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This year marks my 20th year of employment with the Academy. I have learned a lot about health care and health policy in that time. I have also learned a great deal about organizations. Much of that knowledge has reaffirmed previously held beliefs and conclusions.

There are many reasons why the Academy is the successful, vibrant and continually evolving organization it is. Family Medicine is a truly important discipline and the people who gravitate to it are remarkable in their personal standards and values. I have found that they generally make significant professional sacrifices to pursue their interest in Family Medicine. It is that personal commitment and quality that, for me, distinguishes Family Physicians from other physicians. So too, it is the personal element that contributes immeasurably to the character of the Academy and the priorities we pursue together to advance the mission of this fine organization.

I believe our journal reflects these high standards and the essential decency and commitment of those whose membership and work define the Academy. We have an outstanding team of individuals who comprise our editorial and production team.

Our editorial board, chaired admirably by past president Rich Bonanno, MD, does an excellent job of defining themes, recruiting authors, contributing articles and editing contributions. Dr. Bonanno’s colleagues on the editorial board include Drs. Robert Bobrow, Rachelle Brilliant and Bob Ostrander. All give generously of their time and talent and together they have shaped a journal which we are immensely proud of.

The unique appearance of the journal is the result of our talented and creative designer, Traci Kachidurian of Lane Press of Albany. Lane prints the journal and Traci has been the designer and layout manager of all issues of our journal. Management of production has been ably overseen by Sylvia Daigle — Vice President of Lane and an expert in all aspects of publishing.

Don McCormick sells advertising which helps immeasurably to support and sustain the journal. The cost of producing and distributing such a fine product is significant. The revenue generated by Don’s sales efforts helps contain our net costs.

The central figure in our editorial enterprise is our editor — Janet Lindner. Janet began her Academy career as manager of our colorectal cancer screening project after a career in public service with the NYS Health Department. She did an excellent job on that project and then applied her array of talents to management of our diabetes project which focused on assisting members through the NCQA recognition process. When we decided to bring back our journal Janet was eager to take on editorial responsibility. She worked diligently to create a design that was unique and captured the character of Family Medicine. She has cultivated a strong and productive relationship with our editorial board, our printer, our sales team and our graphic designer. Her coordination of the array of activities that collectively define each issue has produced a truly special product which we are enormously proud of. Janet has decided to retire after this issue. We will miss her for her many attributes that have contributed to the success of the various projects she has been associated with, but mostly, we will miss her friendship and good humor. As I previously noted our journal has captured the high standards and essential decency of our membership. In that regard it has also reflected the image of our editor. Thank you, Janet, and good luck in your retirement.

Vito Grasso, MPA, CAE, is the Executive Vice President of the New York State Academy of Family Physicians.
Note from the Editor
By Janet Lindner, MS

It has been an interesting challenge and an honor to work on our journal, Family Doctor, since its inception. It is hard to believe that this is already our 8th issue. I want to thank my review board members: Rich Bonanno, Robert Bobrow, Rachelle Brilliant and Bob Ostrander for their guidance and their commitment to making this a publication we can be proud of. I especially want to thank Vito Grasso for giving me the opportunity to develop the journal - - a great experience. And thanks, too, to all of you who have contributed articles. We’ve had an easy job with your interest and good writing.

Also special thanks to Sylvia Daigle and Traci Kachidurian at Lane Press in Albany. They have given this journal its professional design and have been a pleasure to work with.

I hand the editorial pen (or computer) to Penny Ruhm who comes to the Academy from the Adirondack Health Institute. Penny has lots of public health and health education experience, and a good sense of humor – an important ingredient to success in our office! I will miss this.....

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Some children who had employer-based health insurance coverage within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will depend on your household income and the reason your children lost employer-based coverage.
Spring is near and it is time to come out of our winter hibernation. It is also time to shed those pounds from holidays that we haven’t yet gotten rid of. Many patients will be coming to the doctor for advice on the most trendy diet or even for that magic diet pill. The last thing patients want to hear is that there is no shortcut to the tried and true method of reasonable eating and regular exercise. The efforts of adopting a healthy lifestyle do not have to be painful.

The NYSAFP has outlined a proven method of assisting our patients with weight loss. The program entitled “Manageable Challenges” can be found on the NYSAFP website. The program involves calculation of daily calories needed to lose weight. It sets a schedule for office visits and follow-up physician phone calls. It also suggests a guideline to ease into healthy habits of limiting portions, not eliminating foods and establishes an exercise regime. The patient schedule is based on recommendations from the NIH and USPSTF.

The program even includes a Medicare guide for reimbursement.

As the weather gets better, many of our patients will be interested in losing weight to look their best. This presents us with a rare opportunity to use that motivation for weight loss to assist our patient to adopt a healthy lifestyle change.

Another very practical benefit provided by your Academy is found on the NYSAFP website. It is the job search service, fp jobs online. I encourage all those practices (both academic and private community practices) with employment opportunities to list positions on the website. I also encourage family physicians looking for job openings to list their curriculum vitae with the site and to check out the opportunities available.

Have a Healthy and Happy Spring!

Raymond L. Ebarb, MD, FAAFP, is the President of the New York State Academy of Family Physicians for 2013-2014.
LACTOSE INTOLERANCE

Making the Most Out of Milk
People who are lactose intolerant don’t have enough lactase, the enzyme that breaks down lactose (a sugar naturally found in milk), in their digestive system.

If you are lactose intolerant, it’s still possible to eat dairy foods - the key is to learn what works best for you. There’s an option to meet most needs in the dairy case ranging from lactose-free milk to natural cheese and yogurt.

You can also mix milk with other foods. Blend with fruit, include in soups and cereal or drink milk with meals. Solid foods help slow digestion and allow the body more time to digest lactose.

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Determining which risk factors to use when calculating risks for patients with coronary heart disease can be difficult. The Framingham risk model is currently used to help determine low, intermediate and high-risk patients. If the risk model could be improved, treatment might be better targeted, thereby maximizing screening benefits and minimizing harms. The current Framingham model uses age, total cholesterol, smoking status, HDL cholesterol and systolic blood pressure to determine a ten-year risk score.

The most likely opportunity to improve the model is use of additional risk factors to reclassify those in the intermediate-risk category to either high or low-risk. Approximately 31% of the asymptomatic men and 7% of asymptomatic women fall into the intermediate-risk category. It would be useful if those in the intermediate category could be reassigned to either the low-risk category for reassurance, or into the high-risk category for more aggressive medical management.

The additional risk factors that could be added to the intermediate-risk group are Arterial Brachial Index (ABI), leukocyte count, impaired fasting glucose, periodontal disease, carotid intima-media thickness (IMT), coronary artery calcification (CAC) score on electron-beam computed tomography (EBCT), homocysteine level, and lipoprotein level.

Each one of these risk factors was studied in detail for the intermediate risk groups. The risk factors that had the most influence were ABI, carotid IMT, homocysteine, and lipoprotein (a). When ABI was used as a risk factor with the Framingham risk model for women, it showed an unbiased estimate that approximately 10% of women would be reclassified from the intermediate to high CHD risk. Carotid IMT scores added to a risk prediction equation based on traditional risk factors, modestly improved the prediction of subsequent CHD among healthy adults, particularly for men. In the high-risk group lipid lowering has been shown to be associated with slowing of carotid IMT.

When Homocysteine levels in participants without previous coronary disease were polled, each 5-μmol/L increase was associated with an 18% increase in the risk for coronary events. None of the studies however, addressed the prevalence and applicability of the homocysteine level in the intermediate-risk participants. Lipoprotein (a) level evidence indicates that levels can predict CHD events after adjustment for some Framingham risk factors, but no studies calculated a Framingham risk score, assessed predictive value beyond Framingham risk scoring, or assessed whether lipoprotein (a) contributes to reclassification from intermediate to another risk category.

