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Spring 2017

# Family Doctor

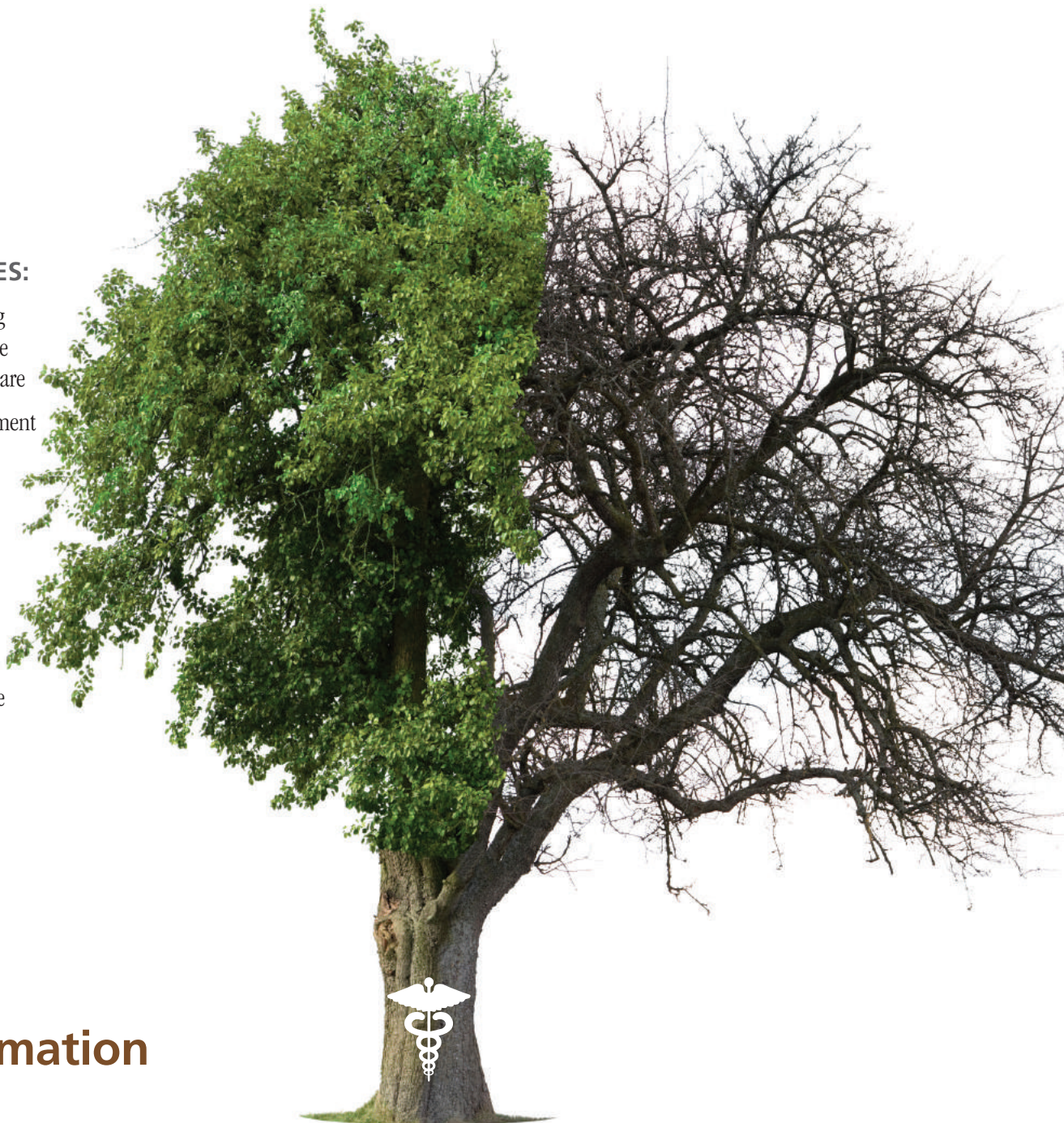
A JOURNAL OF THE NEW YORK STATE ACADEMY  
OF FAMILY PHYSICIANS



## FEATURE ARTICLES:

- Choosing Wisely: Using Evidence to Bring Value and Quality to Healthcare
- Chronic Care Management Billing for the Family Medicine Physician
- Individual Care to Population Health: Experiencing a Paradigm Shift
- Meaningful Use, the Patient-Centered Home and Other Oxymorons

*Focus:*  
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1 United States Department of Agriculture Food and Nutrition Service: School Breakfast Program. <http://www.fns.usda.gov/cnd/breakfast/>. Accessed 9/17/10.z

2 Gleason et al. School Breakfast Program but Not School Lunch Program Participation Is Associated with Lower Body Mass Index. J Am Diet Assoc. 2009;109:S118-28.

3 Hunger Solutions New York. Academics & Breakfast Connection Pilot: Final Report on New York's Classroom Breakfast Project.

<http://hungersolutionsny.org/documents/FinalABCupdated.pdf> <<http://hungersolutionsny.org/documents/FinalABCupdated.pdf>>. Accessed 1/3/2012.



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## From the Executive Vice President

By Vito Grasso, MPA, CAE

### ACA Under Attack

**I**f you are tired of reading or hearing about efforts to repeal and replace the ACA, then you are certainly not alone. The misery you share with so many others is unlikely to be relieved soon. The subject is too complex and the divisions too deep.

The policy discussion about reforming health care began more than two decades ago. Consideration about how to contain costs, encourage and accommodate innovation and assure that people have access to health care has become overshadowed by the partisan debate over how to preserve the insurance model of paying for health care. I believe this occurred because we have never addressed the fundamental question of whether health care is or should be a basic human right. The focus on how we pay for health care distorts the otherwise straightforward question of whether each of us, as members of society, should be entitled to have the health care we need when we need it and under circumstances that do not depend upon our personal socio-economic status.

The essential policy issue which led to discussion about how to reform our health care system, was what to do about the uninsured. Some were depicted as free riders who could afford health insurance but chose not to purchase it. Others were precluded from purchasing private coverage for various socio-economic reasons. Many in this latter category were ultimately found to be eligible for Medicaid.

The ACA, however, was conceived as a vehicle for expanding access to health insurance, not as a means of paying for health care received by the uninsured. Offering a complex combination of mandates, taxes, incentives, penalties and defined benefits, the ACA was supported exclusively by democrats in Congress and opposed entirely by republicans. It was more of a partisan manifesto than a product of deliberation, discussion and compromise. In this regard it was doomed to fail because the political pendulum forever swings back and forth and it was just a matter of time before republicans would gain power and would use that power to reverse it.

Republicans are committing the same error that their democratic predecessors did. They will attempt to use their majorities in the House and Senate to push through another program to undo the ACA; not to address the issue of how to pay for care received by the uninsured.

Since we are apparently not ready to tackle the big question regarding what the foundation for health care policy should be, we are left with the task of addressing gaps in the insurance model which we seem stuck with. Paying for care received by the uninsured could be addressed without the wholesale systemic changes that were included in ACA. We could simply assess the cost of services actually received by uninsured patients uniformly among all carriers, both public and private, through rotating assignment of the bill for services received to carriers in the state where care was provided. The Medicaid fee schedule could be used which would contain costs

and establish consistency. For those who may be concerned about uninsured people getting a free ride, providers could also be able to bill the uninsured patients for the difference between what they were paid and what they would reasonably charge and use all legal collection options to obtain payment.

Is health care a right or a privilege? The question is not whether we are “entitled” to health care, but rather, if we are obliged to help others deal with illness or injury. We certainly see a moral duty for providers to care for people in need. Why, then, is it not a public duty to pay for that care? Society, acting through the instrument of government, provides an array of essential services which are beyond the capacity of people to afford on their own. We do this because it is good for everyone. The high cost of health care can devastate a family. Medical debt is the leading cause of personal bankruptcy in the US. It is apparent that the cost of health care can easily exceed the ability to pay and that it is a public duty to share that cost and to build public policy upon that premise.

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*...as members of society,  
should be entitled to have  
the health care we need  
when we need it and under  
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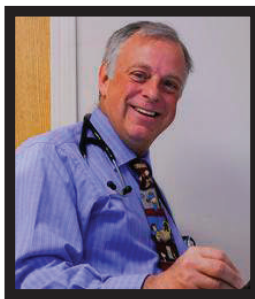
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## President's Post

By Robert Ostrander, MD, FAAFP

### What about the Family and Patient?

It seems like every conference I attend and every journal I pick up devotes a lot of attention to the plight of the physician today—from the obstacles the payment and regulatory system puts in our way to career ending “burnout.” We do not talk enough about the family and patient experience. For me the simple definition of the “Triple Aim” that works the best is **Improved Care Experience-Improved Population Health-Lower Costs**. Yet, maybe because it is hard to measure (most important things are), the Care Experience is ignored by those driving this bus.

My practice team was lucky enough through my work in the Academy to be one of 45 practices nationwide to participate in a 2 year project trying to improve the Medical Home for Children and Youth with Special Health Care Needs (CYSHCN), sponsored by the National Institute for Children's Health Quality in 2002-2004. Each practice team comprised a physician “champion,” a staff member who did care coordination, and a parent partner. It is hard to imagine seeking solutions from patients, doctors and office staff, but they did! At that time the “Family and Patient Centered Medical Home” was a construct devised by the AAP to improve care for CYSHCN, and the focus was heavily on family input and feedback, **personalized care plans**, a sense of security about acute situations, and care coordination. We tracked progress with the validated Medical Home Index ([https://medicalhomeinfo.aap.org/tools-resources/Documents/CMHI-MHI-Pediatric\\_Full-Version.pdf](https://medicalhomeinfo.aap.org/tools-resources/Documents/CMHI-MHI-Pediatric_Full-Version.pdf)). It contains not a single disease based metric. As we all know, since then the medical home concept has been co-opted into a Payer Centered Medical Home, focused on dollars, disease based protocol driven care plans,

dollars, population metrics, and of course dollars. The Care Experience component which had been the centerpiece has been left to wither. (Press Ganey does not impress me as a driver for better care.)

I have been asking questions of patients, family members and friends about what is important to them and what is frustrating, especially when things are complicated and chronic, when seeing their physician themselves or with families. I continue to be involved with CYSHCN though some work nationally with the heritable disease community and we continue to include parents as partners when we discuss policy. These are the things I hear in answer to “What is important to you?”

1. **Take my input into account.** I think the premise that the patient is right until proven otherwise is a good one, especially when it comes to chronic conditions.
2. **Be prepared for my visit.** Take some time to review my chart and what we talked about last time before you come in to see me.
3. **I want time with the physician.** I hear that physicians don't take time to expand on the history information taken by staff and leave discussing the details of the plan to staff, before the patient has a chance to ask questions and have a discussion.
4. **Pay attention to me, not your computer lists.**
5. **Do a good exam.** I had a friend tell me they went to the doctor with a foot and ankle problem, and the doctor looked at the foot, touched it and said, “I can't find anything specific; we'll get an x-ray and have you see orthopedics.
6. **Tell me what to watch for, what it means and when to call.**

7. **Educate yourself about my chronic conditions, even if someone else is primarily managing them.** This is a recurring theme among parents of CYSHCN, especially.

8. **I expect you to know what happened in the hospital and what my consultant's plan is, and I expect my consultant to have information from you so I don't have to explain why I am there. It seems you should speak directly if things are complicated.** This used to be a problem of no information, now it is “click and send” too much information.

9. **I need to be able to see or talk with my physician most of the time if I have an acute problem; I need after-hours access with someone who is part of the team.** Seeing people for acute problems in the office when it is not normally open gets big kudos. It used to be the norm. Insurance company telemedicine is a poor substitute, even for a thoughtful informed phone conversation.

10. **One of the biggest things that affects my quality of life when I am feeling well is worrying that if I do have a problem with my chronic condition, that getting urgent care will be disorganized, scary and stressful, as it has so many times before.** Patients need a plan, patient specific information that they can carry, and access to someone who can coordinate care with emergency rooms and hospitals in real time.

Talking about potential solutions would take a book, and figuring out how to do this in a health care system that focuses on other things is a struggle, but I do think we do better, especially when things are tough if we remember, “It's all about the patient and family.”



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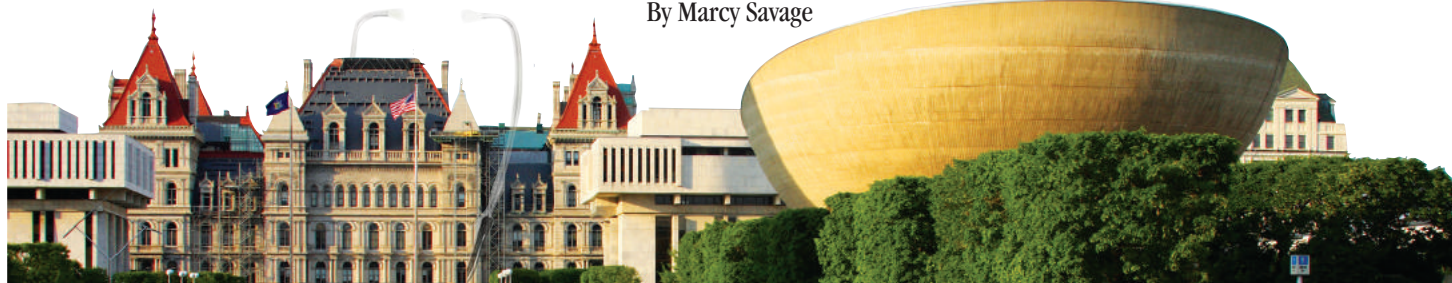


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## Albany Report

By Marcy Savage



In January 17th, Governor Andrew Cuomo released his SFY 2017-18 Executive Budget totaling over \$152 billion. Since the release, the NYS Legislature has been working to develop its own positions and priorities for the budget. Late on March 13th, the Senate and Assembly released their respective, one-house budget bills both responding to the Governor's proposals and staking a claim to priority items that they would like to see funded this year.

Following the release of these bills, both houses will now convene joint budget conference committees to discuss and hash out their own differences. Three-way negotiations with the Governor will also begin with a goal of reaching an on-time budget by the constitutional deadline of April 1st- the start of the new fiscal year. After many years of late budgets, once Governor Cuomo took office he made a priority to have an on-time budget which he has achieved every year so this year is not likely to be different.

Proposals in the Governor's budget of particular interest to physicians are initiatives contained in the following chart. Some of these items were identified as priorities for the Academy and were discussed by members during annual lobby day, also held on March 13th. In the far right columns, we have noted the actions that the Senate and Assembly took on each proposal.

