ing must be found, however, and this year will see important leadership changes so future progress cannot be taken for granted.

These modest but important successes in primary care research funding in Canada have come on the heels of several unsuccessful attempts and so they carry with them some lessons learned. These include framing family medicine more broadly to include a wide variety of primary health care practitioners and investigators, being consistent and persistent in advocacy, bringing policy-makers and national organizations on side, establishing ongoing relationships with funding decision-makers, and, most importantly, finding champions among both researchers and funders. Arguments about the impact and role of primary care in the health system were challenging to make and were not initially accepted. Graphical representations[2,7] of the ecology of medical care were especially valuable and funders did eventually accept that primary care research was of importance. There is much work left to do in Canada and recent gains can easily be eroded. Nonetheless, these lessons may be instructive for advocacy in the United States and elsewhere.

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AAFP **From the American Academy of Family Physicians**

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AAFP WOULD LIKE TO SEE SIGNIFICANT MODIFICATIONS IN 'MEANINGFUL USE' RULE

The American Academy of Family Physicians (AAFP) has responded to the federal government's December 30, 2009 release of electronic health record (EHR) regulations that define the term "meaningful use" with comments detailing how the Academy would make the regulations more helpful and more palatable to family physicians.

Defining meaningful use is important because qualifying for government stimulus funds for the purchase of health information technology depends on how physician practices are meeting the regulations' criteria.

In a February 26,2010 letter to Centers for Medicare & Medicaid Services (CMS) Acting Administrator Charlene Frizzera, AAFP Board Chair Ted Epperly, MD, of Boise, Idaho, began by lauding CMS and the Office of the National Coordinator for Health Information Technology for the amount of energy expended to craft the regulations and the "potential health IT progress made possible with these regulations."

However, Epperly continued, "We believe that certain aspects in the details of these regulations are unworkable, excessive, or redundant and will actually impede the very goals of the legislation."

The Academy noted several areas where it saw opportunities for improvement and suggested CMS consider

- offering partial incentives for physicians using less than 100% of required criteria
- creating parity between first-year requirements for the Medicare and Medicaid programs
- changing calculations of meaningful use measures from recording of percentages to absolute counts or allowing for shorter 30-day reporting periods, and
- ensuring incentives for team-based care

The Academy also expressed concern about the regulations' definition of eligible professionals and suggested that the wording be changed to include practices participating in hospital-based organizations. "We recommend that any physician or practice that purchases certified EHR technology be eligible for incentives under Medicare and Medicaid," said Epperly.

Regarding the AAFP's call for partial incentives, Epperly said he was "greatly concerned about the capacity for many eligible providers, especially those in small and medium practices, to achieve all of the required criteria by 2011 and 2012." He added that CMS could miss a huge opportunity with its "all-or-nothing" approach. Epperly said the AAFP did not want to discourage practices that couldn't achieve 100% of the requirements "from using, improving or implementing EHRs because they will receive no incentive for anything less."

The Academy had no issues with CMS' meaningful use goals but expressed concern about the proposed administrative burdens that would be placed on physicians to report the measures. "We strongly believe that efforts and resources in the practice need to be focused on the transformation of the practice and achieving high-quality care—not on tracking denominators for process measures," said Epperly.

In terms of team-based care, Epperly asked for revised wording that wouldn't require a physician to actually perform a task, but rather would make the physician responsible for ensuring completion of the work. This change "is critical to patient-centered care via a team-based approach to care," he said.

The Academy also spelled out its recommendations for changes in the proposed rule related to goals for meaningful use suggested by CMS, going so far as to ask the government to strike or delay some measures that either were duplicative or overly burdensome for physicians.

For example, the proposed rule has an objective on computerized provider order entry, or CPOE, that would require computerized entry for at least 80% of orders. "We believe that the administrative burden to report on the CPOE measure is excessive to the point of being unachievable for most eligible providers," said Epperly. He noted that most physicians would have to perform double-data entry because many labs, hospitals and diagnostic imaging centers do not accept standard electronic orders. "Based on the current state of adoption of CPOE in the ambulatory environment …we recommend that the CPOE measure be removed until electronic orders are routinely transmittable," he said.

The AAFP also took issue with a measure requiring that at least 75% of prescriptions be transmitted electronically. Epperly pointed out that many physicians with e-prescribing capabilities don't use the technology because of pharmacy or patient resistance. In fact, only about 16% of prescriptions are sent electronically; therefore, the 75% threshold is likely unachievable by the majority of physicians "because of conditions not under their control," said Epperly. The Academy recommended that the e-prescribing measure be reported with an absolute count of e-prescribed medications rather than a percentage of total prescriptions. Epperly also suggested changes in other measures, including

- recording patient demographics and vital signs
- incorporating clinical lab test results
- generating patient lists by specific conditions
- implementing 5 clinical decision support rules
- providing patients with electronic copies of their health information, and
- giving patients electronic access to their health information within 96 hours after a patient visit

The Academy stood up for some of its most vulnerable members when it told CMS that small practices "do not have the resources for elaborate testing on information systems and electronic data interchange." Those practices would be unable to prove capability to exchange key clinical information among providers of care, submit electronic data to immunization registries or provide electronic submission of reportable lab results to public health agencies, said Epperly.

"We believe there is a real risk for entities to gouge eligible providers to 'assist' them with such testing," he added.

Epperly asked CMS to significantly modify the proposed rule to ensure participation by a majority of physicians. Doing so would move America more quickly toward a patient-centered, coordinated and high-quality health care system, he said.

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AAFP News Now

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FIRST COHORT OF PHYSICIANS IN MC-FP COMPLETE SECOND STAGE IN STRONG NUMBERS

The American Board of Family Medicine (ABFM) is pleased to announce as of March 1, 2010, almost 8,500 of the Diplomates who certified or recertified in 2003 successfully met the deadline of completing their Stage 1 and Stage 2 requirements for Maintenance of Certification for Family Physicians (MC-FP) and have been granted a 3-year extension of their current certificate, creating a 10-year certificate. The 2003 Diplomates were the first cohort to begin MC-FP and to be eligible