For males age 45-79 with an elevated risk for CHD it is recommended that aspirin be taken when the potential benefit outweighs the risk of gastrointestinal bleeding. It is recommended that women age 55 to 79 also take aspirin to help lower the risk of CHD when the potential benefit outweighs the risk of hemorrhagic stroke. The recommended dose for patients is 75mg/daily. This has shown to have the same effects as higher dosing without the increased risk for gastrointestinal bleeding. People over the age of 80 may take aspirin, but it is probably best in patients without risk of gastrointestinal bleeding.

Patients that are intermediate-risk for CHD events have the greatest potential for net benefit from ECG screening. However, the screening can raise their risk level and put them at risk for invasive procedures. For patients that are asymptomatic adults at low-risk, ECG is not recommended. Asymptomatic adults can be controlled with diet, exercise, lipid-lowering medications, aspirin, hypertension management and tobacco cessation.

C-reactive protein is an inflammatory marker believed to have some value in the prediction of coronary events. C-reactive levels were
checked in patients post myocardial infarction and from a control group that had no myocardial issues. Reviewing these test results showed a correlation between elevated C-reactive protein and myocardial infarction. Further research is needed to help evaluate its predictive value.4

There is no great risk calculator for CHD. The Framingham calculator is an important tool and helps determine who is at low, intermediate and high-risk. The people in the intermediate group could benefit from further testing. The testing that could change management for this group however, needs further evaluation to help improve the Framingham calculator. Aspirin should be started on all patients that can tolerate therapy to help reduce the risk of CHD. ECG can help intermediate-risk people determine if they need further invasive testing.

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Endnotes


Michael Kernan, MD. is Associate Professor in the Department of Family Medicine at Upstate Medical University in Syracuse, NY. He is also Assistant Team Physician at Syracuse University, a member of the American Academy of Family Medicine and the American College of Sports Medicine. Anthony J. Malvasi, DO, is a resident at St. Joseph’s Hospital Health Center Family Medicine Residency in Syracuse, NY. Dr. Malvasi graduated from Lake Erie College of Osteopathic Medicine in Erie, PA.

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THE ADULT ANNUAL PHYSICAL:
An Opportunity to renew a relationship and identify problems

By Marietta Angelotti, MD

What should we do with the annual physical? There’s been a raft of studies and news articles over the last few years urging the end of this cornerstone of ambulatory medicine. The Cochrane Group published their meta-analysis concluding that there was a lack of evidence to support general health checks for asymptomatic adults over the age of 18. They thought that there was potential, but no proof of harm from over-testing in 2012. This was widely reported as evidence against annual physicals in the lay and medical press. From the Washington Post (2/8/13) to numerous on-line blogs, from the Archives of Internal Medicine (9/24/07) to the U.S. Department of Veterans Affairs (October, 2011 Evidence-Brief), all have come out against the usefulness of the annual physical. Is it really time to stop offering annual physicals, just as more patients than ever will now seek this benefit of the Affordable Care Act?

The benefits of an annual check-up have long seemed self-evident to patients, their doctors, and the public health establishment. It is an opportunity for a longer more wide-ranging visit, less pressured by the need to seek closure on an acute problem. It allows more focus on a comprehensive history and review of systems, including family and social history, a thorough discussion of worries and questions, and a full physical exam including the often neglected skin exam and depression screening, for example. It is a time for the discussion of pros and cons of screening tests and the planning for them. It is the place for the long list of recommended lifestyle interventions like counseling on tobacco, alcohol, weight, nutrition, exercise, seatbelts, and on and on.

Perhaps the most important reason for an annual check-up with one’s primary care doctor is an opportunity to renew the relationship, to refresh “continuity”. The benefits of continuity between patient and physician have been known for as long as physicians have been practicing medicine. Indeed the residency model was premised on the principle that watching a patient continuously over the course of their stay in the hospital was beneficial.

Continuity is a boon for the physician in evaluating the course of disease or recovery and the effect of interventions, as well as the effects of other variables. Continuity also strengthens the therapeutic relationship.

CONTINUED ON PAGE 11

IN SEARCH OF PHYSICAL EVIDENCE:
Why the “annual physical” for healthy adults is a poor use of clinician time

By Natercia Rodrigues, MD and Colleen T. Fogarty, MD, MSc

Physicians are often faced with balancing patient expectations and requests with evidence-based medicine and recommendations. Occasionally, a patient presents, saying, “Doc, can you just check me for everything. Isn’t there a scan to look for cancer everywhere?” Often these questions are rooted in fears and other life stressors. As physicians, our role is to discern the patient’s concerns, educate on preventable disease and offer the best possible care. Few physicians would order a full-body CT scan to look for cancer in an asymptomatic patient; this lacks supporting evidence of efficacy. The harm of radiation would likely outweigh the benefit of such a study.

We learn a complete physical exam in medical school. I recall starting a clinical longitudinal experience and being asked to perform a “full physical” on a patient. I started with her scalp. She wasn’t happy - “Don’t mess up my hair!” she said, “there’s nothing wrong with my scalp.” In hindsight, I certainly recognize that a scalp exam was not a necessary component of this routine physical and as I progressed through medical school and residency I performed more screening heart, lung, peripheral pulses and abdominal exams than scalp exams. Even with our streamlined routines, are we still doing too much?

The United States Preventive Services Task Force (USPSTF) makes three grade-A1 recommendations for healthy, asymptomatic patients.

1. Hypertension screening: Bi-annual blood pressure measurement for adults over age 18 if under 120/80.
2. Obesity screening: annual weight measurement for adults
3. Cervical cancer screening: Obtain cervical cytology (Pap smear) for women with a cervix who are 21 and older (Bloomfield 2011).

The USPSTF recommends against routine Pap smears in women over age 65 who have had adequate screening in the past and are not at high risk for cervical cancer. Pelvic exams to screen for ovarian cancer, testicular exams to screen for testicular cancer, abdominal

A1 – Strongly Recommended: The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

CONTINUED ON PAGE 12
relationship. “The secret in care of the patient is caring for the patient.” The patient needs to be known and to have their experience of illness validated, and addressed. This is difficult to achieve between strangers in acute settings. The annual check-up has long been the setting for the development of continuity. If a patient is either healthy and never comes in, or comes in only when acutely ill and sees whoever is available on short notice, no continuity develops.

Studies have shown that patients with a “usual source of care” are less likely to use emergency rooms for primary care. Other studies have shown that the more frequently a patient changes doctors, the more likely they are to use the emergency room unnecessarily. Many of the components of a typical “check-up”, including screening, immunizations, discussion of end of life wishes, and counseling on lifestyles issues have been shown to be beneficial. So how is it that the setting aside of a specific visit for these beneficial activities would not be itself beneficial?

The answer lies in the studies. The Cochrane review evaluated studies of physicals defined as “screening general populations for more than one disease or risk factor in more than one organ system.” The researchers admit that many of the trials were older, when the benefits of early interventions or even the ability to find disease may have been different than they are now. In addition, since the studies were of asymptomatic adults, they may have excluded high-risk patients who may have been less likely to have physical exams given how frequently they already were seeing their primary care doctor. By excluding these high-risk patients, the effect of screening is potentially dramatically decreased. In addition, we know that the interaction between the doctor and the patient can be uniquely therapeutic depending on the relationship, and depending on the interpersonal and clinical skills of the specific physician. Is an encounter between a patient and any doctor the same as an encounter between a patient and his or her own doctor? We should also consider the range of activities performed at an annual physical, from brief reviews of history and a cursory physical to comprehensive and thoughtful histories with thorough and skilled physical exams. What of valuable activities of which we are not even conscious, like eye contact? The variations of annual exams make comparisons muddy at best.

