old patient who refuses mammography. Every quarter I receive a letter from her health plan reminding me that I'm not performing my job to their approval since I consistently miss opportunities to screen this patient.

> … "quality outcomes" depend on much more than what we can control.

Even when we can generally agree on the standards of care, patients may not have the ability to follow those standards. Consider diabetic patients with cardiovascular disease. Does it mean I'm performing poor quality care when a patient can no longer afford all of their medications and stops taking one or more? What about when their insurance changes or they just lose it altogether? What I'm getting at is what all of you already know – "quality outcomes" depend on much more than what we can control.

So how do we close the gap between what is and what should be? My laundry list would read as follows: better information and tracking systems, better formulary coverage, and a better safety net for un and underinsured. In addition there must be a way to account for patient preferences, co morbid illness, and physician judgment. Until and unless that happens, I fear that a tremendous opportunity for physicians and payers to work together will digress into bickering and an important opportunity will be lost ■

## An Invitation to Precept Medical and PA Students

The UNM Locum Tenens Program continuously strives to improve access to health care through practice relief, education, and assistance with recruitment and retention of New Mexico's health care providers. We support the educational efforts of the UNM School of Medicine and encourage practicing health care providers to participate in precepting students.

The UNM SOM Physician Assistant Program is currently seeking MD, DO, PA, and NP clinicians to precept senior physician assistant students. The Medical School is also seeking MD and DO preceptors for medical students. This is a unique opportunity to participate in the training and education of New Mexico's future physician and mid-level providers. Please feel free to contact me if you are interested in precepting a student or would like more information about the program.

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Medical Director, UNM Physician Assistant Program
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(505) 272-0110

### BUILD UP YOUR BUSINESS SKILLS, THEN YOUR BOTTOM LINE

Could you and your small- to medium-sized practice benefit from a course that covers the basics of financial management? If so, check out the AAFP's Crash Course on Cash, Codes and Computers, to be held April 8-9, 2005 in New Orleans, LA. The course is also geared to third-year residents and includes hands-on work with practice balance sheets, income statements and financial ratios. If undercoding is your downfall, the discussion on the principles of diagnosis and procedure coding could help your bottom line. Registration is open at (http://www.aafp.org/crashcourse.xml)

# Winter Refresher

*(continued from page 1)*

management of asthma and chronic obstructive pulmonary disease.

A buffet-style luncheon of favorite New Mexican cuisine followed. Sara Bittner was introduced to the assembly as executive director. Dr. Darrow thanked the many exhibitors, and Dr. Gallant briefly spoke about legislative initiatives important to the Academy.

The afternoon session kicked off with Dr. James Felberg speaking about emergency toxicology. Dr. Julie Farrer then shared her expertise in the management of hepatitis C. Dr. Cynthia Smith addressed the evaluation and treatment of female dysuria, followed by Dr. Larry Leeman speaking about the problems of pregnancy-induced hypertension and gestational diabetes. Our final speakers, Dr. Kevin Madden and Dr. Mark Leatherwood (residents in Dr. Bert Garrett's program in Las Cruces) gave a concise review of the practical applications for PDA's. Following their lecture, and thanks to the generosity of Dr. Garrett, a new Dell Axim PDA was raffled. Dr. William Borgeson of Rio Rancho was the lucky winner.

Analysis of comments made by attendees indicates a high degree of satisfaction with the content and style of the meeting. Speakers consistently received high praise for their knowledge and delivery, and topics received high marks for practicality and immediate usefulness.

Several topics were suggested for future meetings, with dermatology, orthopedics, and pediatrics topping the list. Many physicians also commented about their desire to have more information about the maintenance of certification (MCO) initiative of the American Board of Family Medicine (no longer Family Practice). See you in Taos in August, as Dr. Dion Gallant is preparing a program that will be sure to please. ■


## THANK YOU

**To the following organizations that participated in the 23rd Annual Winter Refresher in Albuquerque**

Ace Medical Solutions
American Heart Association
Astra Zeneca
Aventis
Bristol-Myers Squibb
ChartWare
Dairy MAX
Dr. Notes
Envision NM: The Initiative For Child Health Care Quality
GlaxoSmithKline
HealthSouth Rehabilitation Hospital
HME Specialists, LLC
Lovelace Sandia Health System
Medical Claim Management
NM Health Care Takes on Diabetes
NM Health Resources
NM Medical Review Association
NM Rehabilitation Specialists
Pfizer
Pfizer, USPG
Quest Diagnostics
Schering Plough
UNM Locum Tenens Program

# ABFM Moves to Online Registration

The American Board of Family Medicine is offering online registration for its 2005 certification, recertification, and sports medicine exams. The online application process has streamlined registering for the examination. In many instances, the physician can complete the entire process in minutes at a single sitting.