### NYSAFP 2017 Lobby Day

Under the leadership of President Dr. Robert Ostrander, Advocacy Chair Dr. Rachelle Brilliant and EVP Vito Grasso, the 2017 NYSAFP lobby day at the State Capitol held on Monday, March 13th was the largest in recent history. Over fifty family physicians, residents and students participated and NYSAFP covered a lot of ground seeing nearly 70 state legislators. Participants visited with their own State Senators and Assembly Members as well as legislators in key leadership positions, certain bill sponsors and other targeted legislators who are essential to achieving the Academy's legislative goals.

Three budget items were identified as priority topics for the lobby day and a number of legislative measures and are summarized below:

### Lobby Day Budget Priorities

- NYSAFP's support for the Governor's proposal to include \$127,400,000 in funding for the Excess Medical Malpractice Program
- NYSAFP's support for the Governor's proposal to include more than \$9 million for the physician loan repayment program and for the physician practice support program as part of Doctors Across New York
- NYSAFP's opposition to the Governor's proposal to remove prescriber prevails protections under Medicaid Managed Care and Medicaid Fee for Service except for atypical antipsychotics and antidepressants

### Lobby Day Legislative Priorities

- NYSAFP's support for universal healthcare coverage through a single payer health system (New York Health - A.4738, Gottfried/S.4840, Rivera)
  - Status: Assembly Ways & Means Committee/ Senate Health
  - \*Note, this passed the Assembly in 2015 and 2016
- NYSAFP's opposition to regressive medical liability measure to change the statute of limitations in medical liability cases to date of discovery (S.4080, DeFrancisco and A.3339, Weinstein)
  - Status: Senate Judiciary Committee/ Assembly Codes Committee
- NYSAFP's support for the Comprehensive Contraception Coverage Act (S.3668, Bonacic/A.1378 Cahill)
  - Status: Passed Assembly/ Senate Insurance Committee
- NYSAFP's support for the Reproductive Health Act (A.1748, Glick/ S.2796, Krueger)
  - Status: Passed Assembly/ Senate Health Committee
- NYSAFP's support for removing non-medical exemptions from childhood vaccine requirements (A.1810, Dinowitz/ S.52, Hoylman)
  - Status: Senate Health Committee/ Assembly Health Committee
- NYSAFP's support for raising the age to purchase tobacco products to 21 (A. 273, Rosenthal/ S.3978, Savino)
  - Status: Senate Health Committee/ Assembly Health Committee

The lobby day was a great success and we would like to personally thank every physician, resident and student who took the time away from your busy practices to join in this very important day to advocate for issues of importance to your patients and your profession.



## SFY 2017-18 Executive Budget Proposals of Particular Interest to NYSAFP

Governor Proposal	Details on Proposal	Senate Action	Assembly Action
Excess Medical Malpractice Funding	Includes \$127,400,000 in funding for the Excess Medical Malpractice Program. Also it extends the program for one year for eligible physicians and dentists for the policy year beginning July 1, 2017. The bill would maintain existing eligibility requirements, and would add a requirement that physicians and dentists applying for coverage receive a tax clearance from the Department of Taxation and Finance before receiving such coverage.  <b>NYSAFP Position: Support Funding</b>	Accepted funding, Rejected tax provisions	Accepted funding, Rejected tax provisions
Doctors Across New York	Includes \$4,705,000 for the physician loan repayment program and \$4,360,000 for the physician practice support program as part of Doctors Across New York.  <b>NYSAFP Position: Support Funding</b>	Accepted Funding Levels	Accepted Funding Levels
Prescriber Prevails	Limited prescriber prevails provisions under Medicaid FFS and Medicaid Managed Care to atypical antipsychotics and antidepressants. All other classes that are currently covered would be repealed.  <b>NYSAFP Position: Oppose Proposal</b>	Rejected Proposal	Rejected Proposal
PA for Controlled Substances under FFS	Includes new prior authorization requirements on controlled substances prescribed in Medicaid Fee for Service (FFS) when more than a 7-day supply should remain if the drug was used as indicated.  <b>NYSAFP Position: No Position</b>	Accepted Proposal	Accepted Proposal
OPMC	Continues authorization for funds of the Office of Professional Medical Conduct (OPMC) through 2020.  <b>NYSAFP Position: No Position</b>	Accepted Proposal	Accepted Proposal



2017 NYSAFP Lobby Team

NYSAFP President Robert Ostrander, MD, Advocacy Chair Rachelle Brilliant, DO, Advocacy Member Wayne Strouse, MD and EVP Vito Grasso with Assemblyman Richard Gottfried, Chair of Assembly Health Committee and sponsor of single payer legislation during March 13th Lobby Day.





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### UPCOMING EVENTS

#### 2017

##### **NYSAFP**

June 24-25

##### **Congress of Delegates**

Renaissance Hotel, Albany, NY

August 5-6

##### **Summer Cluster**

Renaissance Westchester Hotel and  
Bronx Museum

September 16

##### **Capital Region Family Medicine Conference**

Siena College, Albany, NY

November 11-12

##### **Fall Cluster**

Albany, NY

##### **AAFP**

April 27-29

##### **AAFP Leadership Conference**

Sheraton Kansas City Hotel at Crown Center

May 22-23

##### **Family Medicine Congressional Conference**

Washington Court Hotel, Washington, DC

#### 2018

January 11-14

##### **Winter Weekend**

Lake Placid, NY

March 11-12

##### **Winter Cluster and Lobby Day**

Albany, NY

### EDITOR NOTES:

#### *Correction:*

In our winter issue of Family Doctor, the article “HIV Testing and Adolescents” (page 26) stated that in 2010 NYS mandated that health care providers offer HIV testing to individuals ages 13-64 as part of routine care.

Recent changes in this law mandate that medical providers offer the HIV test to patients **ages 13 and OLDER** as part of routine care. Thank you to Terri L. Wilder, MSW, Director, HIV/AIDS Education and Training, Mount Sinai Institute for Advanced Medicine for sharing this update.

#### *Also in our winter issue:*

Enayetullah Neak, MD, was inadvertently left off as co-author from “Vaccination: A Sticking Point” (page 44). Dr. Neak is a resident at St. Joseph’s Hospital Health Center Family Medicine Residency Program in Syracuse, NY. He graduated from Ross University School of Medicine after completing a bachelor’s of arts in biology at the University of Texas, Austin, and has had a previous article in Family Doctor.

### Family Doctors Telling Our Stories: 3rd Annual NYSAFP Writing Contest

Family Physicians have important stories to tell. In this era of evidence-based medicine, where everything has a measure, it seems especially important for doctors to share the essence of their profession. As integral members of the communities you serve, we want to hear your stories—the patient that you will never forget, the diagnosis that changed someone’s life, the family who you cared for in birth and in death.

We are pleased to announce our third annual writing contest open to all NYSAFP members. Submit your stories to us (2 pages or less) by April 28, 2017. Submissions should be non-scientific in nature and tell the reader something unique about you and your profession. For confidentiality, please don’t use actual names.

A top prize of \$200 and three \$100 prizes will be awarded. Winners will also be published in upcoming issues of NYSAFP’s journal, Family Doctor, as well as other outreach channels. Fellow family physicians will serve as our judges.

Submit entries to penny@nysafp.org by April 28, 2017 to participate. Please include your name, address, phone number and email address. Judging criteria will be provided upon request.

Check out last year’s winning entries in our fall 2016 issue of Family Doctor at [www.nysafp.org/News/Family Doctor](http://www.nysafp.org/News/Family Doctor)

### VIEW ONE

#### SINGLE PAYER HEALTHCARE: A PRAGMATIC LIBERTARIAN'S PERSPECTIVE

By Robert Ostrander, MD

**I** believe that the pursuit of happiness is most likely to be successful when individuals are in command of their own destinies. By and large, I think each person is in the best position to decide what is best for them. Individual control of the rewards for achievements and responsibility for the consequences of mistakes motivates success, cultivates thoughtfulness, incentivizes analysis and learning, and provides a sense of fulfillment.

Why, then, do I think the United States should adopt a single payer healthcare system where the federal government is the payer? Put quite simply, from a realistic standpoint, it is the system least likely to lead to day to day government intrusion into care.

For decades, most individuals have ceded decisions about how to pay for healthcare in exchange for someone else paying for it. For most with health insurance, the coverage is bought by either their employer or the government. For those without insurance, the cost of care exceeding their means is largely borne by society—albeit in a haphazard way. The evolution of this has led to a dysfunctional and misshapen payment system, which has inevitably led to a dysfunctional and misshapen healthcare delivery system. Market forces do not create an efficient, highly functional dynamic equilibrium when the buyer and the consumer are two different entities with different interests. Stated less abstractly, when negotiating with an insurer, the employer is affected directly by the price but only indirectly by the value of the service purchased. When an employee/consumer is not satisfied by the service, the vendor, the insurer, is at much less risk of losing a customer (the employer) than if the insurance was purchased directly by the employee.

A more ideologically pure and rigid libertarian would consider all this and conclude that the solution to our broken system would be to design an approach around the direct purchase of health care by the patient for mundane services we all need and the direct purchase of insurance by the individual or family to pay for expensive, infrequent and unpredictable events (as we do when we insure our houses against fire loss)—with societal subsidies for those **who are not able** to contribute. There are two major flaws to this conclusion. The first is humanitarian. Libertarians, in fact, have big hearts. The consequences of “mistakes” in failing to plan and provide for health mishaps are so great, that society cannot, will not, and should not allow the individual to bear them. And so we will all bear those costs by purchasing disorganized, crisis-driven, low value health care for those who have chosen not to be prepared. The second flaw is culturally pragmatic. Most Americans have had someone else picking up the tab for so long that making individuals bear the cost of health care and insurance directly (rather than through lower wages and higher taxes) is a political impossibility.

One



Two



### VIEW TWO

#### SINGLE-PAYER AS A SOCIAL CONTRACT: MY EXPERIENCE IN NEW ZEALAND IN THE SERVICE OF HER MAJESTY

By Wayne Strouse, MD

**F**ull disclosure – I am NOT a libertarian. Still, I find it fascinating that a libertarian and I have arrived at a similar conclusion (albeit taking different paths) when it comes to healthcare.

My conclusion was in large measure based on my experience with a single payer system during my year working in New Zealand. (Parenthetically, I have also worked in a socialized medicine system, the U.S. Navy.)

Our current health care non-system in some ways mirrors the formation of our country. We revolted against the government of the King of England, and in large measure our present system of governing reflects our core mistrust of government. In America, a large portion of the populace believe that government is to be feared, or at the very least, government is not to be trusted. Many also believe that any system created or administered by our government will by definition be wasteful, overregulated, and inferior to the “market driven solution”.

Contrast this with New Zealand, a part of the British Commonwealth, created under the Treaty of Waitangi which is a one page document that spells out the understanding between the Crown and the Maori tribes. No revolution, no distrust of government, and the general feeling that the government is in power to look after the welfare of the people. Government is benevolent, and government is the source of solutions to the problems of the populace. In my discussions with my Kiwi (“Kiwi” is the nickname for a citizen of New Zealand, much like “Yankee” is the nickname for Americans) friends and colleagues about the difficulties of the American health care “system”, typically the first question was, “What is the government doing about it?”

Thus, when it came to providing health care for the population of New Zealand, it is not surprising that they opted for a single payer system. The system is organized around the GP (general practitioner, their version of family medicine doctors), which is the entryway to accessing their system. The GP then contacts the Ministry of Health and obtains NHI (national health insurance) numbers for each patient. A co-pay is paid at each visit, typically in the range of NZ\$ 10 – 20 (about \$7 – 14 US) when I was there. The doctor receives a per-person per month amount for each patient who has identified them as their general practitioner. There are extra monies paid to cover immunizations and complicated care, and the GP can charge the patient directly for any procedures (such as wart treatments, mole removals, etc.).

Interestingly, going to a specialist, as well as hospital and ER care was free. So, you had to pay to have your GP remove a lesion, but not to have it done by a surgeon! However, your GP could probably do the procedure right away, whereas you would likely wait for months to see



## view one, continued

So why is a single payer system better, from a libertarian standpoint, than a mandated, highly regulated mix of employer, government and individually purchased insurance? One thing to bear in mind is that between Medicaid for the indigent, Medicare for those on Social Security, and purchased plans for local (including public school teachers), state and federal government employees, that taxpayers directly purchase a large portion of health insurance already. The primary problems with the present system and its expansion by the Affordable Care Act are the misalignment of incentives described before. Because of them and to reign in the distortions and opportunities for abuse they produce, layers of costly mandates and regulations which **add cost but no value (and which may detract from value)** are put in place. A secondary problem is the drain on productivity that unnecessary variability places on the process of caring for patients. Those who defend this variability describe it as “competition” which should result in more efficient and more valuable service, but as I have noted above, the distortion of marketplace forces by the bizarre relationships in the current system and codified by the ACA negate that argument.

A single payer system, at least, puts us all in the same boat. We as a society have to decide if broader coverage is worth increased premiums (taxes). We, as a society, through our elected representatives, will have a reason to eliminate value-less steps in the process of care and weigh the harms and benefits of utilization management strategies. We as a society will have to decide whether the drain on resources from an ineffective civil liability process warrants reform. We as a society will be in a position to benefit from getting it right and have incentive to fix what does not work.

The system as it exists and as it will expand under the ACA is, from this libertarian’s perspective, the worst conceivable way to address a broken health care payment and delivery system. It has variability without freedom to choose, purchases dictated to the purchaser and out of the hands of the consumer altogether, and misalignment of incentives both for the individual and society as a whole. With a single payer system, at least we will all together reap the benefits and bear the consequences of our choices.

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## view two, continued

the surgeon. In underserved areas (like the city of Gisborne where I practiced) the surgeons would often be kept busy enough with their general surgery demands that they just would not get around to the non-urgent procedures.

As for the medications, they were covered (if on formulary) at NZ \$3 for a 90 day supply.

The government was held accountable for the entire healthcare system, and the Minister of Health had to answer to the Prime Minister, the “loyal opposition”, and the people. If the queues (lines) became too long, or if services were not being adequately provided, it could topple the party in power in the next election. (Go try to do that to the CEO of Blue Cross Blue Shield!)

The malpractice system was also part of the social contract. Malpractice was called a “medical misadventure” and was covered more like an injury at work. The doctor filled out two sides of a very straightforward one page form and the care was covered under the ACC (Accident Compensation Commission) which covered care for all accidents from a child scraping his knee on the playground to an operation on the wrong leg. The medical record was evaluated by the Medical Council New Zealand (MCNZ), by doctors and nurses who decided whether the medical standard of care was breached, and decided on the appropriate remediation (sometimes, the only penalty was that the doctor was told to apologize to the patient!).