Another widely reported study from 2007 that did not find a benefit for annual physical and gynecological exams used the data gathered from a one-page form described as:

“Standard 1-page encounter forms were completed by the physician (17%), office staff (30%), an outside coder using the medical record (32%), or some combination of these respondents (15%) for 30 random patient visits during an assigned reporting week...Our analysis focused on patient demographic characteristics, up to 3 coded reasons for a visit, up to 3 coded diagnoses, and laboratory tests, radiographs, and counseling services provided or ordered at a visit.”

The study used data provided after the visit took place, and only data that could fit into those very narrow parameters.

Consider the following scenario. A generally healthy 48 year old woman comes in for a sore throat and fever. You have not seen the patient in some time so you do a general review of systems and listen to her heart and lungs, do a brief neurological exam, and do a complete exam of head, eyes, ears, nose and throat. The review of systems, as is typical, elicits a few concerns which you also evaluate—perhaps a small skin blemish or funny discoloration on her nails or a concern about nutrition. This was last year, before her insurance paid for an annual physical, though haven’t you just done one? So you bill a Level IV. This patient would not be in the data set on the usefulness of the annual physical.

This year another patient, another sore throat and fever, but insurance now pays for an annual physical exam (PE), which you note the patient has not had in some time. Pointing that out to the patient, he responds by suggesting that you do his PE now since he doesn’t have a co-pay for that. His insurance will not pay for both a Level III visit on the sore throat plus a preventive visit for the PE on the same day, so your choice is to refuse and have him return another time for a PE, do the PE gratis, do whatever additional work is required for the Level III (Rapid Strep?) gratis, or bill him for both, make him pay the co-pay for the Level III, and hope you will get paid for the PE as well. Many plans will not pay for them on the same day. What do you do? The incentive and the reasonable course of action is to do what the patient wants and needs, and then bill in the highest paying legitimate fashion - in this case, billing just for a PE, despite the other services you will provide. Now the data showing an unnecessary physical exam may be counting this symptom-based visit.

Comprehensive clinical data, and perhaps even a physician and patient interview would be a legitimate way to evaluate whether nothing but an annual physical took place on a completely healthy and asymptomatic patient. This would allow for the researcher to include outcomes that occurred because of clinical intuition, the ability of an experienced physician to examine a patient and find and treat pre-cursor conditions below the level of the rational analytic consciousness. Just as an expert ball-player, chess-master, or musician can identify patterns almost instantly without the plodding efforts of the novice, so can the experienced physician, especially in the exam of a known patient. The patient may not have recognized a change in the border of a mole, the pattern of their eyebrows, or down trodden mood or flight of ideas that might jump out immediately to their primary care physician.

These are the surprises in an annual physical exam. An exam that may have started out as the annual physical exam of the asymptomatic adult not due for any screening, and ended as the Level V visit coded not for a physical but for depression, or possible malignancy, or hypothyroidism. It’s easy to say the physical exam wasn’t necessary when it all came out OK. It’s a different matter when a physical is re-coded as something else when it does not come out OK; hindsight is 20-20.
The Cochrane Review and the Archives of Internal Medicine may have shown a lack of evidence to support the annual physical, but it did not find evidence against the annual physical. Lack of evidence to support an intervention is not the same as evidence against an intervention. In the Archives review they estimated yearly exams accounted for 8% of all physician visits. Therefore, 92% of all physician visits were for other unexamined reasons. The cost of one routine visit per year for truly healthy, asymptomatic adults over the age of 18 is a drop in the bucket of the massive waste in our healthcare system. The potential damage to be done by discouraging patients from seeing their primary care doctors regularly could be catastrophic. Let’s move forward to focus on structuring the annual check-up so that it includes both clearly beneficial interventions and an opportunity to renew continuity and the therapeutic patient–doctor relationship.

exams to screen for pancreatic cancer and thyroid exams to screen for thyroid cancer are also not recommended (Bloomfield 2011).

There is little evidence to support or recommend against screening for oral cancer with routine mouth examinations, clinical breast exams to screen for breast cancer, whole-body skin cancer screening and eye exams to assess for visual impairments or glaucoma (Bloomfield 2011). These recommendations apply to healthy, asymptomatic adults. Persons who smoke or who have concerning lesions in any of these body areas no longer fall into the “screening” category.

Even with these recommendations, physician perceptions of patient expectations continue to steer what we examine and screen. In a survey of primary care providers, close to 90% of respondents reported performing annual physical examinations and 78% believed that patients expected annual exams. Despite the robust evidence to the contrary from several professional groups— including the USPSTF, the Canadian Task Force on Periodic Health, the American Medical Association and the American College of Physicians—74% of the surveyed physicians thought that an annual physical exam improved illness detection (Prochazka 2005).

A 2012 Cochrane review evaluated 14 clinical trials that studied the effects of the comprehensive physical exam on primary outcomes such as all-cause mortality and disease-specific mortality and secondary outcomes such as morbidity, new diagnoses, hospital admissions, disability, patient worry, self-reported health, specialist referrals, work absences and acute visits. The authors concluded that “general health checks did not reduce morbidity or mortality, neither overall nor for cardiovascular or cancer causes, although the number of new diagnoses was increased” (Krogsbøll 2012).

These authors go on to state, “One possible harm from health checks is the diagnosis and treatment of conditions that were not destined to cause symptoms or death. Their diagnosis will, therefore, be superfluous and carry the risk of unnecessary treatment” (Krogsbøll 2012).

Based on our review of current evidence, coupled with the recommendations of several expert task forces, we cannot endorse the continued practice and expectation of a periodic comprehensive physical exam in the healthy, asymptomatic adult. The patient-centered medical home is a model moving us to team-based, patient-centered care, in part due to the mismatch between recommended preventive services, necessary disease management, and an inadequate primary care work force. We should no more be providing “annual physicals” in healthy asymptomatic adults than we should be ordering “total body CT scans” for our worried patients, “just in case.”

Blood pressure and weight are the only evidence-based “physical exam” maneuvers, and these are typically performed by nurses or medical assistants. In re-designing our workflows, we could imagine a practice wherein a well-trained staff team could manage the recommended health screenings and tests with related follow-up under the guidance of a physician, with any concerning findings or patient concerns directed to the physician for office evaluation.

Exercising patients will continue to be a crucial role for the Family Physician of the future. We should use our highly honed skills in this realm to care for the many patients who have symptoms and conditions that need to be managed. We should develop expert teams of other staff who can perform the basic duties for routine health.
two, continued
care maintenance and save those “30 minute CPE” appointments for patients in our panels who need our expertise.

References

Vaccine Policy Update
By Philip Kaplan, MD

On February 20th the vaccine bureau of the NYS Department of Health (DOH) convened a phone conference with AAP and AFP which is intended to continue on a quarterly basis. Dr. John Epling, SUNY Upstate Medical University Chair of the Department of Family Medicine, and I represented NYSAFP. Such a conference provides an opportunity for DOH to reach our membership with guidance, and I hope this also provides a vehicle for us to advocate for our concerns.

The DOH agenda contained five items:

• There have been four recent cases of measles in NYS. All were related to travel. Three involved foreign travel, one domestic. The common theme appears to have been extended time in a sealed aluminum can with 300 strangers. We are reminded that travel constitutes potential exposure, that children as young as six months can be immunized if anticipating risk, but such children must be re-immunized after the first birthday. We are reminded that in adults a history of two doses of MMR trumps titres in determining immunity, though one of these cases had a history of two doses, not administered in the USA. One was an adult with religious exemption to immunization. Vigilance for measles risk is advised for your traveling patients.