The online application process began December 1, 2004 and test center selection came online 2 weeks later. The online registration and test center selection applications can be accessed at our website, www.theabfm.org. With the move to computer-based testing last year, the ABFM is now able to offer nine exam dates, including Saturdays, at over 200 test centers throughout the United States, Puerto Rico and U.S. territories.

Diplomates are encouraged to visit the website to complete their applications as early as possible to increase the probability of selecting the test center of their choice. All eligible candidates for the 2005 exam can login to their Physician Portfolio and follow the "Online Application" link to access the application. Once an approved application has been completed, the Diplomate will then be able to choose a test center. The link to Test Center Selection is also found in the Physician Portfolio. For more information, please contact the ABFM Help Desk at (877) 223-7437. ■

## Save these Dates!
## August 4-7, 2005

The annual summer CME conference in Taos promises to both enlighten and entertain. This year's agenda will feature mini courses in internal medicine, pediatrics, geriatrics, ED/critical care, urology and musculoskeletal disorders. **Syd Masters and the Swing Riders** band will be on hand too for the installation of officers and to dance the night away. We look forward to seeing you all in Taos.

## BOARD NOTES

January 21, 2005
The Quarters Restaurant, Yale Blvd.

■ The Colorado AFP chapter shared the design of their outreach program for family physicians in rural areas to obtain CME and attend Board meetings. Video conferencing allows real time participation. Cost is substantial for a small chapter, but the NM Chapter felt it had real possibilities for our state in the future.

■ Medicaid cutbacks will affect most Family Physicians practicing in New Mexico. Members are encouraged to inform their legislators precisely what impact this will have on our practices and patients. A letter will be sent to members bringing them up to date on the issue. Other issues of particular interest during this legislative session include the statewide clean indoor air act, our existing medical malpractice liability act, more on gross receipts, psychologist prescribing expansion, healthy weight for children action, and legislation to fund residency programs in New Mexico.

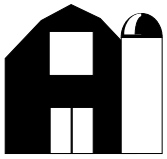
■ The recent survey of NMAFP members was discussed (see accompanying article by Michael Dupont). The Board chose areas for improvement, and plans to further the Chapter's efforts at the next Board meeting.

■ Next meeting will be April 16th. Please contact the NMAFP office for location.

■ The Annual Meeting will be held in August in Taos, in conjunction with the FP Seminar.

# FP and IOM Study Director Ask Congressional Aides to Champion Rural Health Funding

Twenty percent of Americans live in rural or small-town communities, but only 9 percent of the nation's physicians work there. To resolve that discrepancy, Congress should beef up programs that bring more health professionals to rural America, two speakers insisted at a Capitol Hill forum Jan. 25.



"Only 3 percent of recent U.S. medical school graduates say they plan to work in small-town or rural areas, so we're not even going to be close to replacing those who are already there," warned FP Howard Rabinowitz, M.D., director of the Physician Shortage Area Program at Thomas Jefferson University, Philadelphia.

The PSAP graduates about 14 students a year who enter rural family medicine.

"In our program, the admissions component is probably the most powerful part," said Rabinowitz. "We recruit and preferentially select students from rural areas or small towns who are committed both to practice the specialty of family medicine and to return to a small town or rural area."

PSAP students have a rural mentor for all four years of medical school, they take rural clinical clerkships for 10 weeks during their third and fourth years, and they receive "miniscule" loans, Rabinowitz told about 80 people, including 30 legislative aides to congressional health committees.

He named six other programs with successful track records in creating rural FPs. "What needs to be done is to incent medical schools and students with the kinds of programs we and others have shown would work," Rabinowitz said.

Speaker Janet Corrigan, Ph.D., study director for the Institute of Medicine report Quality Through Collaboration: The Future of Rural Health, issued last fall, agreed.