The cost of medical school was covered mostly by the government, and decisions regarding the number and location of GPs and specialists were also managed by the government through the Minister of Health in consultation with the MCNZ. Likewise decisions to purchase high-cost technology were managed centrally.

Negotiations for the contract between doctors and the government were negotiated through a union, which seemed to generate a reasonable contract. Included were such things as three weeks extra time off every three years (mini sabbatical), and a three-month sabbatical every seven years (fully paid, of course). This contract included all specialists who worked in the public hospitals, and any GPs who were working directly for the government.

Payment for all this was through taxes, which were higher than our taxes in the United States. The top tax bracket was 38%, but it “kicked in” at a much lower income (around NZ\$70,000). Also, at the low end, people start to pay taxes at significantly lower income than in the US (around NZ\$10,000 to 12,000).

Clearly, I cannot, in the space provided, give you all the nuances of the New Zealand system; this is only a brief overview. So, what are my thoughts having lived – and worked – under this kind of single payer system?

I loved working in New Zealand! I found the system was truly a social contract between government and the governed. Unless a person chose not to present to a GP, they were “in” the system. There was a real balance between the various stakeholders. Doctors were paid fairly, and without hassle. There were no insurance companies to fight. Though it took me a bit of time to learn how the system worked, once I learned it – it covered everyone who walked through the door in the same manner. There was one national formulary for everyone. In an entire year, I did not enter one code! Delightful!

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# Choosing Wisely: Using Evidence to Bring Value and Quality to Healthcare

By Colleen T. Fogarty, MD, MSc, FAFAP

**A**s I began a presentation called “Choosing Wisely: How Quality can be Improved by What we Don’t do” to a packed room at the New York State Academy of Family Physician’s Winter Weekend, I asked the question, “How many of you are familiar with the Choosing Wisely campaign?” and approximately 2/3 of the attendees raised their hands. Puzzled, I asked the group, “Why, then, are you attending this session?” Attendees answered, “Because I need help implementing these practices,” and “I need support... I need to feel like I’m not alone in trying to do this.”

This article, which will review the history and premise of Choosing Wisely campaign, is the first in a series of articles to bring the evidence-based guidelines and suggestions for implementation, to the readership of Family Doctor. In addition to reviewing the history and presenting the American Academy of Family Physicians list, the article will focus on several strategies to use to implement changes in practice. This is a particularly crucial time in U.S. healthcare history, as our systems are being called upon to eliminate waste and demonstrate value, that is, the ratio of quality to cost, to the nation. Family physicians as the point of first contact are in an ideal position to incorporate these values into practice.

## The History of Choosing Wisely

In 2009, The American Board of Internal Medicine Foundation funded the National Physician’s Alliance proposal, “Promoting Good Stewardship in Clinical Practice” which set out to identify a “Top 5” list in internal medicine, family medicine, and pediatrics, to improve quality. The criteria for making the list were interventions that were common in primary care, strongly evidence supported, and would reduce risk, harm, or cost overall.<sup>1</sup>

The project involved experts from each discipline and employed a nominal group process to identify and test the suggested interventions. The initial round of field testing involved 83 practicing primary care physicians, and the second round involved an additional 172.<sup>2</sup>

Using similar methodology, the ABIM launched the Choosing Wisely campaign in 2012, and it has since grown into a multi-specialty, multi-organization movement to encourage the use of evidence based diagnostics and treatment in medical practice, while recommending physicians not provide interventions found to be ineffective or harmful.

In April 2012, the AAFP joined the Choosing Wisely campaign, with the endorsement of the first five recommendations developed by the National Physicians’ Alliance project. Since then, Choosing Wisely has partnered with dozens of other medical specialties, developing specialty-relevant lists of interventions to avoid. Additionally, Consumer Reports has become an important partner, developing patient-oriented documents and other patient education materials.

## The Family Medicine Lists

See **Table 1** for a complete list of the fifteen items on the AAFP list. The first five items on the list were the original five chosen as part of the NPS project. The subsequent ten were chosen by family physician experts using evidence reviewed from varying sources, including the Cochrane Collaboration Reviews and the Agency for Healthcare Research and Quality (AHRQ).

Related patient education materials were developed in collaboration with Choosing Wisely in partnership with Consumer Reports. The Choosing Wisely website contains a searchable field that includes topic, keyword, society, category, and age group.<sup>3</sup> However, based on my searches, the keyword field seems to relate to the title of the resource, not necessarily to any word content in the resource. **Table 2** shows the links available with downloadable patient education materials for the AAFP lists. Some of these are from the Choosing Wisely site, and others are from other reputable sources.

The first item on the list (Table 1), addresses the fifth most common presenting complaint to primary care clinicians: “Don’t do imaging for low back pain within the first six weeks, unless red flags are present.” Red flags include severe or progressive neurological deficits, or historical features that suggest underlying infection.<sup>4</sup>

The American College of Physicians, American College of Emergency Physicians, American Society of Anesthesiologists – Pain Medicine, the American Association of Neurological Surgeons and Congress of Neurological Surgeons, and the American College of Occupational and Environmental Medicine all have similar evidence-based recommendations.<sup>5</sup> This item is similar to a National Quality Foundation and NCQA endorsed measure, which means it will be part of the growing quality and value based payment initiatives.<sup>6</sup>

Item 4 focuses on the lack of benefit for annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms. The important element here is asymptomatic, and low-risk. Recall that the definition of screening is, “the systematic application of



a test or inquiry, to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder.”<sup>7</sup> This EKG guideline states that screening asymptomatic and low-risk individuals is an activity devoid of value. However, we should continue to employ clinical judgment when “case-finding” or seeking early detection of a disease in a patient with a known risk factor, e.g. obtaining an EKG in an asymptomatic patient with a longstanding history of hypertension is an example of “case-finding.” Similarly for item 8, carotid artery stenosis, screening is not warranted in asymptomatic individuals.

Two elements focus on antibiotic prescribing, which the literature shows to be unnecessary or potentially causing harm. Number 2, “Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement”, can cause problems for practicing physicians, when patients have come to learn that “they only way for my sinus symptoms to disappear is for me to take a Z-pack!”

Using the Consumer Reports patient education materials (for partial example, Figure 1 below) in combination with a caring conversation with the patient may be effective ways to dissuade patients from a demand for unnecessary antibiotics. The New York State Department of Health, in collaboration with the Centers for Disease Control and Prevention, has produced clinician and patient education materials related to unnecessary antibiotic use. The NYSDOH 7 minute, 40 second training video provides strategies to help clinicians explain the potential harms of unnecessary antibiotics.<sup>8</sup>

**Figure 1:** <http://www.choosingwisely.org/patient-resources/treating-sinusitis-aafp/>

**Treating Sinusitis (AAFP)**

**Don't rush to antibiotics**

[DOWNLOAD PDF](#)

The sinuses are small, hollow spaces inside the head. They drain into the nose. The sinuses often cause problems after a cold. They can also cause problems if they get blocked up from hay fever and other allergies. The medical name for sinus problems is sinusitis.

Sinus problems can be very uncomfortable. You may feel stuffed up. You may have yellow, green, or gray mucus. And you may feel pain or pressure around your eyes, cheeks, forehead, or teeth.

Each year, millions of people use antibiotic drugs to treat sinus problems. However, they usually do not need antibiotics. Here's why:

**Antibiotics usually do not help sinus problems.**

- Antibiotics kill bacteria. They do not kill viruses or help allergies. Viruses or allergies cause most sinus problems.
- Sinus problems usually get better in a week or so without drugs, even when bacteria cause them.

**Antibiotics cost money.**

Most antibiotics do not cost very much. But why waste your money? Patients often ask for antibiotics, and doctors often give them. As a result, Americans spend an extra \$31 million a year on health care costs.

**CR ConsumerReports**

**AMERICAN ACADEMY OF FAMILY PHYSICIANS**  
STRONG MEDICINE FOR AMERICA

**ADVICE FROM CONSUMER REPORTS**

**How should you treat sinus problems?**

Most people get over a sinus infection in about a week. These tips may help you feel better sooner:

**Rest.** Your body needs rest to fight the infection. Try to rest as much as you can, especially in the first few days.

**Drink warm liquids.** Drinking warm water, tea, and other liquids helps thin and loosen mucus. This helps it drain away faster.

**Breathe warm, moist air.** The steam from a warm shower or bath, or from a kettle of boiling water helps to loosen mucus and soothe your throat.

Recommendation 11, “Don’t prescribe antibiotics for otitis media in children aged 2-12 years with non-severe symptoms where the observation option is reasonable” also can be difficult to apply, because despite years of good evidence that “watchful waiting” for 48 to 72 hours, focusing on pain relief and symptom management, many parents and physicians still believe that antibiotics are routine and first-line. To implement this guideline, physicians need to educate parents, be able to re-evaluate as needed, and be working with a family who has the means to follow-up by telephone or in-person. The CDC’s “Get Smart” Campaign focuses on wise and appropriate use of antibiotics. Their fact sheet about Otitis Media in children, provides good guidance in 2 pages of attractive art and text.<sup>9</sup>

Recommendations 5, 9, and 10 focus on cervical cancer screening. It is worth reviewing that cervical cancer screening is NOT indicated in women younger than age 21, women who have had a hysterectomy for non-cancer disease, and low risk women over 65 with adequate prior screening. Women under 30 years of age do not benefit from human papillomavirus testing. Consumer Reports’ concise one-pager “Pap tests: When you need them, and when you don’t” provides an overview by age of cervical cancer screening recommendations.<sup>10</sup>

Recommendation 15 reinforces that there is no evidence to support requiring a pelvic or other physical exam prior to prescribing contraception. This guideline is not suggesting no office visit, but rather no pelvic or other physical exam. Obviously if the appropriate evidence based interval and age for cervical cancer screening, chlamydia testing, or colon cancer screening applies, an office visit could provide these services coincident with a prescription for contraception, but not related to the contraception per se.

AAFP items 6 and 7 were produced in 2013 in collaboration with the American College of Obstetricians and Gynecologists (ACOG) and coincide with the first two recommendations of the ACOG lists. Even family physicians who do not attend births may encounter questions from pregnant women who are requesting early induction of labor or who may have this recommended to them. The related patient education documents provide a good overview.

Recommendation 3 advises not to order dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors, based on the evidence showing the test is not cost-effective for these age groups. To re-iterate, the recommendation is for those patients with no risk factors. A patient younger than 65 with a known risk factor or early fracture suggestive of osteoporosis is no longer covered in this guideline.

**Table 1: Choosing Wisely**

1. Don't do imaging for low back pain within the first six weeks, unless red flags are present.
2. Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
3. Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
4. Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.
5. Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.
6. Don't schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age.
7. Avoid elective, non-medically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable.
8. Don't screen for carotid artery stenosis (CAS) in asymptomatic adult patients.
9. Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.
10. Don't screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.
11. Don't prescribe antibiotics for otitis media in children aged 2-12 years with non-severe symptoms where the observation option is reasonable.
12. Don't perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2 -24 months.
13. Don't routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.
14. Don't screen adolescents for scoliosis.
15. Don't require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

Choosing Wisely List: American Academy of Family Physicians (AAFP)  
Accessed January 26, 2017  
<http://www.choosingwisely.org/american-academy-of-family-physicians/>

Recommendation 12 focuses on avoiding routine voiding cystourethrograms in first febrile urinary tract infection (UTI) in children aged 2 -24 months. The evidence reviewed from several sources found that the risks of radiation coupled with the cost of procedure in dollars and inconvenience outweighs the risk of delaying the detection of the very few children with correctable GU abnormalities until their second UTI.

Recommendation 13, not doing prostate specific antigen or digital rectal examination as screens for prostate cancer, mirrors the current recommendation of the United States Preventive Services Task Force (USPSTF), most recently updated in 2012. The evidence shows that screening leads to over-diagnosis and treatment which causes significant harms, including urinary incontinence, erectile dysfunction, and bowel dysfunction. During our session at Winter Weekend, several downstate attendees reported that there were vans driving through their communities, recommending patients have prostate screening. In

addition to our usual work with patients, we as family physicians also need to advocate for health resources being used wisely.

Finally, recommendation 14 shows that there is no evidence of benefit for screening adolescents for scoliosis. This mirrors the 2004 USPSTF guideline, which is undergoing revision in 2017. Attendees at Winter Weekend reported that this physical examination item remains on the New York State school health exam form. Perhaps after the 2017 update of the USPSTF, the NYSAFP Public Health Commission can advocate to have this removed from the school health form.

To summarize, the American Academy of Family Physicians signed on as partners in the Choosing Wisely campaign, and provide 15 recommendations of tests or interventions to avoid in practice, based on the lack of benefit and/or possibility of harm to patients. The above summary provides a brief overview and related patient education materials for each.

## Choosing Wisely in Practice

When thinking about actual practice, it's wise to use principles from behavior change. First, consider the list, and consider what practices you and your partners or employed clinicians in your practice do. Consider choosing one recommendation to improve. Use the Plan-Do-Study-Act methodology to plan a change. This could be as simple as paying careful attention to the next 5 patients who present to the practice with acute back pain without red flags, and auditing those charts, to changing an office protocol for routine refills on contraception. You may choose to make a change solo and then spread to others in the practice, or you may prefer the support of your full team of colleagues and staff.

For example, you may enlist the help of nursing staff and others to disseminate information about antibiotic use in uncomplicated sinusitis, or you may choose to send information about otitis media treatment via the patient portal to any families with young children.

Improving practice and quality relies heavily on what we as family physicians recommend for our patients; the Choosing Wisely campaign highlights how we can improve quality by what we DON'T recommend.