• By publication time the school law regarding immunization for varicella, meningococcus and polio will have been adjusted to require conformity to Advisory Committee on Immunization Practices (ACIP) guidelines. These changes can be reviewed at http://www.health.ny.gov/prevention/immunization/schools/.

• By publication time vaccines for children (VFC) ordering must be done electronically through the New York State Immunization Information System (NYSIIS) inventory module.

• DOH has a grant to issue reminder/recall letters for patients age 12-15 who have not yet received HPV vaccine. This will result in patients approaching your practice for information or immunization.

• Parents will soon have direct access to NYSIIS data for their children.

AAP asked about proposed legislation that would expand immunization of children in pharmacies and in retail clinics. There is no regulation or standardization of manufacturers of vaccine refrigerators/freezers or thermometers. We have heard from our members frustrated with VFC. Restrictions on borrowing VFC stock for commercial patients, or commercial stock for VFC patients can result in missed opportunities for immunization. Offices near county borders experience complexity in providing VFC vaccines for their patients. To credibly advocate for our members regarding such problems, we need data.

Please respond to surveys from our Advocacy Commission. Your responses constitute data which can result in solutions. Please direct concerns about vaccine policy to vaccine@nysafp.org. Together our voice is louder.

1“Horton Hears a Who” Dr. Seuss, Random House

Philip Kaplan, MD, is the immediate Past President of the NYSAFP. Dr. Kaplan has been in a small group private practice for 40 years, and is Clinical Professor at SUNY Upstate Medical University in Syracuse, NY.
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t was New Year’s Eve and as expected the emergency room was filled mostly with intoxicated celebrators who tried to party like it was “1999.” What was unexpected were the two female patients, who, unbeknownst to them, shared a similar history of intimate partner violence (IPV).

The United States Preventative Services Task Force (USPSTF) estimates that more than a quarter of our population, about 31% of women and 26% of men, reported some form of IPV. This problem is not unique to the United States with the World Health Organization (WHO) estimating about one in three women throughout the world has been exposed to physical and/or sexual violence. Research has shown that current or past individuals who have had IPV have increased incidence of acute and chronic physical and mental health issues.

Perhaps this, in part, is what led the USPSTF in 2013 to revise their 2004 recommendations which did not advise routine screening. The current recommendation is to “screen (all) women of childbearing age for intimate partner violence, such as domestic violence, and refer women who screen positive to intervention services.” (Grade “B” recommendation.) However, it still had insufficient evidence “to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect.” (Grade “I” Statement.) The American College of Obstetricians and Gynecologists recommends that all women be screened for IPV. Recommendations for men who have experienced IPV is lacking as women are more likely than men to seek medical care. However, this may be changing soon as more data will likely be forthcoming.

This initial screening promotes primary prevention which is in contrast to the previous focus on secondary and even tertiary intervention. Secondary and tertiary intervention identifies patients already in relationships where IPV was occurring. The CDC, in agreement with the WHO Ecological model of violence, categorizes risk factors into four groups: individual, relationship, society, and community. Some individual risk factors include alcohol and drug use, childhood history of witnessing family violence or personal history of sexual or physical abuse. Poor family support, unemployment and societal norms that support sexual violence were listed as some of the other factors included in the relationship, society and community groups respectively.

Although there is no set interval for screening, some sources recommend asking at first patient visits in the office and even in the emergency room. Screening tools developed are limited by their
lack of reference standards. However, the USPSTF has recommended several tools with high levels of sensitivity and specificity be used for screening to include: HITS, Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT), STaT, HARK modified CTQSF, and WAST. HITS is a questionnaire that encompasses 4 main items, more simply summarized as Hurt, Insult, Threaten, Scream. STaT (Slapped, Threatened, and Throw) and HARK (Humiliation, Afraid, Rape, Kick) similarly have a limited number of questions. These tools can either be self-administered or directed by provider-patient interview. However, one article did note a higher percentage of reported abuse in patients who were assessed through provider interview versus self-assessment.3

Primary prevention, on the other hand, focuses on WHO identified “protective factors.” The protective factors are derived by accounting the risk factors of IPV and using this to understand the possible causes. These patterns are then used to create preventative measures. For example more highly educated women are 20-55% less likely to experience IPV according to WHO resources. This held true for men as well as they were found less likely to participate in IPV if they were more highly educated. Other factors included in the WHO report that were “protective” included: a safe and supportive environment as a child and a woman’s understanding of the risks of IPV. The WHO does place a disclaimer that more research is still needed in these areas and recommends that primary prevention be aimed at younger age groups.

Our role as physicians is to create a safe place where the patient can freely communicate. Questions are asked directly and non-judgmentally.

In a study at a community health center coordinated by the Suffolk County Coalition against Domestic Violence, some resident exam rooms were arranged with posters and literature about IPV, while other rooms did not have either the literature or the poster. In addition, residents in the test rooms wore buttons that bore the title on the posters, “Tell me, I’ll listen.” The residents did not specifically ask about IPV. Four patients in poster rooms (148 patient encounters) volunteered information. No patients in the non-poster rooms volunteered information (173 encounters).4

Hospitals and clinics have also employed strategically placed posters that include hotlines for seeking further help. Patients can obtain the needed resource without feeling the pressure of face-to-face dialogue and at the same time be comforted that a conversation can be started in their provider’s office.

Once a patient has been identified to be a risk for IPV, the SOS-DoC5 is used as a guideline for the next step:

“S—offer support and assess safety (this includes reassuring the patient about confidentiality, a reminder that violence is never acceptable and evaluation of potentially escalating violence such as weapons at home); O—discuss options (this includes giving the patient needed resources to shelters or police, development of a safety plan); S—validate the patient’s strengths; Do—document observations, assessment, and plans; C—offer continuity”.

The two women I had met in the emergency room that night also had some other similarities. They had recounted how their relationships began with no warning signs of the things to come. There were many instances of hope when their partners led them to believe that the violence would stop but it then continued for years. They were both also mothers. As I write this, I am humbled and shaken that I may have been the first physician they ever told. Did I tell them the right things?

I recall that as I was counseling these women, what helped me the most were the flyers I had seen in the bathroom about IPV. Reading the “call this number for…” pamphlet definitely helped me to guide the patient interview from reassurance to the dreaded next step. But I wonder, didn’t these women have physicians who might have noticed the scars on their arms, legs and torso? Were opportunities available as well when these mothers brought their children in for yearly physicals?

In the end, the mother of the infant who told me she was kicked in the stomach when she was pregnant decided to return home. The other woman, a mother of two, despite her husband’s family’s protest and denial of any violence, left to the safety of a friend’s house.

If a quarter of the men and women in our population have experienced some form of IPV, then perhaps one of the most important things we can do as family physicians is just to ask.

Endnotes
4 Poster presentation at New York State Academy of Family Practice (2003).