"Our (IOM) committee felt there was a strong sense that family medicine prepares physicians better for the rural practice setting and therefore they're more likely to practice in rural areas – they have a broader scope of practice, which is what the need is in those communities," she said. "I think we should focus particular attention on family medicine, but not exclusively. We'd also like to increase the supply of pediatricians and internists. And physician assistants are really critical; nurses, emergency care providers – all those other members of the health care team."

So what should Congress do?

"Increase the funding streams that already exist," said Rabinowitz. He and others at the forum specified Titles VII and VIII of the Public Health Service Act and other Health Resources and Services Administration programs, as well as funding for area health education centers and for graduate medical education.

Zeroing in on the rural physician shortage, Rabinowitz concluded, "If all 146 medical schools produced five to 10 more docs a year who practiced in rural areas and stayed there, we could solve this problem in 10 years. Then the one out of five Americans who choose to live in rural areas would have access to basic care."

The forum was sponsored by AAFP's Robert Graham Center in partnership with the IOM, Society of Primary Care Policy Fellows and Academic Family Medicine Advocacy Alliance.

– From http://www.aafp.org



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# CMS Selects 10 Practices For Pay-For-Performance Demonstration Project

Ten large medical groups across the country – including five that provide family medicine residency training – will participate in a pilot program to test the efficacy of pay-for-performance reimbursement. The 10 participants were named by CMS Administrator Mark McClellan, M.D., Ph.D., in a Jan. 31 announcement that, observers say, marked the beginning of federal efforts to shift Medicare to a pay-for-performance system.

In making the announcement, McClellan hinted that President Bush would likely recommend a pay-for-performance system similar to that proposed Jan. 12 by the Medicare Payment Advisory Commission. (See http://www.aafp.org/x31675.xml for more coverage.) MedPAC indicated the program should be a budget-neutral system in which a percentage of current Medicare monies would be set aside in a fund from which pay-for-performance incentives would be paid.

"We are working to apply this in every setting" in which Medicare and Medicaid pay for care, McClellan said.

AAFP opposes a budget-neutral pay-for-performance program. Noting the already meager Medicare reimbursement for primary care, the Academy contends a budget-neutral program would further penalize already struggling physician practices that cannot afford electronic health records and other reforms required to meet many pay-for-performance quality measures.

Under the demonstration project, participating practices will continue to be paid on a fee-for-service basis. If they reduce Medicare costs and improve patient care, they will receive up to 5 percent in additional payment. The incentive payments are expected to derive from savings wrought by improved care management.

Participating practices will evaluate 32 ambulatory care measures that focus on common chronic illnesses and preventive services. Among them: HbA1c management and control, lipid measurement, and eye and foot exams for diabetes management; left ventricular function assessment and ejection fraction

testing, blood pressure screening, beta blocker and ACE inhibitor therapy for congestive heart failure; antiplatelet therapy, blood pressure screening, lipid profiles and low-density lipoprotein cholesterol levels for coronary artery disease; and blood pressure screening and control and breast cancer and colorectal cancer screening for preventive care.

The 10 physician groups represent 5,000 physicians and more than 200,000 fee-for-service Medicare beneficiaries.

Participating providers that have family medicine residency programs are Dartmouth-Hitchcock Clinic in Bedford, N.H.; the University of Michigan Faculty Group Practice in Ann Arbor, Mich.; Park Nicollet Health Services in St. Louis Park, Minn.; Middlesex Health System in Middleton, Conn.; and Deaconess Billings Clinic in Billings, Mont.

Details about the demonstration program are at: http://www.cms.hhs.gov/researchers/demos/PGP.asp.

– From http://www.aafp.org



# Extend Moratorium on Specialty Hospitals, Says Board

A recommendation on specialty hospitals approved Jan. 15 by the AAFP Board of Directors clearly reflects the Academy's commitment to evidence-based decisions. Yet the Academy's cautious approach to specialty hospitals puts it at odds with the AMA.

At issue is a congressionally mandated moratorium on new specialty hospitals or expansion of existing specialty hospitals, many of them wholly or partly physician-owned. Originally considered exempt from Stark II prohibitions of physician self-referrals under the "whole-hospital exception," about 100 specialty hospitals sprang up nationwide between the early 1990s and December 2003, when Congress called the halt.

The Board recommendation – developed by the Commission on Health Care Services in consultation with the commissions on Education and on Legislation and Governmental Affairs – supports extending the moratorium on specialty hospitals beyond its scheduled June 30 expiration. The Board said it would support continuing the freeze until "the AAFP is convinced by evidence of their benefit on the health and well-being of our communities."