## Endnotes

- 1 <http://abimfoundation.org/what-we-do/choosing-wisely>
- 2 The "Top 5" Lists in Primary Care--Meeting the Responsibility of Professionalism. Arch Intern Med. 2011;171(15):1385-1390. doi:10.1001/archinternmed.2011.231
- 3 <http://www.choosingwisely.org/patient-resources/>
- 4 <http://www.choosingwisely.org/clinician-lists/american-academy-family-physicians-imaging-low-back-pain/>
- 5 [http://www.choosingwisely.org/clinician-lists/#keyword=back\\_pain](http://www.choosingwisely.org/clinician-lists/#keyword=back_pain)
- 6 <https://www.qualitymeasures.ahrq.gov/summaries/summary/49748>
- 7 N J Wald. Journal of Medical Screening. Vol 15, Issue 1, pp. 50 – 5 published date: March-01-2008 10.1258/jms.2008.008got
- 8 <https://www.youtube.com/watch?v=YHYmb2OKoMU>
- 9 <https://www.cdc.gov/getsmart/community/downloads/ear-infections-antibiotics.pdf>
- 10 <http://www.choosingwisely.org/patient-resources/pap-tests/>

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**Table 2 - Patient Education Materials to Support Choosing Wisely**

Recommendation	Patient Education Materials
1. Imaging in Low Back Pain	<b>Imaging Tests for Lower-Back Pain</b> <b>You probably do not need an X-ray, CT scan, or MRI</b> <a href="http://www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/">http://www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/</a>
2. Antibiotics for acute sinusitis	<b>Treating Sinusitis (AAFP)</b> <b>Don't rush to antibiotics</b> <a href="http://www.choosingwisely.org/patient-resources/treating-sinusitis-aafp/">http://www.choosingwisely.org/patient-resources/treating-sinusitis-aafp/</a>
3. DEXA screening age recommendations	<b>Bone-Density Tests</b> <b>When you need a test and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/bone-density-tests/">http://www.choosingwisely.org/patient-resources/bone-density-tests/</a>
4. EKG and cardiac screening *	<b>EKGs and Exercise Stress Tests:</b> <b>When you need them—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/ekgs-and-exercise-stress-tests/">http://www.choosingwisely.org/patient-resources/ekgs-and-exercise-stress-tests/</a>
5. Pap smears under age 21 or status post hysterectomy for benign disease.	<b>Pap Tests</b> <b>When you need them—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/pap-tests/">http://www.choosingwisely.org/patient-resources/pap-tests/</a>
6. Elective inductions of labor or Cesarean deliveries before 39 weeks	<b>Scheduling Early Delivery of Your Baby</b> <b>Why scheduling early delivery is not a good idea</b> <a href="http://www.choosingwisely.org/patient-resources/scheduling-early-delivery-of-your-baby/">http://www.choosingwisely.org/patient-resources/scheduling-early-delivery-of-your-baby/</a>
7. Elective inductions of labor between 39 weeks, 0 days and 41 weeks	
8. Carotid artery stenosis screening in asymptomatic adults *	<b>Clogged Neck Arteries</b> <b>When you need a screening test—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/clogged-neck-arteries/">http://www.choosingwisely.org/patient-resources/clogged-neck-arteries/</a>
9. Cervical cancer screening for women over 65	<b>Pap Tests: When you need them—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/pap-tests/">http://www.choosingwisely.org/patient-resources/pap-tests/</a>
10. Cervical cancer screening under 30 with HPV testing	Pap Tests: When you need them—and when you don't <a href="http://www.choosingwisely.org/patient-resources/pap-tests/">http://www.choosingwisely.org/patient-resources/pap-tests/</a>
11. Antibiotics for Otitis Media in children	<b>Preventing and Treating Ear Infections fact sheet</b> <a href="https://www.cdc.gov/getsmart/community/downloads/ear-infections-antibiotics.pdf">https://www.cdc.gov/getsmart/community/downloads/ear-infections-antibiotics.pdf</a> <b>Antibiotics for Ear Infections in Children</b> <b>When you need them—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/antibiotics-for-ear-infections-in-children/">http://www.choosingwisely.org/patient-resources/antibiotics-for-ear-infections-in-children/</a>
12. VCUG screening in first UTI in 2-24 month olds	None available on Choosing Wisely
13. Prostate cancer screening *	<b>PSA Blood Test for Prostate Cancer</b> <b>When men need it—and when they don't</b> <a href="http://www.choosingwisely.org/patient-resources/psa-test-for-prostate-cancer/">http://www.choosingwisely.org/patient-resources/psa-test-for-prostate-cancer/</a> <b>Screening for Prostate Cancer</b> <a href="https://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers">https://www.uspreventiveservicestaskforce.org/Tools/ConsumerInfo/Index/information-for-consumers</a>
14. Scoliosis screening in adolescents *	<b>Screening Tests</b> <b>When you need them—and when you don't*</b> <a href="http://www.choosingwisely.org/patient-resources/screening-tests/">http://www.choosingwisely.org/patient-resources/screening-tests/</a>
15. Pelvic or physical for contraceptive prescription	<b>Pelvic Exams, Pap Tests and Oral Contraceptives</b> <b>When you need tests to get birth control pills—and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/pelvic-exams-pap-tests-and-oral-contraceptives/">http://www.choosingwisely.org/patient-resources/pelvic-exams-pap-tests-and-oral-contraceptives/</a>
	<b>Antibiotics: Will They Help You or Hurt You?</b> <a href="http://www.choosingwisely.org/patient-resources/antibiotics-will-they-help-or-hurt-you/">http://www.choosingwisely.org/patient-resources/antibiotics-will-they-help-or-hurt-you/</a> <b>Antibiotics: When you need them and when you don't</b> <a href="http://www.choosingwisely.org/patient-resources/antibiotics/">http://www.choosingwisely.org/patient-resources/antibiotics/</a>
Clinician Communication Education about Antibiotics	<b>Educating Patients About Antibiotic Use</b> <a href="https://www.youtube.com/watch?v=YHYmb2OKoMU">https://www.youtube.com/watch?v=YHYmb2OKoMU</a>

\* **Screening Tests: When you need them—and when you don't**, available at <http://www.choosingwisely.org/patient-resources/screening-tests/> is a generic patient education about screening tests; it mentions the tests which appear with an \* in the table.

# Chronic Care Management Billing for the Family Medicine Physician

By Veronica Rivera, MD and Audrey Chun, MD

## Background

Primary care providers have long been providing services, both during and after the traditional face-to-face visit, that have not been captured and reimbursed with traditional billing evaluation and management codes (E/M). More recently, the Centers for Medicare and Medicaid (CMS) developed new billing opportunities and codes that allow for reimbursement outside of these traditional evaluation and management codes. For example, Transitional Care Management (TCM) presented in January 1, 2013, Chronic Care Management (CCM) presented in January 1, 2015 (updated January 1, 2017), and Advanced Care Planning (ACP) presented in January 1, 2016 are additional codes available to help compensate primary care providers for the complex care that they are providing to their patients.

For this piece, we will focus on Chronic Care Management, which had a recent update in 2017, and review steps for primary care providers to implement processes in their practice to facilitate billing for CCM services. Per the Medicare Physician Fee Final rule in 2017, CMS improved care management services payment, recognized additional CPT codes, and adjusted payment for the visit during which CCM services are initiated.<sup>4</sup>

## Chronic Care Management Overview

Chronic Care Management (CCM) applies to patients who have fee-for-service Medicare and includes services provided by a physician or non-physician practitioner, such as a nurse practitioner or physician assistant, and their clinical staff. CCM requires that a patient have at least two or more chronic conditions expected to last at least 12 months, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.<sup>3</sup> Chronic Care Management includes work that involves non face-to-face time, such as communication with the patient and other care providers involved in the care of the patient and medication management. This work needs to involve direct contact via phone or electronic communication, either with the patient or another health care professional.

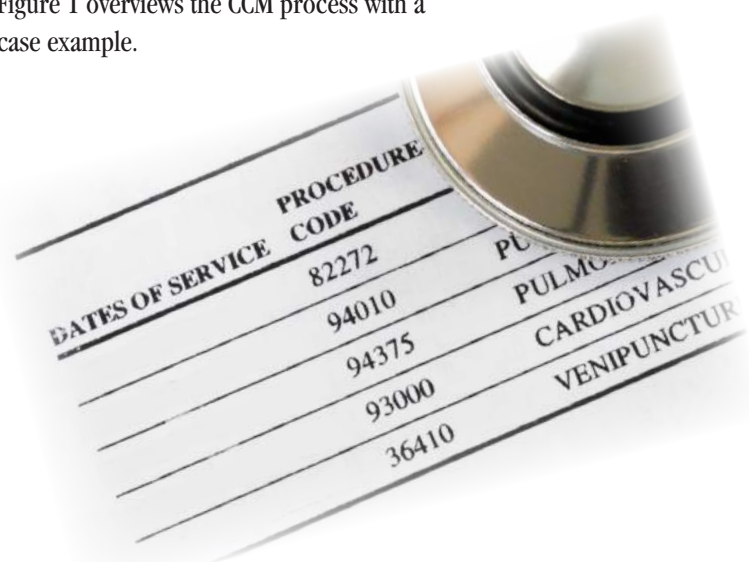
An additional requirement of CCM is that an electronic comprehensive care plan for all of the patient's health problems must be provided to the patient and must include a summary of the physical, mental, cognitive, social, functional, and environmental assessment. There is no specific format but the care plan needs to be incorporated in the electronic health record (EHR) and must include the patient's problem list and medications.<sup>3</sup>

CMS introduced the code 99490 in 2015 and in 2017, added 99487 and 99489 for higher reimbursement for longer services and G0506 for creation of the initial care plan. Of note, only one service per calendar month is allowed, and only one single physician can submit per month. CMS tried to relax the administrative requirements somewhat although an initiating visit is still required (for new patients or patients not seen within the last year), as well as a certified EHR, 24-hour access to care, comprehensive care management, and a comprehensive care plan.

## CCM Process

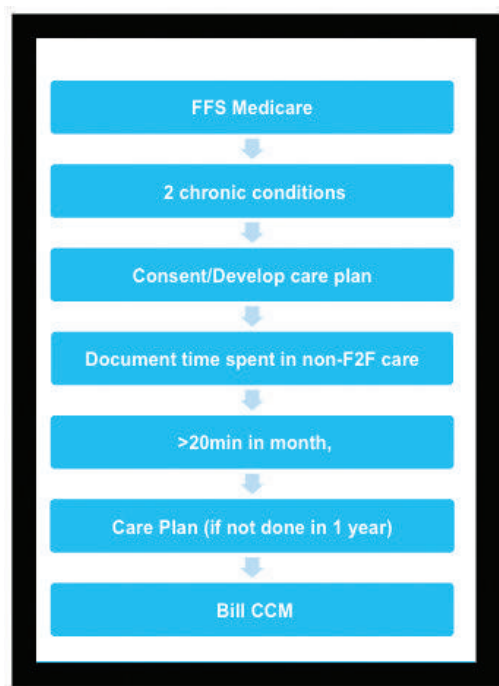
In 2015 the American College of Physicians developed a Chronic Care Management Tool Kit to help providers review the steps involved to implement and bill CCM codes.<sup>1</sup> This is a nice resource and provides physicians with eight suggested steps. Based on personal experience at our institution, we will provide the following suggestions and modified steps.

First of all, there is some preparatory work that must be initiated prior to identifying patients eligible for CCM and prior to billing for these services. Initially, you must work with your EHR support team to support the overall process. For example, your EHR can help you develop a process to identify and consent CCM patients, build templates for care plans, and set up new billing codes. It is also helpful for your EHR to adjust the format for documentation of telephone encounters so that you can record the number of minutes spent per chronic care management encounter and also have the capability to run a report with the number of minutes spent per patient each month. Once the frameworks are built, you can start the process to enroll and consent eligible patients to CCM. Figure 1 overviews the CCM process with a case example.





**Figure 1: CCM Flow and Example**



**Case Example:**

You see a 75 year old woman with COPD, Hypertension, type 2 Diabetes who has been admitted to the hospital 3 times in the last year for falls, COPD exacerbation, and hypoglycemia. As her PCP, you see her about every 3 months.

1. She is identified as having FFS Medicare and is scheduled to see you in January.
2. At her visit with you in clinic in January, you explain to her Chronic Care Management Services and consent her to CCM services.
3. During your established visit (that you bill as a 99213), you also create a comprehensive care plan in the electronic health record and provide her with a paper copy. When you complete your billing, you add a modifier and also bill for G code G0506.
4. In the next calendar month of February, the following happens.
  - You call her to go over her Hemoglobin A1C and lipid results and you adjust her insulin regimen. This phone call takes 5 minutes.
  - Your RN calls her a week later to follow up on her finger sticks and provides additional education. This phone call takes 7 minutes.
  - The physical therapist who is working with her calls you to update you on her progress and to give you her most recent blood pressure reading that was elevated at 160/90. This phone call takes 3 minutes.
5. At the end of February, you receive notification from reports that she has met the threshold of 20 minutes of chronic care management and you can drop the charge for a 99240.

1. Identify eligible Medicare FFS patients needing consent

Patients eligible to be enrolled into CCM services must have fee-for-service Medicare and two or more chronic conditions expected to last at least 12 months, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.<sup>3</sup> Your EHR should be able to run a report to identify CCM-eligible patients based on the above criteria. This could help you target patients to consent and ask staff to schedule these patients to come in for a face-to-face visit. Additionally, with our EHR, my daily schedule of patients for the day does show if my patients are “CCM Eligible” or if they are already enrolled in the CCM program. This is helpful way to remind providers to consent patients on the day of visit.

2. Consent patient to CCM services

Initially, CMS required a signed consent form to be on file. As per the 2017 updated ruling, verbal consent is sufficient, but must still be obtained in a face-to-face encounter (either a new or follow-up visit).<sup>3</sup> You must also inform the patient that there may be cost-sharing (20% co-payment) and that they

can stop enrollment in the program at any time. It is also important to remind the patient that only one practitioner a month can bill for CCM services. For example, a specialist cannot also bill for CCM services the same month. In my practice, we provide verbal consent but also print out patient education information for patient to take home as a reference. Example consent forms can be found in the ACP tool kit.<sup>1</sup>

3. Create and provide comprehensive care plan

If possible, it is ideal to provide patient with a copy of a comprehensive care plan at the time of initial visit and consent to CCM program. CMS now reimburses for creation of the care plan via the code G0506 which reimburses about \$65. This service is in addition to a face-to-face service such as an established visit code or even a Transitional Care Management code. This was intended to be billed only once and was proposed to happen during the initial visit.

4. Document and track time

In order to track time spent monthly, it is essential to document time spent in each telephone encounter in a time

capture section of your EHR. Since most clinical providers and staff are not used to the practice of documenting time, it does require some training. If possible, you might want to consider having a reminder pop-up for providers and staff who are documenting appropriate care management services for consented patients. This can help with changing practice habits. Typical CCM activities can be seen in Table 1.

5. Bill CCM

Finally, now that all the work is completed, you can actually bill for the services provided each month. It is time consuming to tally the total number of minutes spent per consented patient if you do not have automatic reporting set up with your EHR. If this has been instituted, a monthly report can be sent to your practice manager or another designated person who can coordinate with the billing provider. Once the provider is alerted, the provider should review the patient’s eligibility for CCM billing. If appropriate to bill, the provider should document a brief note, make sure a care plan is up-to-date, and bill for the appropriate CCM

**continued next page**

code depending on time spent. Billing and documentation flow should be concordant with other billing flow in the practice.