Additional web resources for physicians and patients:
The Center for Prevention of Abuse http://www.centerforpreventiononabuse.org/medical-resources.php
Suffolk County Coalition Against Domestic Violence http://www.sccadv.org/

Hang Fong Kitty Chan, MD is a family medicine resident at Stony Brook University Hospital in Stony Brook, New York. She graduated from New York College of Osteopathic Medicine and obtained her undergraduate degree at Stony Brook University.
The delivery of clinical preventive services is a core function of primary care and particularly family medicine. Understanding and remembering the guidelines and configuring our practices in order to deliver all indicated preventive services is challenging. Today’s practice environment makes preventive service delivery more challenging by increasing chronic disease measures on which we are measured and perhaps paid, and by a reimbursement model that is transitioning from volume-based to value-based care leaving primary care physicians caught in the middle. We must focus on the preventive services proven to be valuable to our patients and re-engineer our practices to deliver these services in the most efficient way possible. Much of the literature on delivery of preventive services has concentrated on screening programs and vaccinations – two easy-to-measure categories of preventive services. This article will focus on the two “other” categories: chemoprophylaxis (medications used for the primary prevention of disease) and behavioral risk factor counseling. These categories are less frequently discussed, but are no less important to the health of our patients, as evidenced by their ratings from the US Preventive Services Task Force (USPSTF). This task force, commissioned by the Agency for Health Research and Quality in the Department of Health and Human Services, is a board of independent clinicians and researchers from primary care, nutrition, nursing and mental health, that weighs the evidence and magnitude of benefit of clinical preventive services delivered in primary care. This task force has been an objective arbiter of what works in primary care prevention, and has recently gained additional leverage as the body that determines first-dollar insurance coverage of billable preventive services as mandated by the Patient Protection and Affordable Care Act.

The USPSTF’s recommendations are created using a standard, methodologically rigorous process. Full details of this process can be found at http://www.uspreventiveservicestaskforce.org/methods.htm, but it is essential to know that the Task Force weighs two elements: the “certainty of net benefit” (the strength of the research evidence behind the proposed preventive service) and the “magnitude of net benefit.” This last element is important because it recognizes that there can be real harm from preventive services: from unnecessary anxiety with a false-positive screening test, to unnecessary biopsies and other invasive procedures to follow up on positive screening, to the harm and side effects of the therapies for the diseases discovered. Each of these potential harms must be weighed against the overall benefit from the service to ensure that we are actually doing good for our patients by offering the service. The letter “grade” for the preventive service comes from the balance between these elements, as illustrated in Table 1. This article will discuss preventive services that are generally recommended (A and B recommendations), as well as services that are recommended against (D recommendations). The USPSTF has two other grading levels, C recommendations (where the benefit/harm ratio is too close to call) and I statements (where there is insufficient evidence to make a recommendation). While there are many services that are graded with these levels, only the services with strong recommendations will be covered in this article.

### Table 1. USPSTF Grading of Preventive Services Recommendations

<table>
<thead>
<tr>
<th>Certainty of Net Benefit</th>
<th>Magnitude of Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Substantial</td>
</tr>
<tr>
<td>High</td>
<td>A</td>
</tr>
<tr>
<td>Moderate</td>
<td>B</td>
</tr>
<tr>
<td>Low</td>
<td>Insufficient</td>
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</tbody>
</table>

### Chemoprophylaxis Recommendations

Chemoprophylaxis is the prescription of medications, supplements, or vitamins to accomplish the primary prevention of disease – to prevent disease from even starting in the body. The list of recommended chemoprophylactic agents is in Table 2, with their grade of recommendation. Aspirin prophylaxis has been recommended to prevent vascular disease in the past, but the USPSTF has updated and clarified the recommendation to make it easier to weigh the known risks of gastrointestinal and intracranial bleeding against the value of aspirin in preventing heart attacks and strokes. The evidence review showed the effective dose of aspirin...
was between 75 and 100 mg daily – most low-dose aspirin in the US is 81 mg (“baby” aspirin). As for the target population for this recommendation, the USPSTF relied heavily on two recent studies on primary prevention. These studies showed that the benefit vs. harm calculation was favorable for men aged 45 years and older in preventing heart attacks. For women, however, the benefit/harm ratio was only favorable for women aged 55 years and older to prevent strokes – heart attack rates were not improved for women in the studies reviewed. In weighing cardiovascular benefit vs. risk of gastrointestinal bleeding, the USPSTF recommends assessing 10 year cardiovascular (CV) risk via the Framingham Heart Study risk equations (http://cvdrisk.nhlbi.nih.gov/calculator.asp), and using that to assess risk of bleeding given age (see table at reference). Patients with a history of chronic heavy non-steroidal anti-inflammatory drug use or a history of peptic ulcer disease are likely at too high a risk of bleeding to achieve an overall benefit from aspirin.

Vitamin D screening and supplementation has been a source of controversy for several years. The Institute of Medicine has advised universal supplementation for adults as an alternative to routine screening and treating, but the only high-level evidence found by the USPSTF is that for preventing fall-related injury in the elderly. There is good quality evidence that a combination of either an exercise regimen or physical therapy combined with vitamin D supplementation at a dose of 600 IU (65-74 years) or 800 IU (age 75 and older) daily can prevent falls and fall-related injury in high-risk elderly patients. High-risk for falls is defined as a history of falls, a known gait disturbance, or a positive screening on a screening test for fall risk.

Folic acid has been a consistent recommendation to prevent neural tube defects (anecephaly and spina bifida) for years, but is used only about 40% of the time by women capable of childbearing. The USPSTF recommends 400 mcg daily in all women capable of childbearing – regardless of the intention to get pregnant, since half of all pregnancies in the United States are unplanned. For women who have experienced neural tube defects in previous pregnancies, a dose of 4 mg daily is recommended.

Assessment of fluoride intake is important for dental health in children older than 6 months and supplementation is advised for children who are solely breastfeeding or who use a water source that is not sufficiently fluoridated. The CDC maintains a database of public water supplies and their fluoridation levels (for New York: http://apps.nccd.cdc.gov/MWF/CountyDataV.asp?State=NY) and the dosage table for fluoride supplementation is available at the American Dental Association’s web site. Careful attention to dosing is required to avoid dental fluorosis – staining of the teeth due to excessive fluoride intake – and other complications.

Finally, breast cancer risk assessment is recommended for women who have 1 or more first-degree relatives with breast cancer. The Gail model (http://www.cancer.gov/bcrisktool/) is used to assess this risk, and in women with a 5-year risk of greater than 3% benefit from preventive medications. Tamoxifen 20 mg per day or raloxifene 60 mg daily for 5 years, have been shown to decrease the risk of developing breast cancer, with an acceptable risk of side effects. These side effects are not trivial. Venous thromboembolism, uterine cancer and development of cataracts are some of the more serious effects of these medications that should be discussed with women who are interested in this preventive therapy.
Behavioral Risk Factor Counseling

An important priority in family medicine is knowing our patients’ social histories and behavioral risk factors over their lives and engaging in relationship-centered discussions with them to improve their health. The recommendations presented in Table 3 should not be viewed as the only ways to effect behavioral change in our patients, but instead as guidelines to help us focus our efforts in evidence-based ways. The best evidence is available for alcohol use, tobacco use, risky sexual behavior in adolescents and obesity. There are important commonalities and differences in the approach to this counseling. For all behavioral risk factors, counseling should be personalized to the patient’s attitudes toward changing and should involve helping the patient find their own motivation and strategies that will help them quit. In addition, the importance of this screening and counseling should be made obvious to the patient by in-person screening by the clinician, as well as intentional office-based or telephone follow up during the active change process. The degree and setting of the counseling for these behaviors varies. For at-risk drinking (defined as greater than 2 drinks/day on average for men and 1 drink/day for women or greater than 4-5 drinks in one setting for men and greater than 3 for women8), brief and repeated counseling from the physician seems effective.9 For obesity in children and adults, more intensive counseling is necessary, involving nutritionists or other health coaches. The most resource intensive counseling involves sexually transmitted disease risk in adolescents, where the proven intervention requires group counseling – ostensibly due to both peer support and cultural factors. The studies on tobacco cessation counseling – for adults, pregnant women and children – have developed a useful framework for any counseling regarding preventive services: the Five-A’s approach. This approach (Table 410) is developed from behavior change models such as the transtheoretical model of change11 and motivational interviewing12 and highlights the important steps physicians can take to help our patients achieve the health-related change they desire.