The AMA House of Delegates, on the other hand, voted at its December interim meeting to adopt several measures related to physicians' interests in so-called specialty hospitals - including calling for an immediate end to the moratorium.

According to AAFP Board Chair Michael Fleming, M.D., of Shreveport, La., the issue is far from clear-cut.

"We all have opinions about the appropriateness of this issue and whether it's hurting private hospitals - particularly the safety net hospitals – to 'cherry-pick,'" said Fleming. "Some of these specialty hospitals are actually providing excellent, very high-quality care. Some are even owned by the very hospitals that are complaining about them. So it's not a simple issue."

The Government Accountability Office defines specialty hospitals as facilities in which the diagnoses of two-thirds of Medicare patients fall into no more than two major diagnosis-related group classifications or in which at least two-thirds of Medicare patients are classified into surgical DRGs.

In making its decision, the Board focused on several key points. Among them:

- Specialty hospitals are not subject to the same regulatory requirements, such as the Emergency Medical Treatment and Labor Act, as are community hospitals.
- The current DRG system does not fully capture differences in case severity, leaving open the possibility that specialty facilities might accept only patients yielding the highest profit margins.
- Congressionally mandated studies by CMS and the Medicare Payment Advisory Commission regarding the impact of specialty hospitals on the viability of community hospitals and the essential services they provide have not yet been completed. Results of those studies are not due until March.

Those results will be key in determining the AAFP's final policy on specialty hospitals, Fleming explained.

"We want to wait to see what these studies show," he said. "The whole moratorium was produced to allow these quality studies to proceed, and I can't think of anything more appropriate. So to do something before that moratorium is over just doesn't make a lot of sense."

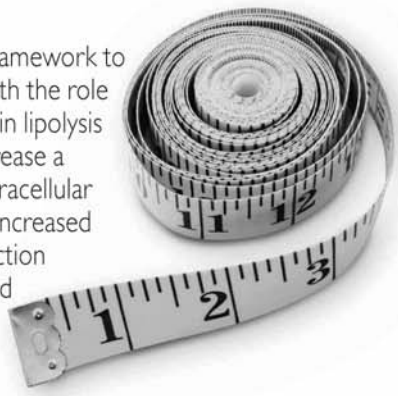
– From http://www.aafp.org

# The Skinny on Milk, Cheese and Yogurt

## 3-A-Day of Dairy Increases Weight Loss When Part of a Reduced-Calorie Diet

Research continues to support the relationship between dairy foods and weight management. In a clinical trial, people on a reduced-calorie diet who consumed 3 servings of milk, cheese or yogurt each day lost significantly more weight and body fat than those who just cut calories while consuming little or no dairy.[1]

## How It Works

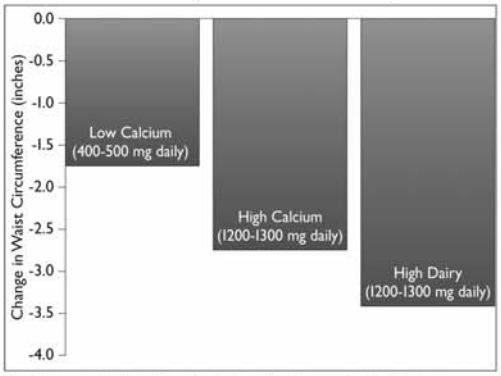


Cell culture and animal studies provide a strong potential framework to explain dairy's weight loss effect, part of which has to do with the role that dietary calcium, and potentially dairy protein, may play in lipolysis and lipogenesis. Low-calcium diets have been shown to increase a key calcium-regulating hormone, which in turn increases intracellular calcium concentrations in human adipocytes and results in increased fat storage. Conversely, a high-calcium intake inhibits production of the hormone, thereby decreasing intracellular calcium and ultimately the fat content of fat cells. Moreover, studies in animals and humans show that dairy foods promote substantially greater loss of body weight and fat than calcium supplements.

## A Motivating Benefit: Losing Inches in the Waist

Research also indicates that including 3 daily servings of dairy in a reduced-calorie diet may help patients lose more inches and burn more fat in the abdominal region.[1] Visual results can help motivate patients to decrease a high waist circumference, a trait that indicates abdominal obesity and an increased risk for the metabolic syndrome, hypertension and cardiovascular disease.