As a reminder, CCM cannot be billed in the same month as transitional care management, care plan oversight, or hospice care supervision.<sup>2</sup> CCM cannot be billed on the same day as an E/M code. Lastly, the number of minutes cannot count time twice if two members of the team are involved (for example the number of minutes spent by both a nurse and a doctor on the same team speaking in conference about the patient).

## CCM Reimbursement

For 2016, there was just one CCM code 99490 reimbursed at \$42. Now, there are 3 codes which can range from \$42 to over \$141 depending on the complexity of the needs. The add-on G code G0506 is billed “in addition to the initiating visit service code when the billing practitioner performs extensive assessment and CCM care planning beyond the usual effort for the initiating visit code.”<sup>3</sup>

For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) only 99490 is payable and there is no add-on code for initiating visits. Also, CCM can be billed to beneficiaries in both non-facility and facility (example nursing home and assisted living) settings.

For non-complex CCM, the date of service can be at the end of the calendar month or whenever the minimum threshold is met. For complex CCM code, the practitioner should report code at the end of the calendar month and also should include medical-decision making of moderate-high complexity.

**Table 1: Typical CCM Activities**

Communication and engagement regarding aspects of care	Identification of available community and health resources
Communication with home health agencies and other community services	Facilitating access to care and services needed by patient/family
Collection of health outcomes data and registry documentation	Management of care transitions not reported as part of TCM
Patient/family/caregiver education	Ongoing review of patient status including labs and other studies
Assessment and support for treatment regimen adherence and medication management	Development, communication, and maintenance of comprehensive care plan

Source: AGS Webinar Dec 2016.<sup>5</sup>

Additionally, complex CCM requires that oversight must be performed by the billing provider and cannot be subcontracted to a case management company. Table 2 provides CCM codes with descriptions and payment.

## Conclusion

Primary care providers have long advocated for improved reimbursement for the care of complex patients which occurs outside of traditional face-to-face visits and E/M billing codes. CMS has provided us with new opportunities for reimbursement, but significant time and effort is required to capture and record this work and time. Initially, the implementation can be arduous, but if a process is put into place and a team-based approach is utilized, the additional revenue can help better compensate providers for time that is not usually accounted for.

## Endnotes

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**Table 2: CCM Reimbursement**

Code	Description	Payment (non-facility)
99490	CCM 20 Min	\$42.21
99487	Complex CCM 60 Min	\$92.64
99489	Complex CCM 30 min add-on to 99487	\$46.86
G0506	Initial care plan creation	\$64.67

Source: Chronic Care Management Changes for 2017<sup>4</sup>



# German Health Insurance System: Another View

By Khaula Tauqeer, MD

**G**ermany spends 11.5% of its GDP on healthcare as compared to 17.1% in the USA but enjoys longer life expectancies with only 0.2% of the population being uninsured. It is unlawful to be without health insurance in Germany. Insurance is provided by competing, not-for-profit, nongovernmental health insurance funds, also called sickness funds or by private health insurance companies or a combination of the two. The government has no direct role in the delivery of healthcare with regulation being assigned to a Federal Joint Committee, composed of delegates from sickness funds, physician, hospital and dental associations, and patient representatives.

About 86% of the population is covered by publicly financed health insurance/state health insurance (SHI). Private health insurance covers 11% of the population, including freelancers and self-employed people from the EU, and civil servants. The remaining small percentage is comprised of military personnel or police personnel who have a separately organized insurance system through their organizations. Social security is used to pay for undocumented immigrants requiring hospitalization.

SHI premiums are 14.6% of income, 7.3% of which is paid by the employer. Employees pay the other 7.3% plus 0.1-1.8% in supplemental payment. SHI provides medical benefits including in-patient care, outpatient care with registered clinicians, mental health care, basic dental care, optometry, physical therapy, rehabilitation, prescriptions, preventative care and maternity care, hospice and palliative care and sick leave compensation. It extends coverage to dependents, specifically, unemployed spouses or those spouses with low earnings and children up to age 23 at no additional cost. It does not cover private doctors or surgeons, private hospital rooms, alternative/homeopathic medical care, dental implants and vision products. Those interested can purchase supplemental private insurance that can provide additional benefits.

SHI also has a cap of 2% of household income, with individuals with chronic illness having only a 1% cap. Copayments include 5-10€ per outpatient prescription, 10-14€ per inpatient hospital/rehab stays for the first 28 days, and 5-10€ for prescribed medical devices. SHI also includes sick pay insurance. In an attempt to reduce the cost of drugs, discounts have been forced from large drug companies and pharmacies are now required to search for the lowest possible price for a generic drug.

Primary care providers are mandatory members of regional associations that negotiate contracts with sickness funds to come up with a fee-for-service scale under which they are paid. Germany does not as yet have a pay-for-performance system or bundled payments. Moreover, hospitals must perform a minimum number of procedures in order to receive reimbursement for certain procedures.

Similarly, primary providers receive reimbursement for no more than a limited number of patients they can see and must perform no more than a set number of procedures per person for which they will get reimbursement. In-patient care is paid per admission based around 1,200 DRG categories.

Despite these measures, healthcare costs in Germany, as throughout the world, are on the rise secondary to both demographic transitions including a burgeoning refugee population, as well as medical cost inflation. Further measures and strategies are needed to try to control costs while insuring the population.

## **Editor's comments:**

*According to U.S. News and World Report, the German health care system ranks 5th in the world based on perceptions made by its users. (Denmark was ranked 1st, New Zealand 10th and the United States 15th.) According to former labor secretary Robert B. Reich\*, about 17 percent of middle-class wages in the U.S. go to health coverage. German wage earners, after deducting 7.3% for SHI, and an additional 1.175% and 1.3% (average) for old age/nursing care and long-term care, respectively, top out at about 10%. It seems the Germans pay less and get more. American physicians do make more money, once they get out of debt.*

*\*quoted in Gut Check on NBCNEWS.com*

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# Individual Care to Population Health: Experiencing a Paradigm Shift

By Louis Verardo, MD, FAAFP

My training in the 1970s reflected the changes occurring in both the healthcare system and American society at the time. Family practice (the initial designation of our newly-formed specialty) had been developed from a long-standing tradition of general practice, but with a new mandate: to serve as a response to not only the increasing fragmentation of scientific medical care, but also its oft-perceived impersonal nature. New understanding from the social sciences helped in the creation of the biopsychosocial model, which became a response to a purely reductionist view of illness as experienced by the patient. Recognition that “common things occurred commonly” provided the rationale for curriculum which emphasized the usual reasons people sought medical assistance, the typical diseases and conditions seen in community practice, the need to provide care in a variety of settings, and the expectation that newly-graduated residents would be integrated into the existing healthcare systems throughout the country by joining a practice, taking an academic position, and serving on a hospital staff. All of this, while providing the full scope of practice which this new specialty envisioned for its members.

And for a while, that was how it went. Family physicians spread into communities throughout the country, although we were most warmly welcomed in rural locations, where a “jack of all trades” clinician filled a real and necessary need. In my own experience, my initial practice was in such a community, where I was able to reverse a prior trend of 85% of medical care going “off-island” (I was in coastal New England) and where I was able to utilize the full scope of the training I had previously completed in a suburban community hospital.

Which brings to mind another important note: most of the residency programs initially approved in our discipline were located in community hospitals, often with no other competing graduate medical education programs. This was a departure for the AMA (the main body responsible for postgraduate training at the time), and it allowed for the explosive growth of residencies once family practice became a recognized specialty in 1969. However, there would be a catch: the hospitals hosting these new, training programs would struggle continually to balance service

and education for the trainees in its programs, and would need to recruit clinical faculty to serve as teachers for the residents. This is where an affiliation with an academic medical center would provide the prestige of a faculty appointment to the generalists and specialists on the hospital’s medical staff, plus bring in continuing medical education resources useful to the local medical community. Enthusiasm for the graduate medical education presence within the hospital was at times variable, but economic incentives, enhanced opportunities for specialty referral, and genuine commitment to medical excellence all combined to create a workable system which turned out good clinicians able to admit hospitalized patients, perform common office surgical procedures, provide well child and maternity care, and deal with a range of behavioral conditions seen regularly within the general population.

There were several core values emphasized during my training, and repeatedly highlighted by my preceptors during our work in a variety of settings. One was care of the whole family: we were given a panel of patients during our first year and expected to deal with any illness encountered by those family members throughout our three years of residency. That required a knowledge of any needed vaccinations and an understanding of other preventive care measures across a wide age spectrum, plus a working database of disease states expected in both children and adults. Another was continuity, which meant following your patients longitudinally across a variety of healthcare platforms, and often regardless of whether you were officially on duty. A third was the need for continuous self-learning, given the ongoing explosion of medical information. A final core value was a sense of being part of a medical community. Our hospital had a doctor’s lounge and a small coffee shop where a surprising amount of informal consultation and inter-specialty medical communication was exchanged; in addition, it fostered a strong sense of professional identity.

The subsequent years and beyond brought significant changes to undergraduate and graduate medical education, to daily practice, to the primary care workforce, and to the medical profession’s sense of itself. Increasing medical student debt burden provided incentives to shorten undergraduate education from four to



three years. At the same time, consideration was given to “track” medical students into differing class schedules, based on a stated preference for surgical versus non-surgical career choices. Graduate education was now undergoing significant restriction in the hours worked as a result of the Libby Zion case, with concerns raised about the implications for resident readiness to assume full clinical responsibilities upon graduation. Managed care had appeared as a solution to rising medical costs but became a transformative (and disruptive) force in the patient-doctor relationship, as the main focus became not an individual patient seeking care from a specific doctor, but rather a clinician taking responsibility for a panel of patients grouped solely by the fact of having similar insurance coverage. New colleagues appeared, in the form of PAs and NPs, who were eager to become part of the clinical workforce and were initially willing to work collaboratively with existing doctors as “physician extenders”. Finally, the medical profession saw itself being transformed from a “cottage industry” (individual private practitioners, autonomous in setting their own rules and regulations, including fee structures) into a more corporate entity, now subject to mounting regulations on a variety of fronts (government and insurance companies) and increasingly perceived as a business rather than as a learned profession.

Along with these changes came the perceived need to fundamentally revamp the entire care delivery system. While the official reason given was improved health, economic motivation was apparent as well, as local, state, and federal government officials struggled to contain costs. Now, the plan was to look at a population (defined in various ways), project its potential for illness (including mental health issues), promote its wellness, devise a way to provide primary, specialty, and tertiary care, and do so in a way which brings down overall costs. Quality of care would be assessed with a variety of metrics (developed through national guidelines), finances would be used to reward “good” clinicians (and perhaps weed out “low value” care being given to patients), large aggregates of data would be collected from EMRs via computerized links, and statistical analysis would enable hospitals, “providers” (a term which now included non-physician practitioners), and communities to generate a health “scorecard”.

There are some practical problems inherent in such a system. One is the current lack of interoperability among the different EMRs. Currently, there are a handful of large systems which have achieved some limited capability to exchange data between different electronic medical records. My own experience with our current EMR has given me a sense of the hurdles that must be overcome in trying to collect simple data from several independent community hospitals as well as the local labs and x-ray facilities. Another is the fact that all the clinicians present in a local population are not either employed by, or even affiliated with, some central medical entity. Until that happens, there will be medical impacts on a community which will not be under some form of centralized

control. That means not only economic control, but also in terms of providing some form of standardized care. My own institution, like other groups around the country, is growing its network and utilizing standard care measurement metrics to “brand” itself in a distinctive way, with expectations for quality control, name recognition, and economic success.

An additional issue is the need to gather large volumes of data during what had traditionally been a highly personal encounter between the doctor and patient. Patients are increasingly subject to an intense series of questions, beginning from the creation of an appointment, continuing throughout the office encounter (accompanied usually by a harried clinician typing on a keyboard with back turned to the patient), and often followed by a “post-marketing survey” designed to assess the effectiveness of said encounter. Clinicians are required to document large volumes of data detailing not only the chief complaint, reason for visit, and the actual physical exam (all required previously as well in a paper system), but also key preventive items, various behavioral aspects of the social history, and significant measurements defining a patient’s readiness to participate in their own health decisions. It’s not that such information isn’t important, it clearly is; the issue is whether documenting such information during a time-limited visit is an optimal use of an already tightly-scheduled clinician. One other point and this is philosophical. I perceive some of this information as more appropriate to the realm of public health, or at least some version of preventive medicine not involved in direct patient care. Taking care of patients is messy, burdensome, and difficult; it is also joyful, fulfilling, and extremely satisfying. Those of us who see patients understand these sentiments. Had we wanted something a step removed from the bedside, we would have opted for that.

So what implications are there for our current and future workforce? For those of us well into our work, change requires adaptation. That may mean discarding certain treasured workflow processes and creating new ones. I never learned to type, so I dictated throughout most of my career. Voice recognition programs exist, but the EMRs often still require keyboarding to get the needed “clicks” for billing and metric data collection purposes. Scribes are one answer, but they are an expense which may not be an available option for everyone. I have been advised to learn typing; at my age of 66, I will attempt to renew the synaptic plasticity of my neurons one more time, having used most of that reserve for learning new drugs from *The Medical Letter*. I have reluctantly surrendered my devotion to continuity to the needs of accommodating a hectic schedule of patients shuttling to and from nearby hospitals and their EDs for “transition of care” appointments (made more challenging by the fact that my colleagues and I no longer personally attend to our admitted patients, due to the presence of hospitalists). I spend hours

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connected to my “virtual office” after I leave my physical one, and the availability of instant digital communication has meant that I am really never “off call” (sadly, even on vacation, otherwise I face an overstuffed digital message box crammed with labs, prescription requests, and reports to review while I am facing a packed schedule of patients requiring my full attention).

And what about our future colleagues in family medicine? Are we training our residents correctly to enter a field very changed from our own experience? Well, like everything else in medicine, the answer is: it depends. Having been involved in residency training as faculty until recently, I feel that ACGME guidelines for our specialty have continued to stress the needed breadth of training expected for a family doctor to work in a variety of settings. What I might begin to add would be enhanced training in clinical epidemiology and statistics usually given in preventive medicine residencies (especially via an MPH degree), plus exposure to some administrative training beyond practice management, a subject already covered in current core content guidelines. Both of these would provide tools for future work within the care of focused populations, as well as prepare physicians for functioning within a healthcare team in which he or she might be managing teams of advanced practice nurses, physician assistants, and non-degree patient care specialists.

Future colleagues in family medicine have grown up in a digital world from day one. While their familiarity and comfort with computers in general will make them uniquely qualified for managing large data sets and whole populations, they will also need to maintain the fund of knowledge, bedside manner, and communication skills required to deliver competent and compassionate personal care to individual patients.