Table 3. Behavioral Risk Factor Services18

<table>
<thead>
<tr>
<th>Behavioral Risk Factor</th>
<th>Target Population</th>
<th>Recommendation</th>
<th>Grade</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk alcohol use</td>
<td>Adults</td>
<td>Alcohol screening and brief intervention</td>
<td>B</td>
<td>2013</td>
</tr>
<tr>
<td>Obesity</td>
<td>Adults and children</td>
<td>Intensive diet and physical activity counseling for obese adults and children</td>
<td>B</td>
<td>2010-2</td>
</tr>
<tr>
<td>Risky sexual behavior</td>
<td>Adolescents at risk of sexually transmitted infections</td>
<td>Sexually transmitted infection counseling for adolescents and young adults at high risk</td>
<td>B</td>
<td>2008</td>
</tr>
<tr>
<td>Tobacco Smoking</td>
<td>Adolescents and adults</td>
<td>Tobacco cessation counseling</td>
<td>A (adults), B (children)</td>
<td>2009 (adults), 2013 (children)</td>
</tr>
<tr>
<td>Tobacco Smoking in pregnancy</td>
<td>Pregnant women</td>
<td>Tobacco cessation counseling in pregnancy</td>
<td>A</td>
<td>2009</td>
</tr>
</tbody>
</table>

Additional Recommendations

Screening for intimate partner violence and sexual violence among women of childbearing age is a relatively new recommendation from 2013 (B recommendation). Several screening approaches can be used: the HITS questions (Has anyone Hurt, Insulted, Threatened or Screamed at you?), the HARK questions (Humiliation, Afraid, Rape, Kick), and the STaT questions (Scream, Threaten and Throw) are among the several useful quick screening inventories that can be used. Once identified, patients should be referred to local agencies with resources for counseling and advocacy for victims of intimate partner violence.13 The physician should not recommend marriage or couples’ counseling or discuss the disclosure with the victim’s partner at any time, as this can increase the risk for injury and death for the victim.

For adolescents (age 13 years and older) and adults, screening for depression has been found to decrease depression-related morbidity (B recommendation, 2009).14,15 However, these recommendations...
Table 4. The Five A’s of behavior change.10
1) Ask about tobacco use;
2) Advise to quit through clear personalized messages;
3) Assess willingness to quit;
4) Assist to quit; and
5) Arrange follow-up and support.

are conditioned upon the presence of a system in the practice to ensure that identified patients are tracked to ensure follow up and/or appropriate referral. In the research supporting these recommendations, this has usually meant a care management system using nurses or other office staff that can ensure compliance with medications and counseling visits, periodic monitoring of their status and timely follow-up. The use of primary care friendly instruments for the diagnosis and tracking of depression treatment, such as the nine-item Patient Health Questionnaire (PHQ-9) and others is recommended to ensure patients are adequately screened and treated for depression.16

Implementation

Implementing these recommendations in a systematic way requires creativity and system thinking in any size family practice. For the screening questions, using electronic health record documentation templates can help ensure that these questions get asked during the important health maintenance visits. In addition, the judicious use of health risk appraisals and other written questionnaires can be used to accomplish this screening. Careful attention must be paid, however, to reviewing these questionnaires with the patient in a confidential setting so that disclosures are not missed. For age or diagnosis-related chemoprophylaxis, electronic health record reminders and a system of audit and feedback (random chart review, etc.) can be used to ensure that these recommendations are applied consistently. Nurses and other office staff that are appropriately trained can help with screening for the behavioral risk factors, and can alert the physician to the need for counseling or referral. Finally, engaging patients in their own preventive care, through educational materials, office/exam room posters and mailed (or emailed) reminders, can help ensure that these important discussions are had between family physicians and their patients.

Conclusion

The scope of preventive services with strong evidence behind them is manageable and with some forethought and cooperation in our family medicine practices and medical homes, can be accomplished for the benefit of our patients. All family physicians should familiarize themselves with the recommendations and resources from the US Preventive Services Task Force and implement these recommendations as a routine part of good patient-centered primary care.

Endnotes

16 O’Connor EA, Whitlock EP, Gaynes B et al. Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review [Internet]. (Evidence Syntheses, No. 75.) 3. Results. 2009.

John Epling, MD, MSED, FAAFP, is Associate Professor and Chair of Family Medicine at SUNY Upstate Medical University in Syracuse, NY. He teaches family medicine, population health, clinical prevention and evidence-based medicine at the University, and co-directs SALT-Net - the Studying, Acting, Learning and Teaching Network - a practice-based research network in the Department of Family Medicine.
CME POST-TEST

Instructions:
Health care professionals seeking AAFP credits will receive 1 credit for the year in which the quiz is taken upon the completion of this quiz online at www.nysafp.org under the Education and Events tab. Health care professionals seeking Category 1 AMA credits are eligible to receive 1 credit in Category 1 of the Physician’s Recognition Award of the AMA.

NYSAFP staff will notify those who take the quiz of their scores.

Physicians are responsible for reporting their own CME credits to their respective organizations.

1) The US Preventive Services Task Force develops their recommendations from weighing:
   a) Cost and expert opinion
   b) Research evidence and benefit/harm ratios
   c) Tradition and availability of diagnostic tests
   d) Benefit to physician's practice bottom line

2) Aspirin is recommended for prevention of cardiovascular disease:
   a) In doses over 325 mg per day
   b) Only in patients over age 65
   c) If the cardiovascular risk outweighs the risk of GI bleeding
   d) If the risk of GI bleeding is from the lower GI tract only

3) Vitamin D supplementation is recommended in the elderly:
   a) At high risk of falling and in combination with exercise or PT
   b) After a screening test shows deficiency
   c) At high doses – 50,000 units per week for 8 weeks.
   d) Only in intravenous form

4) Which of the following is NOT one of the Five-As of behavior change counseling:
   a) Advise – firm advice from the physician about the need to change a behavior
   b) Assess – finding out whether the patient is interested in change
   c) Arrange – following up on a behavior change demonstrates its importance
   d) Adjust – if the patient is not willing to change, do not discuss the change again.

5) Screening for depression is recommended:
   a) When there is a practice system in place to monitor treatment
   b) Only when there is a high prevalence of depression in the area
   c) For psychiatry practices only, given their experience in treating it
   d) Once during adolescence and once during pregnancy only

To complete the test, please go to: www.nysafp.org > Publications > Journal and select the current edition 'Post Test'.
We have all seen the statistics from the CDC that more than 1/3 of adults and 17% of children and adolescents are obese, and that more than 2/3 of American adults are overweight or obese. In 2010 the CDC reported that less than 50% of adults met physical activity guidelines for aerobic activity and less than 25% met physical activity guidelines for muscle strengthening.2,3

As providers of primary care medicine we are familiar with the daily struggles of combating the profound side effects of obesity and lack of exercise, including heart disease, diabetes mellitus, hypertension, physical disabilities and the association of obesity with cancers of the colon, breast, prostate, uterus and other organ systems.1,2,3 Many overweight and obese patients come to us with a sincere desire to lose weight. We encourage them, may make suggestions for weight loss, and also advise them to exercise. Some patients lose weight, but most regain weight over time and find that exercise gets lost behind the other demands in their lives. In this common circumstance, what practical approach to weight gain can we use that does not require large resources in time and training and how can we promote exercising consistently, when the demands of work and family are so great?

The suggestions that follow evolved from a program I developed called On Track for Life which I have been using in my practice and which deserves to be explored within the larger primary care community. A more comprehensive look at this program is on the On Track for Life website at www.OnTrack-ForLife.com. (Please note the dash in the website title!)