**Dairy Foods Accelerate Loss of Abdominal Fat[1]**
***Results after six-month study***




Motivate patients with what they find important. Adults may lose more inches in the waist when including 3 servings of milk, cheese or yogurt each day as part of a reduced-calorie diet.

## Benefits Beyond Weight Loss

The newly released Dietary Guidelines for Americans also acknowledges the important role of dairy products' unique nutrient package. The guidelines recommend people consume 3 servings of fat-free or low-fat dairy foods every day as part of a healthy diet. It also recommends dairy products like lactose-free milk or yogurt first for individuals who are lactose intolerant.

NATIONAL DAIRY COUNCIL®

**To learn more about the body of research supporting dairy's role in weight loss and to download a free Healthy Weight Education Kit with patient education materials, visit nationaldairycouncil.org. Also encourage your patients to assess their diet at assessyourdiet.webmd.com.**

[1]Zemel MB, et al. Dietary calcium and dairy products accelerate weight and fat loss during restriction in obese adults. *Obesity Research.* 2004; 12(4): 582-590.



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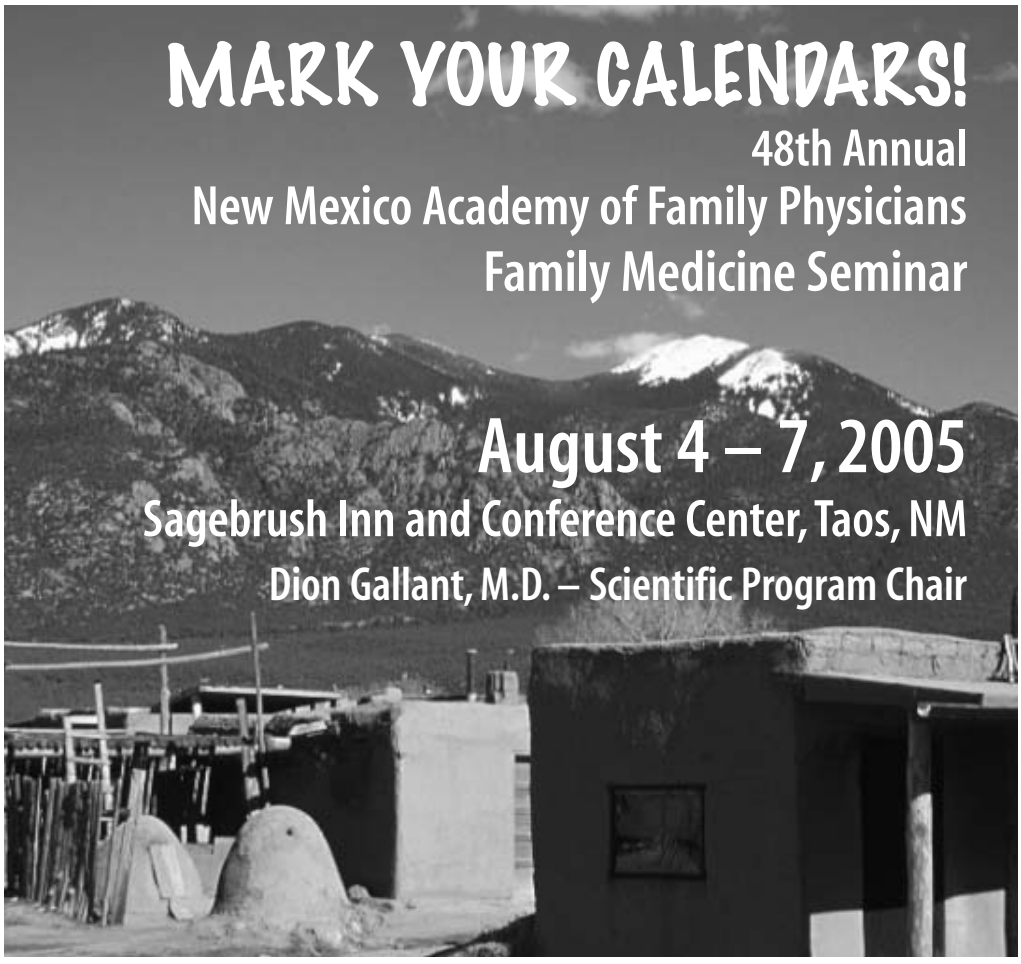


## The Roadrunner

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