In this paradigm shift, we gain the ability to improve “throughput” of patients, but we lose the continuity of keeping those patients and their doctors together. We gain the potential to provide an impressive array of preventive services, including mental health services, but we lack the infrastructure within most primary care practices to replace the loss of a robust public health safety net for some communities. We have a business model now for health care, more corporate in structure, and not at all like the “mom and pop” nature of the primary care landscape in which I trained, but we struggle with the loss of our former professional identity as we create a new sense of ourselves.

Finally, a couple of quotes:

**This from the 1949 issue of a British medical journal:**

*‘How does one become a good doctor? When one doctor says of another, “He is a good doctor”, the words have a particular meaning. You will hear the expression used not only about some general practitioners, but also about some specialists. As I understand it a good doctor is one who is shrewd in diagnosis and wise treatment; but, more than that, he is a person who never spares himself in the interest of his patients; and in addition he is a man who studies the patient not only as a case but also as an individual... The good doctor, whether general practitioner or specialist, is also a man who studies the patient’s personality as well as his disease’*

**And the second one is from Dr. William Bean, in a 1963 issue of Archives of Internal Medicine:**

*‘The one mark of maturity, especially in a physician... is the capacity to deal with uncertainty’*

I can’t imagine better advice heading into a paradigm shift.

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# Meaningful Use, the Patient-Centered Medical Home and Other Oxymorons

By David Silverstein, MD

## Introduction

In a 2016 Medscape survey of more than 19,000 physicians, 73% of family physicians said that they would again choose medicine as a career but only 29% said they would again choose the same specialty.<sup>1</sup> They still viewed medicine as a potentially rewarding profession but felt they had made a terrible mistake by becoming family doctors. A 2017 survey found that only 29% of family physicians reported being very happy at work and 55% reported burnout, increased from 43% only four years earlier. The top four causes of burnout were: too many bureaucratic tasks; too many hours at work; feeling like just a cog in a wheel; and increased computerization of practice.<sup>2</sup>

It is my thesis that the main culprit behind physician dissatisfaction is the widely heralded “practice transformation” movement that has taken hold over the last decade, particularly as spearheaded by the Health Information Technology for Economic and Clinical Health Act (HITECH) (commonly referred to as Meaningful Use) and the Patient-Centered Medical Home (PCMH) initiatives. In spite of the best intentions, these programs have demonstrated at best limited benefit at tremendous cost; at the same time disrupting the practice of medicine in general and in particular compromising the doctor-patient relationship that is at the core of family medicine.

## Electronic Health Records

Although physicians were being encouraged to adopt electronic health records (EHRs) in their practices, by early 2008 only four percent of physicians reported having an extensive, fully functional electronic records

system.<sup>3</sup> In 2009 as part of the American Recovery and Reinvestment Act, HITECH authorized up to 30 billion dollars in incentive payments through Medicare and Medicaid to clinicians and hospitals in order to encourage the rapid adoption of EHRs. Beginning in 2011, the Electronic Health Records Incentive Programs were developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology. Each physician was eligible for incentive payments of up to \$44,000 through Medicare or \$63,750 through Medicaid for demonstrating meaningful use.<sup>4</sup> As of October 2015, more than 479,000 health care providers received payment for participating in the Medicare and Medicaid EHR Incentive Programs,<sup>5</sup> and 78% of all office based physicians reported use of a certified EHR.<sup>6</sup>

There is no arguing with the success of HITECH’s meaningful use incentives in bringing EHRs into family doctors’ offices. Although EHRs remain imperfect tools, few continue to debate their utility or demand a return to paper records.<sup>7</sup> Electronic prescribing, monitoring test results and tracking preventive services are just a few of the ways EHRs vastly outperform paper records. However, it is the way we have incorporated them into our practices that has challenged our ability to provide care to our patients and resulted in physician unhappiness. In a survey of 6375 physicians, doctors reported high levels of dissatisfaction with their EHRs which impaired their efficiency without improving patient care.<sup>8</sup>

Much of the dissatisfaction with EHRs results not from the EHR itself, but from

the necessity of reporting quality measures. State and regional agencies currently use 1367 quality measures, few of which are used by more than one agency. A study of 23 health insurers found 546 provider quality measures, few of which matched across insurers. Practices report spending 15.1 staff hours per week per physician dealing with external quality measures, including 2.6 hours of physician time that could otherwise be used seeing nine additional patients. At an annual cost of \$15.4 billion dollars, few physicians believe the measures they are reporting are representative of quality of care.<sup>9</sup>

As EHRs have become the norm in most practice settings, the computer has come to command most of the physician’s attention. In a recent study, physicians spent approximately half of their office time on EHR and desk work – twice as much as they spent on direct clinical face time. Additional hours were spent outside the office completing EHR related tasks.<sup>10</sup> A study of Swiss internal medicine residents found that in a typical shift they spent an average of 1.7 hours with patients and 5.2 hours using computers.<sup>11</sup>

In spite of the time and money invested in EHR use, numerous studies have documented the inaccuracies introduced into the EHR and negative outcomes that may result.<sup>12-15</sup> Put more plaintively, “The records are full of lies.”<sup>16</sup> With the ease of point and click, drag and drop, cut and paste – compelled by the demands of coding and documentation guidelines, quality reporting, defensive medicine, meaningful use attestation and PCMH recognition, the resulting EHR is a bloated, unreadable

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document that at best fails to tell the patient's story and clearly state the physician's thinking about the case, and at worst is a fiction with a detailed templated history that was never taken and a physical exam that was never performed.

It is the patients' and physicians' descriptions of their personal experiences with EHRs that tell the full story more compellingly than any research report. Dr. Elizabeth Toll, in an "A Piece of My Mind" commentary in JAMA that should be required reading for all medical students, residents and practicing physicians, describes the "stunning feedback" a highly regarded pediatric chief resident received from his seven year-old patient in the form of a crayon drawing of her recent office visit. It showed the patient on the exam table, her family sitting around her smiling, and the pediatrician with his back to them, staring intently at his computer.<sup>17</sup> Also worth viewing are a series of promotional videos produced by Athena Health called "Let Doctors Be Doctors." In one vignette, proud parents watch their young son typing at a laptop before declaring "Honey look! He's playing doctor!"<sup>18</sup>

## PCMH

The first mention of the term medical home appeared in Standards of Child Health Care, a book published by the American Academy of Pediatrics (AAP) in 1967. The book defines a medical home as one central source of a child's pediatric records and emphasizes the importance of centralized medical records to children with special health care needs. In 2002 the AAP published a policy statement, The Medical Home and implemented a Medical Home Training Program.<sup>19</sup>

Also in 2002, the leadership of seven national family medicine organizations initiated the Future of Family Medicine project. "The goal of the project was to develop a strategy to transform and renew the discipline of family medicine to meet the needs of patients in a changing health care environment." "In this new medical home, patients receive a basket of acute, chronic, and preventive medical care services that are accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians."<sup>20</sup>

In 2006 the American Academy of Family Physicians (AAFP) launched the first national demonstration project on practice transformation to a patient-centered medical home through its wholly owned subsidiary "TransforMED" and subsequently guided the PCMH transformation efforts of nearly 700 primary care practices.<sup>21</sup> In that same year the American College of Physicians issued a policy monograph calling for a "comprehensive public policy initiative" supporting what they called an Advanced Medical Home.<sup>22</sup>

In 2007, the AAFP, the ACP, the AAP and the American Osteopathic Association (AOA) issued a joint statement of the principles of the PCMH. Those principles included having a personal physician trained

to provide first contact, continuous and comprehensive care; a focus on quality and safety; enhanced access and appropriate payment.<sup>23</sup>

In 2008 The National Committee for Quality Assurance (NCQA) launched its medical home recognition program at the request of and in collaboration with the AAFP, the ACP, the AAP and the AOA.<sup>24</sup> This recognition is accomplished by receiving a passing score on the NCQA survey tool, measuring performance on 6 standards comprised of 27 elements containing 178 factors. In the overview of its 2014 Standards and Guidelines, NCQA asserts that "patient-centered medical homes (PCMH) are transforming primary care practices into what patients want: a focus on patients themselves and their health care needs. Medical homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and cost."<sup>25</sup>

By May 2015 the total number of PCMH sites with NCQA recognition stood at 10,098 with 48,617 recognized clinicians in 50 states, the District of Columbia and Puerto Rico.<sup>26</sup>

At its website, the NCQA annually highlights the latest evidence of the benefits of the PCMH. In its 2016 review it concludes, "Patient-Centered Medical Homes are driving some of the most important reforms in healthcare delivery today. A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes. The evidence we present here outlines how the medical home inspires quality in care, cultivates more engaging patient relationships, and captures savings through expanded access and delivery options that align patient preferences with payer and provider capabilities."<sup>24</sup>

Others less sanguine, report mixed results.<sup>26-28</sup> A 2013 review concluded, "The PCMH holds promise for improving the experiences of patients and staff and potentially for improving care processes, but current evidence is insufficient to determine effects on clinical and most economic outcomes."<sup>29</sup> A multistate PCMH demonstration project conducted by CMS concluded by finding "very few consistent, favorable changes associated with the...Demonstration across the eight states."<sup>28</sup> The RAND Corporation reported on its independent review of another CMS demonstration project intended to support the transformation of 500 Federally Qualified Health Centers (FQHC) into NCQA Level 3 PCMHs. CMS provided technical assistance and quarterly payments of \$18 per Medicare beneficiary in support of transformation. It concluded that transformed practices showed significantly higher utilization and costs, more hospital admissions and readmissions and more ER visits. Costs per beneficiary per quarter were \$65 to \$101 more in the intervention sites than in the control sites. In a remarkable understatement, the authors of the RAND study concluded that "it is unlikely that overall costs associated with the demonstration at its completion will be lower for demonstration FQHCs than for comparison FQHCs."<sup>30</sup>

It would seem that at the least, a Patient Centered Medical Home



would have as its central focus the things that patients really want from their physicians – expertise, competence, and good judgment that they use to treat illness and relieve suffering; listening carefully to their concerns and responding to their questions; truly caring about them as individuals; showing kindness, empathy and respect while offering hope for the future.<sup>31-32</sup> “When people are asked about their health care experiences, they speak about the interaction between them and their doctors. The doctor-patient relationship remains at the heart of people’s perceptions of health care...innovations that aim for patient-centeredness should aim to strengthen the doctor-patient relationship.”<sup>33</sup> Yet the six standards of the 2014 PCMH program and their six “must-pass” elements make no mention of the doctor-patient relationship.<sup>25</sup> Thus it is not surprising that at least one study concluded that “highly motivated practices can implement many components of the PCMH in 2 years, but apparently at a cost of diminishing the patient’s experience of care.”<sup>34</sup>

While failing thus far to convincingly demonstrate meaningful results in achieving the Institute for Healthcare Improvement’s “triple aim” of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care,<sup>35</sup> PCMH transformation has been highly disruptive to the primary care practices that have chosen to transform and has imposed a tremendous additional layer of cost onto the provision of care. In a seminal analysis of PCMHs in Utah and Colorado, it was determined that the annual cost to a practice of sustaining a PCMH averaged \$105,000 per FTE clinician.<sup>36</sup>

Dr. Jan Gurley voices the experience of many practicing physicians in concluding, “The data on the much-lauded PCMH approach, a cornerstone of ACA, shows that it is expensive, onerously bureaucratic, a drain on health care resources, especially for primary care providers, and a distraction from health care delivery.”<sup>37</sup>

## “Solutions”

Although EHRs have improved tremendously over the last 10 years, the user interface remains suboptimal – far inferior to the most commonly used commercial and consumer software. This is not surprising if we understand that EHR adoption was not the result of market-driven user demand, but instead resulted from external mandates and incentives that were not aligned with the needs of the user. The process of data entry needs to be streamlined and more intuitive, the number of clicks slashed, redundancies eliminated. Voice recognition needs to be more seamless. Two-way natural language interaction enhanced (think “Siri”). Interoperability of different systems needs to be improved to fulfill the promise of a universal medical record. In particular, in addition to knowing in real-time what is happening to our patients in other settings, we need to avoid expensive, unnecessary duplication of services such as diagnostic testing and immunizations. In some cases physicians are not being reimbursed for services because the payer (but not the physician) is aware that they are redundant and unnecessary. Regional Health Information Organizations (RHIOs) such as HealtheLink<sup>38</sup> are a step in the right direction.

It has been suggested that we need to expand the Triple Aim to a Quadruple Aim that includes improving the work life of health care clinicians and staff.<sup>39</sup> This is to be accomplished by adjusting workflow and adding staff to perform tasks that do not require a physician’s participation. We are encouraged to employ more scribes, clerks, medical assistants and nurses. It is of course better to delegate meaningless, time-consuming tasks to staff – but better still not to perform meaningless tasks at all! Instead of *meaningful use of medical records*, the entire health care team wants to be engaged in meaningful work that clearly benefits the patients we care for. We need to stop investing scarce resources and increasing the cost of care to rearrange the deck chairs on the Titanic.

## Conclusion

With the best of intentions and indisputably worthwhile goals, HITECH, PCMH and similar initiatives have inadvertently contributed to the transformation of US healthcare into an enterprise that increasingly fails to address the most basic concerns of patients and doctors alike. The specious assumption underlying “transformation” is that the problems with the US healthcare system rest in the primary care office, and that by reengineering primary care into a medical home that can navigate 178 factors, the laudable goals of transformation can be achieved.

The NCQA has identified the following goals for PCMH<sup>40</sup>:

- Primary care clinicians will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.
- Primary care will be the foundation of a high-value health care system that provides whole-person care at the first contact.
- PCMHs will show the entire health care system what patient-centered care looks like: care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions.”
- PCMHs will revitalize the “joy of practice” in primary care, making it more appealing and satisfying.

Every family physician will recognize these goals as being virtually identical to the core principles of our specialty that were learned in residency and which we continue to strive for in our practices. Only by continuing to stand up for those principles and implementing them in our daily practice while resisting efforts to transform the doctor patient relationship into a lifeless computerized facsimile, will we sustain the joy in practicing medicine while providing what our patients want most – a competent, caring, compassionate family doctor.