Focus on Weight Maintenance Rather than Weight Loss

A number of studies have demonstrated that daily weights in the morning before breakfast are an effective way to promote weight maintenance.4,5,6,7 This technique can be easily adapted in medical practice and has the potential to have very meaningful health benefits.

Due to the medical risks associated with obesity, there has been an understandable focus on weight loss. There are many methods to lose weight and an enormous commercial industry has grown up around it, some of questionable value. However, I believe that the continued focus on weight loss has resulted in many failed opportunities to reduce the risks associated with additional weight gain.

The CDC has provided detailed color-coded images of the markedly increased numbers of obese Americans in every state over a period of 30 years (http://www.cdc.gov/obesity/data/adult.html scroll to bottom of page). These images also reflect the millions of Americans who continued to gain weight over time, moving them from normal to overweight and obese BMI levels. For the sake of discussion, the illustration in Figure 1 is a hypothetical example of weight gain in an American adult between the ages of 25 and 65.

Though not the usual solution that comes to mind, a focus on weight maintenance can be a more practical approach in primary care. In practice I use what I call the 1 Pound Method with my patients who are overweight or obese. The patient’s goal is to prevent gaining 1 extra pound. Patients find this appealing because it is a simple concept and do-able. I encourage weight loss when
they are ready. In the meantime, there is no downside to stopping additional weight gain.

I emphasize that *daily* weights in the morning before breakfast have an advantage over weighing less frequently because we are more likely to remember the details of our dietary behaviors from the prior day or two. I also find that many patients with negative feelings about using a scale see the value of not gaining even one more pound until and unless our dietary behaviors from the prior day or two. I also find that many patients with negative feelings about using a scale see the value of not gaining even one more pound until and unless they are on an effective diet plan. This method makes good use of the inverse relationship between motivation and the perceived difficulty of a task (Figure 2).

**Figure 2**

I provide patients with written instructions which review the most common reasons for normal variation in the morning weight. We also discuss slowed metabolism, lack of activity, hypothyroidism, the effects of increasing age and the use of certain drugs, to explain how weight tends to increase. The use of this method should also be kept in mind as a means to prevent cycles of weight gain which become increasingly difficult to reverse and begin in circumstances such as:

- The college freshman 15-25 lbs
- Finding a steady boyfriend or girlfriend.
- Marriage
- Pregnancy
- Beginning to drive to work
- Menopause
- Aging
- A desk job
- Frequently eating fast foods
- The holidays
- Vacations and cruises
- High carb diets
- Injury to a lower extremity
- Periods of confinement to a wheelchair or bed

- Eating frequently at restaurants
- Overuse of vending machines

**Promote Consistent Exercise as Part of a Daily Routine Rather than Leaving it to Chance**

“But doctor, I don’t have time to go to the gym!” We hear this statement frequently and we certainly understand it. As medical providers, these concerns affect our lives too!

In 2007 The American College of Sports Medicine (ACSM) and the American Heart Association published “Physical Activity and Public Health: Updated Recommendations for Adults” in the journal *Circulation*, which updated the 1995 recommendations made by the ACSM and the Center for Disease Control. The primary recommendation is as follows:

“To promote and maintain health, all healthy adults ages 18 to 65 yr need moderate intensity aerobic (endurance) physical activity for a minimum of 30 minutes on five days each week or vigorous intensity aerobic physical activity for a minimum of 20 minutes on three days a week.” Recommendations have also been made for maintaining muscle strength, such as progressive weight training, weight bearing and calisthenics. In addition, a companion recommendation applies to adults 65 and over and adults aged 50-64 with chronic conditions or physical limitations that affect movement ability or physical fitness. Recommendations for school age children are also available.

How can we accomplish these worthy goals? For many of us an image of working out in a gym comes to mind when thinking about exercise. Gyms are an excellent solution, but they are not a practical solution for many people. Depending on individual circumstances, gyms can be too expensive, have limited hours, may require additional travel time, time to change clothing and frequently do not provide child care.

Similarly, many experts recommend physical activities that we currently enjoy, such as participating in a favorite sport, walking, playing or working out with others. Of course, no one disagrees with these recommendations, but can these methods be relied upon to achieve consistent exercise throughout the year? Consistency in exercise is the key to success, and consistency in the performance of many activities is subject to bad weather, finding others interested, the expense of memberships, equipment, uniforms or other fees, available space, available supervision, convenient hours, and is especially subject to additional work and family responsibilities. The circumstantial barriers surrounding many activities affect their value as a means to accomplish exercise consistently, and unfortunately when a barrier cannot be overcome, the activity ends.

In contrast, exercise as part of our daily routine, in and around our homes, reduces the number of barriers to achieve the 30 minutes of exercise recommended by the ACSM, AHA and the CDC. Exercise, especially when part of a morning routine has the advantage of getting it done, before the demands of the day defeat our attempts.

There certainly are families and individuals who are extraordinarily stressed for time and even 30 minutes seems like a mountain they cannot climb. However, with focus and patience it is possible for many more of us to find 30 minutes to devote to this purpose. We prioritize things that we perceive as pleasurable, or related to our own and our family’s survival. Physical activity is not always experienced as pleasurable, or as one of our major responsibilities. It is often perceived as boring, and there is never enough time for anything boring. But exercise at home can be enjoyable when it is infused with variety, music, creativity and the thrill of improvement. The kinds of activities that can be done in and around our own homes include calisthenics, aerobics, yoga, dancing, floor and wall Pilates, Tai Chi, jogging, walking and
much more. I recommend use of the body without equipment, because like the Wii, the novelty of equipment wears off and ultimately dampens our commitment. Most adults and older teens will have no difficulty adapting to an appropriately designed, progressive exercise program. Patients with significant cervical, lumbar, knee and other joint or other medical concerns should have access to qualified physical therapists and other medical professionals for appropriate guidance. Programs for younger children should be developed with attention to their special psychological and physical needs.

A well designed national program promoting routine exercise in and around our homes has the potential to improve the declining health of adults and children and deserves further exploration as a way of living within our society. Research within the primary care community would be especially valuable.

With the continued expansion of technology, the demands of work, and the gradually decreasing requirement to use our bodies for almost any purpose, weight management and physical activity are no longer options in the 21st Century. Simple and convenient solutions are needed. Just like a bathroom scale for weight management, the solutions for consistent physical activity are right in front of us, but are made invisible by our previously conceived notions of what can be done.

Examples of a home based exercise program, tips increasing motivation, how to make exercise routine and tips for nutrition and weight loss can also be found on the OnTrack-ForLife.com website. Please feel free to email me with your comments at espositovm@gmail.com.

HOW TO STOP WEIGHT GAIN

1. If you are overweight or obese, it is important to focus on maintaining your weight. The natural tendency for almost everyone is to gradually put on more weight even if you have been planning to go on a diet. If you think back months or years, having started to maintain your weight at that time would have avoided the extra weight you have gained.

2. The key to stopping weight gain is to focus on not gaining 1 pound. It’s a lot easier to lose 1 or 2 pounds than to lose 5, 10, 15 or 20!

3. Since we can’t measure just one pound, we need to use a scale to help us out.

4. Weigh yourself only in the morning, after using the bathroom, before eating breakfast and before putting your clothes on.

5. Your weight will change every morning. This is normal and is due to the following:
   a. What did you eat the night before? How much did you eat and what time did you eat?
      For example, if you ate very late, your weight will be higher in the morning because you haven’t burned it off. If you ate a small meal, your weight will tend to be lower in the morning.
   b. What is your state of hydration?
      Have you become dehydrated from exercising, not drinking enough fluids, or being in a hot climate?
   c. If you are in the middle of a menstrual cycle, have you added a few pounds of water weight?
   d. Is your metabolism slowing down due to a lack of physical activity, aging, or a metabolic condition? Ask your doctor if you are concerned about that. You may have a slow thyroid, other metabolic condition, or this may be due to a side effect of a medication.
   e. Have your bowel movements been regular, or have they slowed?