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# Anabolic Steroids

By Michael Kernan, MD and Payam Hadian, MD



**In** a passage from Jose Conesco's 2005 *Juiced*, the six-time Major League All-Star wrote an illuminating passage regarding his admission using performance enhancing steroids, "Sure I tampered with my body chemistry — and I emerged more than human! It's only a matter of time before an entire race of people are raised on steroids, and who knows what they'll be able to accomplish? Live to 150 years old, remain sexually potent into your nineties, interbreed with dolphins and whales, there's literally no limit to what steroids can do for a person. *Do you know what it means to feel like God?*"<sup>1</sup>

This passage from *Juiced* delves deep into the psyche of an individual who abuses steroids. His words are striking; "Do you know what it means to feel like God?" This is not a patient who is having active psychosis. This text reflects the euphoria of smashing through plateaus and experiencing a metamorphosis that can take a "scrawny chump" into a modern Hercules. With that in mind; imagine having a discussion with Mr. Conesco during a 15 minute encounter discussing the serious risks of steroids. How would you start a conversation? How would you discuss risks? How would you address their concerns? Would you prepare to discuss their personal fears? Individuals decide to take steroids for various and complex reasons, from "everyone else is doing it" to "impressing a former significant other." As a family physician, our medical opinions for the most part are based on scientific evidence. As the knowledge base expands guidelines can be created, remain, be modified, or removed. But most importantly, when it comes to helping our patient's make the best decision for their health it requires us to understand the world of steroids from their perspective.

Steroid abuse is not limited to Jose Conesco and other professional athletes. Estimates from the Substance Abuse and Mental Health Administration release of the National Household Survey on Drug Abuse estimate that 0.5% of the adult population have used steroids illicitly; between the ages of 18 and 34 it is estimated that 1 percent have used illicit steroids.<sup>2</sup> Individuals at risk of using steroids include athletes and bodybuilders, but also individuals in professions that require strength to excel in their occupation like police officers, construction workers, or fashion fitness models.

With that information, the question of how to identify individuals using steroids in the clinical setting is challenging. Currently there are no specific steroid screening guidelines for the general population. In an ideal world, patients would be forthright and candid about their use. However the internal conflict about the ethical and legal use of steroids has led to a plethora of anonymous internet forums where open discussions exist between steroid users. For example, a forum board topic titled "Do you tell your Doc you are on Steroids?" where patients consider disclosure of the use of anabolic steroids to their primary care physician.<sup>3</sup> The common concern of most patients is about the documentation of their use of anabolic steroids in their medical records. The message forums between anabolic steroid users discuss the possibility of information in their chart being used against them in the future for various types of instances; for example "life insurance." Of note- there is a wide consensus that the only scenario to fully disclose anabolic steroid use is for an acute life threatening emergency. So this brings us back to the original question of how to determine if a patient is abusing steroids. The simplest way is if the patient volunteers this information via questionnaire or during your clinical encounter. Suspecting steroid use requires experience and contextual information that is just not available during one office encounter. Building a trusting relationship through a non-judgmental environment ensuring the comfort of the patient is the most effective method to pick up on steroid abuse. You may recall in the media that finding athletes using steroids is often felt among the steroid community as a political witch-hunt where the steroid user is deemed a "cheat" and further demonized as a person of "fundamentally flawed character." As a family physician, our primary goal is to lend an empathetic ear and understand. The more our patient's feel our empathy, the more they will be willing to share.

It is extremely important to detect anabolic steroid abuse. These drugs carry a substantial list of harmful effects.

The National Institute of Health publication on drug abuse lists short and long term effects of steroid abuse.<sup>4</sup> Short term effects include paranoia, jealousy, extreme irritability, impaired judgement, and

extreme mood swings. Long term effects of steroids include renal failure and liver damage, as well as cardiomegaly. Physical signs in males include hypogonadism, decreased sperm count, gynecomastia, and increased prostate size. In women, the signs are more dramatic in their appearance: women can experience patches of facial hair, male pattern baldness, deepened voice, clitoromegaly, as well as menstrual irregularities.<sup>4</sup> Patients who are using steroids often only see the benefits of increased muscle mass and the overall appearance of vitality. For that reason it is extremely important to have a discussion of the long term effects that steroids can have on the body. The idea is to bring up the risks of steroids so patients can make the best informed decision for their health and life goals.

The United States Drug Enforcement Administration brochure on steroid abuse details the effects of steroids that users find extremely beneficial. Primarily the promotion of lean body mass, increased strength, decreased recovery time between workouts, and finally the substantial increase in muscle size.<sup>5</sup>

Use of steroids without a prescription from an authorized provider is illegal in New York State as it is across the United States. The source of illicit steroids according to the Drug Enforcement Agency includes the reallocation of properly prescribed steroids for various ailments like hypoandrogenism, illicitly smuggled from other countries like Mexico and China, to home synthesis with basic lab sets.<sup>5</sup> The general truth is that if someone wants to be on steroids, they will have very little difficulty obtaining them.

Steroids are taken via various routes including intramuscularly, subcutaneously, by mouth, or applied to the skin thru gel or patch. Of note, for illicit use the most common routes are intramuscularly and by mouth. There are various dosing strategies that users employ when administering steroids. The first is the concept of the "cycle." Cycle or cycling employs a schedule of taking a single steroid or multiple steroids over a period of weeks. A typical cycle lasts approximately six to twelve weeks but can be up to 18 weeks. When a user takes more than one steroid during a cycle the term is called "stacking." The combination of taking multiple steroids during a cycle or stacking allows the abuser to further increase his or her protein synthesis potential during the cycle. For a novel user of steroids the cycle which stacks both Testosterone-Enanthate and Deca Durabolan for approximately 12 weeks can be used.<sup>6</sup> Results can be dramatic; it is typical for users to put on at least 15 to 20 lbs. of pure muscle.

Androgen anabolic steroids that are used illicitly are synthetic variants modeled after naturally occurring molecules. The first term, androgen, describes the influence for the development and promotion of male features and attributes. The term anabolic refers to the synthetic molecule's ability to promote a state of synthesis and growth as opposed to molecular breakdown. Finally the term steroid elucidates the molecular structure and cellular action mechanism; an organic compound. This differentiates steroids from other androgenic molecules such as anabolic peptides (e.g. human

growth hormone). The family physician may feel overwhelmed with the numerous synthetic options available to steroid abusers- indeed the mechanism of cellular action for steroids is complex and varied. However most of what the family physician should understand is that the end result is generally a substantial increase in the amount of protein synthesis in the affected cell.<sup>7</sup> The molecular characteristics of steroids occurring naturally in the human body are derived from cholesterol as the template molecule, thus giving the steroid lipophilic properties. It is the steroids lipophilic properties that allow the molecule to transverse the plasma membrane of the cell into the cytoplasm. In the cytoplasm or in the nucleus, steroid hormones bind to specific protein regulators that then target specific promotor regions in the genome to increase transcription, with the effect lasting from hours to days. It is through this general mechanism that patients using steroids can expect rapid gains in muscle. The results are often dramatic and can be noticed by a physician if they have seen the patient before they start the cycle.

Each person has a different story as to why they take steroids, each with his or her own risk/benefit calculation. The answers can range from "I was tired of getting bullied at school" to "I need steroids to help me reach my goals in the gym." In the end, the family physician is in a unique role to provide a safe, compassionate environment to discuss the serious risks of anabolic steroids. It is important to be empathetic, address concerns and listen to what makes steroids beneficial to them. The primary goal is to have an honest discussion about the use of steroids. My goal as a family physician is not to persuade an individual to take one particular course because of my view. I believe the individuals I treat will find what is right for them and best fits their story.

## Endnotes

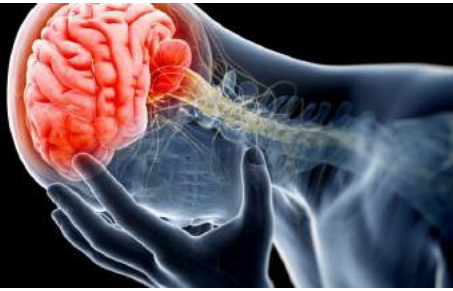
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# Chronic Traumatic Encephalopathy: A Review

By Sergio Guiteau, MD

## Case

A 59 year old male presents for initial evaluation of memory loss. He states that over the last 5-10 years he has had progressive trouble remembering both recent and past events. On a recent family vacation to Hawaii he repeatedly struggled to remember why he was on the plane and where he was going. These are episodes he says he often experiences when traveling. His wife who accompanies him today states that he has become more agitated and has been having emotional outbursts which she states is out of character for him. He denies any family history of dementia and reports no history of substance abuse. When questioned about a history of recent fall or head trauma he states that he doesn't remember falling but reports multiple concussive events as a running back during his 8 year professional football career. When asked about the number of concussions he may have experienced, he replies that he doesn't recall how many but knows they were numerous.

## Introduction

In spite of recent rule changes and a more heightened focus on player safety, concussions continue to be an unavoidable problem in many sporting events. While we in the medical community have made some advancement in our understanding, management, and prevention of acute concussions, we continue to struggle in our understanding and ability to treat the effects of chronic concussive events. What we do know is that multiple concussions over time seem to result in a process which we have termed *Chronic Traumatic Encephalopathy* (CTE). More formally, CTE is defined as a progressive decline in mental health and function as a result of repeated cerebral trauma.<sup>10,13</sup> Traditionally, when these symptoms were seen in boxers it was known as dementia pugilistica – a term derived from the word pugilist, which is the classic definition of the word boxer. In the 1920's, Harrison S. Martland was the first to observe that chronic cerebral injury which resulted in multiple concussion hemorrhages seemed to be correlated with eventual neurologic and physical impairments.<sup>11</sup> His findings were published in JAMA in his keystone article aptly titled *Punch Drunk*.<sup>11</sup> Fifty years later, Corsellis and his colleagues examined the neurologic anatomy of 15 deceased boxers with symptoms of dementia pugilistica, which had now been accepted as the term CTE.<sup>4</sup> Based on this study they were able to describe certain gross neurologic findings which seemed to be common among the deceased athletes. These changes are thought to directly contribute to a wide range of symptoms such as depression, memory loss, gait abnormalities, speech abnormalities, and confusion.<sup>1,9,13</sup> Because of these alarming symptoms and some of the high profile athletes that have been

linked to CTE, the long-term effect of multiple concussions over time has become a popular topic both in the media and within the field of sports medicine. In this article we will examine our most current understanding of CTE, with special attention given to pathophysiology, diagnosis, prevention, and current advancements in research.

## Pathophysiology

More recent advancements in molecular science and imaging have demonstrated that CTE is associated with tau protein deposition that is distinct from other tau related diseases because of its preference for specific areas of neuronal deposition.<sup>13</sup> Tau protein diseases often referred to as tauopathies, include such neurodegenerative processes as Alzheimer's disease, Parkinson's disease, and frontotemporal dementia. Tauopathies result when a neuro-protein known as tau dissociates from microtubules and becomes hyper-phosphorylated. These dissociated proteins then aggregate to form neurofibrillary tangles (NFT's). Tau NFT's are thought to result in the process of cerebral cell death by a currently unknown mechanism that is the subject of ongoing research.<sup>5,8,10</sup>

## Diagnosis

Despite our understanding at the cellular level, we have yet to establish a neuropathological or clinical guideline for diagnosing CTE ante-mortem. In fact our knowledge of CTE and its explicit clinical correlation is so limited that it does not yet have an associated ICD-10 code. As of today CTE is a post mortem diagnosis that can only be made through brain autopsy and evaluation looking for evidence of abnormal tau, NFT's, as well as other anatomic variations in specific neurologic distribution.<sup>12</sup> Current research as it pertains to an in vivo diagnosis of CTE has looked at a number of factors. These factors include CSF and serum markers such as the afore-mentioned tau, clinical evaluation and history, and neuroimaging approaches. One of the more recent neuroimaging techniques that has shown promise is the use of an MRI associated imaging technique known as Diffusion Tensor Imaging (DTI). DTI can more specifically determine damage to neuronal white matter tracts by evaluating the diffusivity of water molecules within different white matter regions, thus quantifying the location and extent of damage to specific areas of the brain.<sup>2,7</sup> Ultimately it is the hope that by elucidating a set of diagnostic criteria, either through protein antibody markers or by imaging technique, that we can begin to work on a set of guidelines to aid in the diagnosis, prevention, and treatment of CTE.<sup>6,14</sup>





# A SYSTEMATIC APPROACH TO THE DIAGNOSIS AND TREATMENT OF UNIPOLAR DEPRESSION AND BIPOLAR DISORDER

By Paul Rosen, MD, MA; Evangelos Giakoumatos, MD, MSc; and Scott Klenzak, MD

## Introduction

Increasingly, primary care doctors are called on to diagnose and treat a variety of common mental health conditions as part of their standard medical practice. These conditions cover the spectrum of mood disorders including unipolar depression, bipolar depression, adjustment disorder with depressed mood, and substance induced mood disorder. While some providers may feel confident in their ability to diagnose and treat depression, other providers may feel uncertain in their ability to diagnose and manage mental illness and may find it difficult to sort through the many diagnostic and treatment options. For those providers struggling with diagnostic uncertainty and selecting from literally dozens of medication choices, this article outlines a streamlined and effective approach to diagnose and manage depression.

Mood disorders are extremely common conditions and most often identified in primary care settings. While the incidence and prevalence of depression in the general population has been stable over the last several decades, the rate of disabling mental illness has dramatically increased.<sup>1</sup> The principal reason for applying for social security disability is now depression (having replaced musculoskeletal complaints of all kinds) and the leading cause of economic loss from disability worldwide is depression.<sup>2,3</sup> Primary care providers provide the bulk of care to these patients. Even as the number of primary care doctors per 100,000 population continues to shrink, the number of

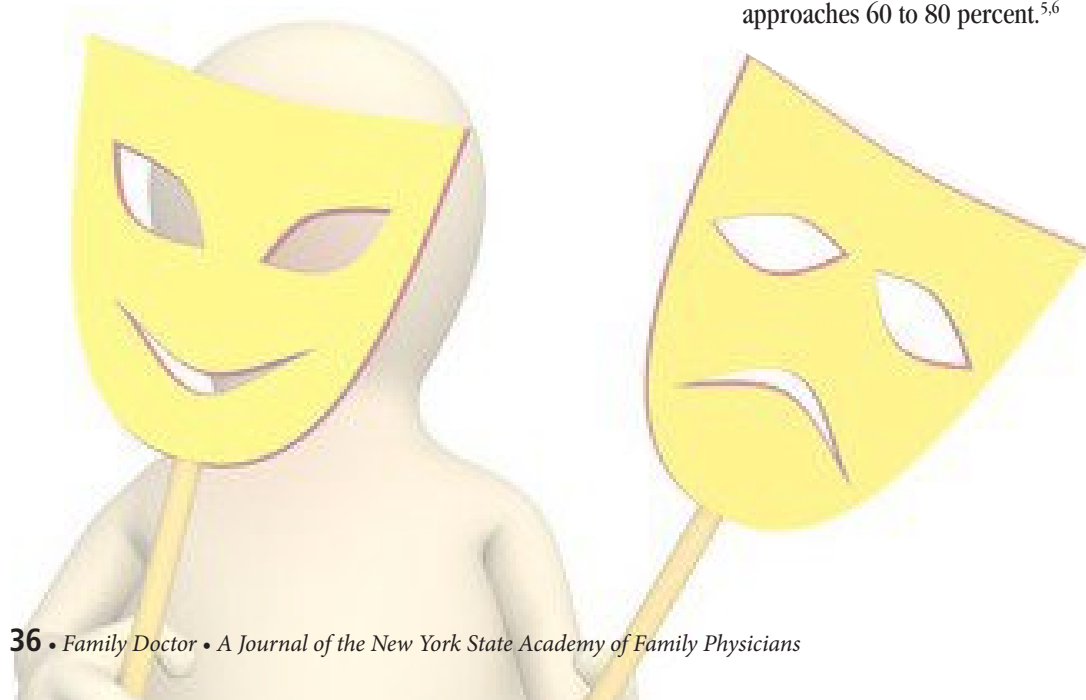
psychiatrists and mental health workers per 100,000 has fallen even further. Using New York State as an example, Manhattan has nearly 30 psychiatrists per 100,000 while other upstate urban areas like Buffalo and Syracuse have just over 10.<sup>4</sup> This contrasts with 93 active primary care physicians of all types per 100,000 in NYS.<sup>4</sup> Statistics for rural counties are even more alarming with little to no access to specialized mental health care. See Table 1 for psychiatrists in NYS city-centers.