6. If you see your weight moving up 1 or 2 pounds and staying up for 2 days or more, you may be on the road to weight gain.

7. If that happens, work to return to your original weight by losing that additional pound or two.

8. When you are ready, find a good diet and stick to it. After you reach a weight you are more comfortable with, start back on this method to maintain that weight.
Endnotes

Vincent Esposito, MD. is a family physician who graduated in 1978 from the Residency Program in Social Medicine at Montefiore Medical Center in the Bronx. He is currently working in his family practice in Manhattan and employed by the St. Lukes-Roosevelt division of the Mount Sinai Health System. He is interested in developing lifestyle based models for the Medical Home of the future. Please send any inquiries to espositovm@aol.com

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Is Diabetes Preventable? The Role of the Adult Health Assessment in Beating the Community Epidemic

By Robert Morrow, MD

Diabetes can be prevented. We can help.

Those are two messages that we can carry into our health assessments of adults. Conceptually, they fit together with the idea that smoking can be prevented, and that we can help.

But do we have the time for this kind of assessment and intervention in our busy practices?

The connection between obesity, exercise and diabetes is well established, and prediabetes is the first warning of its onset. Similar to diabetes, prediabetes risk increases with weight (30% among obese New Yorkers versus 20% among those with normal weight), and is itself a diabetes risk factor. The risk of both is lessened through a healthy diet and regular physical activity. (NYC Vital Signs, NYSDOH 2009). People with prediabetes can usually delay or prevent diabetes by eating a healthy diet, getting regular physical activity, and maintaining a healthy weight.

The CDC National Diabetes Prevention Program (NDPP) focuses on making modest behavior changes to help participants lose 5% to 7% of their body weight—that is 10 to 14 pounds for a 200-pound person. Studies have shown that people with prediabetes who lose a modest amount of weight and increase their physical activity to 150 minutes a week can prevent or delay the onset of Type II diabetes (CDC 2012) and that for every 5% reduction in dietary fat intake, incident diabetes was reduced by 25% (Davis et al, 2013). The CDC study also demonstrates that people assigned to the DPP intensive lifestyle intervention can achieve and sustain dietary change over a decade of follow-up, and that dietary changes made during the higher intensity initial phases of the intervention contribute to greater long-term sustainability.

The challenge is now one of translation into real world settings with high-risk populations. Despite its well-accepted validity, for many reasons, including lack of personnel, space, and a systematic focus on prevention, the NDPP has not been widely implemented. Its outstanding promise for low-income populations overwhelmed by the diabetes epidemic still remains unfulfilled.

Which all brings us back to the question: How do we as busy family docs prevent diabetes? Do we become diabetes educators? Do we learn to be official LifeStyle Coaches ourselves, or appoint a member of our staff to do so, and hope payments for group visits will cover the costs of prevention? Or do we hook up with other practices in our region to sponsor classes, 12 in a year? Not bad ideas, any of these, but I know that I don’t have that much free time, and doubt that insurers have that much money to invest in prevention. So what are good strategies that really will work?

The answer, as in many things, lies in community collaborations. Many of you have already heard of the role of YMCAs, which have been recruited by the CDC and by the NYSDOH and the NYS Health Foundation, to teach the NDPP. Several other community groups have been funded to build infrastructure to deliver the NDPP. This work includes training LifeStyle Coaches, who are interested people, many with diabetes or prediabetes, who are rooted in their communities and have access to their peers. What they don’t have, or at least they are not required to have, is an advanced degree or healthcare license. They are true peer educators who have accrued a track record of success in the projects which have followed the original DPP studies.

In order to extend the reach of the NDPP, we are recruiting, training and supporting coaches in our most vulnerable communities. Different groups of people appear to be attracted to different settings, such as religious institutions, or even community rooms where they live – in other words, to places where they feel comfortable.

For example, in Harlem, a coalition of community and academic leaders tested the effectiveness of a peer-led weight loss course called Project HEAL: Healthy Eating, Active Lifestyles (Goldflinger et al., 2008) involved extensive collaboration with community members and experts in nutrition, exercise, and peer education. The course was piloted in a local church and its impact assessed through pre and post course weights, self-reported behaviors and quality of life. Participants lost a mean of 4.4 pounds at 10 weeks, 8.4 pounds at 22 weeks, and 9.8 pounds at 1 year. Participants reported decreased fat consumption and sedentary hours, and improved health-related quality of life. Achieving initial success in reducing fat and energy intake to achieve weight loss and long-term success in maintaining physical activity goals appear to predict long-term diet-related success. These lifestyle changes reduced the risk of developing Type II diabetes by 59% in people with prediabetes and by 71% for those 60 and older (DPRG, 2002).

Implementation as a Science

Designing this type of program and proving it works is tough. Implementing it is much tougher, and requires collaborative work between health services [us], community peer leaders, and public health officials, who need to certify trainers and advocate for incentives for participation. Although
this usually ends up costing about $250-300 per participant, and about the same for the staff, the cost in NY of a person with diabetes on Medicaid is approximately $20,000 annually. And yet the CDC-organized NDPP has languished since first publications appeared in 2002. Many studies have supported the original findings, as discussed above. The NDPP is designed, produced, authenticated, and quality-controlled. So what has prevented prevention? Our NYSAFP-led research team aims to find out, but that’s a story for another day.

If we had a pill that prevented more than half of diabetes, and it cost less than a dollar daily, would we offer it? And what should we do as family physicians, overwhelmed as we are with low payments and large practices?

One clear answer is to support our patients’ and communities’ participation in these programs. We don’t need to invent anything, and we don’t need to change our practices to accommodate the NDPP sessions, although it would be reasonable for practices to share coaches to teach the NDPP. We can participate in a cultural shift to evidence-based prevention, and truly change the lives of our patients and communities.

Break for controversy: Should we place our trust in community peer Lifestyle Coaches, who have no degree or license, but only their experiences and the training provided through the CDC certified centers [in NY State this is the QTAC at the University at Albany]? Rather, should we rely on Certified Diabetes Educators?

References


Who qualifies for the NDPP intervention?

Participant Eligibility

Recognized organizations will enroll participants according to the following requirements:

1. All program participants must be 18 years of age or older and have a body mass index (BMI) of ≥24 kg/m2 (≥22 kg/m2, if Asian).

2. A minimum of 50% of a program’s participants must have had a recent (within the past year) documented, blood-based diagnostic test indicating they have prediabetes, or a history of gestational diabetes mellitus (GDM), according to one of the following specifications:

   a. Fasting plasma glucose of 100 to 125 mg/dl

   b. Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl

   c. A1c of 5.7 to 6.4

   d. Clinically diagnosed GDM during a previous pregnancy (may be self-reported)

3. A maximum of 50% of a program’s participants may be considered eligible without a blood-based test or history of GDM only if they screen positive for prediabetes based on the CDC Prediabetes Screening Test, which was validated for prediabetes using 2007-2008 National Health and Nutrition Examination Survey data.

A health care professional may refer potential participants to the program, but a referral is not required.

www.cdc.gov/diabetes/prevention/eligibility

This address has the CDC standards and operating procedures for the program.

The authors can help you connect with programs around NY State, and if you have an interest, you can contact us to participate in research projects around the implementation of the NDPP. Implementation Science is a technique which permits realistic experiments by those of us in the community to collaboratively design and test strategies to improve the health of the public.
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