**Table 1.** Number of psychiatrists per 100,000 people of major city-centers in New York State.

Data and table adapted from the Dartmouth Atlas of Healthcare.<sup>4</sup>

Location (in the state of NY)	Psychiatrists per 100,000
Albany	14.4
Binghamton	10.6
Bronx	21.2
Buffalo	8.6
East Long Island	17.3
Elmira	10.6
Manhattan	28.9
Rochester	10.3
Syracuse	11.3
White Plains	29.6

Further, both in NYS and nationally the emerging drug and alcohol epidemic (including injectable heroin and PO opioids [oxycontin]) has overwhelmed healthcare providers with patients requiring a high level of dual diagnosis care, i.e. substance abuse and dependency coupled with mood disorders.<sup>3</sup> Substance abuse overlaps mental illness of all types but in bipolar disorders and schizophrenia the rate approaches 60 to 80 percent.<sup>5,6</sup>



# DIAGNOSIS AND TREATMENT OF DEPRESSION ORDER FOR THE PRIMARY CARE PHYSICIAN

**Table 2-** DSM 5 Diagnostic Criteria for Major Depressive Disorder and Depressive Episodes

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) anhedonia:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The episode is not attributable to the physiological effects of a substance or to another medical condition.

Finally, it is well established that many patients often feel more comfortable and less stigmatised discussing mental health and substance abuse issues with their primary care doctor.<sup>7</sup>

## Evaluating the Patient who Presents with Depressed Mood

Patients with depression present in a variety of ways. There are several evidence based screening tools that providers can use (see link at the end of the article for resources). Some patients clearly state that they are depressed with little inquiry or prodding from the treating physician. The physician can use the mnemonic SIGECAPS to flesh out the patient's symptoms. The clinician should ask about: Sleep, Interest, Guilty feelings, Energy level, Concentration, Appetite, Psychomotor changes, and Suicidal ideation or actions. This well-known mnemonic correlates well with the DSM-V diagnostic criteria for major depression (**See Table 2**). Further questioning should aim to determine if this is a unique event or a recurrence of an underlying depressive disorder with past episodes.

Other patients may simply appear sad (sad affect), depressed or even hopeless at the time of their office visit or may present with verbal clues that they are depressed. Clinicians should take the time to probe further: "Have you been feeling sad or depressed lately? Have these feelings interfered with your ability to function at work or at home?" Patients may need some empathic prodding to share their symptoms and suffering.

Another subset of patients often presents with vague or even specific somatic complaints that may be caused by an underlying depression, i.e. fatigue, lack of energy, chronic aches and pains, insomnia, poor appetite, lack of concentration at work, decreased libido, etc. Although somatization in depression is more common in children and adolescents, it is estimated that almost half of adults with depression present with primarily somatic complaints.<sup>8</sup>

The provider will need to clarify the diagnosis with additional questions including: Is the depressed mood associated with total or near total loss of interest in previously pleasurable activities (anhedonia)? Has this state lasted for at least a few weeks? During this period of time has the patient taken alcohol or drugs like cocaine that could account for fluctuations or changes in mood? These are often delicate personal questions and must be approached with care and a non-judgmental attitude by the provider. There is a technique called pseudo-normalization of abnormal states that providers can use. For example, the clinician may ask: "Many patients drink alcohol from time to time as a type of self-medication to improve their mood. Does this apply to you?"

Patients who express significant suicidal ideation or harmful impulses during this questioning may need emergency treatment. The acutely suicidal patient may need to be sent to the ED to be

continued next page



assessed for possible psychiatric hospitalization. If so, you should emphasize that you will remain a key part of the treating team and will be included in their future care.

For the non-suicidal patient, the primary care doctor will need to review a few additional diagnostic concerns:

1. Is there a medical condition that is contributing to the patient's depressed mood e.g. hypothyroid, diabetes, fibromyalgia, post-CVA, post-MI?
2. Are alcohol or drugs part of the mood picture? If so, will the patient require detox, rehab or referral for substance abuse treatment?
3. Is the depression really part of a bipolar disorder? Two simple questions can help rule out a bipolar component: "Have you ever had or are you now experiencing racing thoughts?" You must explain to the patient that racing thoughts are too many thoughts at one time or the mind racing "like an engine out of control." You may be surprised at how many depressed patients recognize this element as part of their depression. The second question is: "Have you ever gone one or more days without sleep because you felt that you had too much energy? Or- have you ever willingly substituted lots of activities for sleep, activities like cleaning the house, spending all night on the internet?"
4. You want to find out if these "hypomanic episodes" (racing thoughts and energetic sleeplessness) are frequent, are distinct from feelings of depression or are mixed into the depressive feelings. Even one such isolated episode of hypomania or mania distinguishes this current depressed patient as bipolar.

Based on this clinical exam, you should have enough data to determine if the patient has unipolar major depression single episode, unipolar depression recurrent, depression secondary to a medical illness, depression secondary to use or abuse of substances (drugs or alcohol), or exhibits features of bipolar depression.

If this patient has no bipolar component and you determine that this is a new or recurrent unipolar depressed episode, you are now ready to start therapeutic medication. SSRIs remain the first line treatment for major depression, single episode or recurrent.<sup>9,10</sup> To make things even more straightforward for the clinician, there is considerable evidence that it is better for the provider to prescribe one antidepressant first line all the time for unipolar depression vs. trying to choose among several medications geared to the patient's specific circumstances.<sup>11</sup> One of the most neutral and safest SSRI for several reasons remains one of the oldest: sertraline. It is neither sedating nor activating, causes minimal weight gain, has been shown to be heart friendly, age friendly and has minimal drug-drug interactions and minimal contraindications.<sup>12</sup> With a benign side effect profile and a simple two-dose schedule starting at 25 mg and potentially

going to 50 mg, we recommend sertraline for every primary care physician.

If the patient's chief complaint associated with depression is insomnia, it may be tempting to prescribe a sedating antidepressant like mirtazapine or paroxetine. However, this type of prescribing has been shown to be counterproductive. The evidence demonstrates that one doctor prescribing sertraline as a first line all the time will have better results than the same doctor prescribing several different medications for different patients.

What are our expectations? We are looking for a 50% reduction of presenting symptoms associated with depression in the first month and a total resolution of the depression by the second month. Failure at either juncture is a cause to increase the sertraline to the maximum 50 mg. Of note, sertraline is sometimes prescribed at higher doses, for OCD for example, but there is minimal increased efficacy for depression beyond 50 mg.

Is the depression more complex based on the two-question interview (racing thoughts and purposeful activity in place of sleep) and more likely to be part of a bipolar diathesis? For these patients we recommend lurasidone 20 mg and titrate up over the next month to a max of 40 mg. The response of bipolar depressed patients to lurasidone is much more rapid than an SSRI for unipolar depression and within a week the patient should experience some improvement. Primary care providers may hesitate to prescribe an "antipsychotic" to their patients. However, we recommend lurasidone not only because it is FDA approved for bipolar depression, but primarily because it has a far more benign profile than other atypical antipsychotics with minimal weight gain and only rare instances of transient hyperglycemia or elevation of lipids. It is recommended to take in the evening with a small amount of food before bedtime because it can be sedating and the food helps with proper absorption.<sup>13</sup>

These patients should be seen weekly or biweekly as long symptoms persist. Upon complete remission of the depression in two months, the patient can come in monthly, and/or be referred for added psychological or social work counselling (assuming such support services are available). Many studies show that talking therapies when combined with medication work best.

### **Which Patients should be Referred Directly to Social Work or Psychiatry?**

- Any patient with a primary diagnosis of alcohol abuse or dependence and whose depression is secondary to substance use or abuse. These patients need a higher level of dual diagnosis care that allows for detox and rehab.
- Any patient with psychosis as part of their mood disorder. A psychiatrist should see these patients.

- Any patient with a probable double depression i.e. major depression superimposed on dysthymia. These tend to be more difficult to treat and may require a higher level of care.
- Any patient with complex social issues that lead to demoralization in addition to depression. These patients need a higher level of integrated care involving psychiatrists, social workers, and therapists.
- Any patient who after two months of therapy fails to achieve a complete remission of the depression despite noticeable partial remission.
- Any patient who is actively suicidal or involved in dangerous behavior directed toward self or others.
- Any recognized bipolar patient whose predominant mood is mania or hypomania or who rapidly cycles in and out of depressed and hypomanic states.
- Any patient who has failed multiple therapies in the past or who has been institutionalized or hospitalized in the past for mental illness.
- Any patient with intrapartum or postpartum depression. These patients require a higher level of care.

## Conclusions

Primary care physicians and physician extenders can and should treat common mental health conditions. We hope that this article encourages providers to expand their tool-kit to include the diagnosis and management of major depression and bipolar disorder. Treating these conditions can be extremely satisfying in helping patients experience significant relief from the substantial burden of depression on their lives and relationships. While some aspects of mental health treatment will require outside consultation and referral, we hope all providers make diagnosing and treating depression part of their routine screening and care. For those seeking more information, the AAFP has recently collected their best articles on depression and bipolar disorder, including screening, diagnosis, treatment, special populations, etc. These can be found on their website at the following link: <http://www.aafp.org/aafp/topicModules/viewTopicModule.htm?topicModuleId=6>

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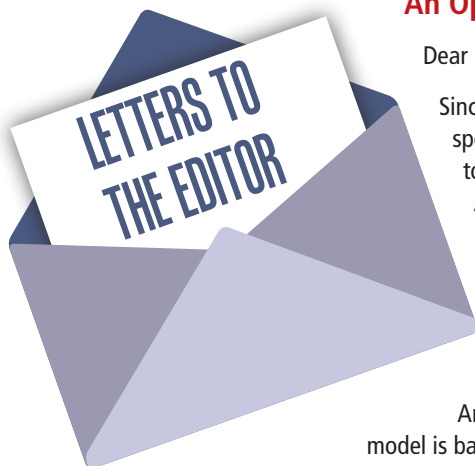
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## An Open Letter to President Donald Trump

Dear President Trump:

Since you are the newly elected leader of our country, I think it is a good time to bring you up to speed on the latest developments in my medical specialty which is family medicine. I am proud to say that America's family physicians have taken a leadership role in trying to ensure that all Americans have access to high quality affordable health care. Our quest has involved an historical evolution of different models of care. Discussion of these models sometimes makes me feel that we are awash in alphabet soup.

Let's start with the Patient Centered Medical Home (PCMH). This model was initially developed by our pediatric colleagues several years ago. It has been embraced by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA) and the American College of Physicians (ACP). Briefly, this model is based on the principles of team based care, population health and (my favorite) the notion that everyone in the US should have their own personal physician. Many family physicians currently utilize this model and it continues to evolve.

I am sure you have heard of the Affordable Care Act (Obamacare). You have already promised to repeal and replace it. Before you do that, I would like to call your attention to the fact that the ACA has decreased the number of uninsured Americans from 17% to 9.5% since 2011. This is a major achievement. I would hate to see these patients jettisoned without being offered an equally robust and affordable form of health insurance. I know there are problems with rising premiums and other issues related to Obamacare. But I believe there are enough geniuses in the federal government who could come up with a reasonable plan to provide affordable health insurance for all our people.

One of the care models that came out of Obamacare is known as the Accountable Care Organization (ACO). This model is based on the principles of team-based care management, more sophisticated electronic health records and the hiring of care managers to aggressively follow-up with patients who are not meeting quality parameters. Many family physicians have formed ACOs which involves extensive communication and negotiation with the Center for Medicare and Medicaid Services (CMS). The ultimate goal for ACOs is to reduce the cost of care by providing high quality value based care. Any savings achieved are shared by CMS and the participating physicians. My initial impression of ACOs is there is not a lot of savings to be shared. Starting an ACO is very labor-intensive for physicians. CMS needs to invest in primary care groups that want to start an ACO. We need investment in physician development and more sophisticated information technology. We can't pay for all of this out of pocket. The federal government and the insurance companies need to invest in family medicine and primary care in general if we are to achieve better health and improved life expectancy. These goals are already within our reach.

Mr. President, your selection of Dr. Tom Price as Secretary of Health and Human Services has thrown an element of confusion into our efforts to promote family medicine as a potential solution to some of the country's health care problems. Dr. Price is an orthopedic surgeon and has called for repeal of the ACA and privatization of Medicare. I haven't heard him say much about primary care or family medicine. My fear is that the discussions family physicians have been having with CMS and private insurance companies regarding value-based payment (VBP) strategies are going to get swept under the rug. My opinion is that physicians should be paid for the quality of care their patients receive rather than the number of procedures they can do.

Lastly Mr. President, I would like to call your attention to an article in the January 23, 2017 issue of *The New Yorker* written by Dr. Atul Gawande. Dr. Gawande is a surgeon at Brigham and Women's Hospital in Boston and a professor at Harvard's School of Public Health. He notes that we have reached a point in American health care where the ability of primary care physicians to reduce the morbidity and mortality of their patients by effectively utilizing the principles of population health and chronic care management actually surpasses the ability of procedural specialists to do the same. He notes that the income differential between proceduralists and primary care doctors can be as high as 2:1. My assessment tells me that this differential can be as high as a factor of 5:1. I don't want to sound like sour grapes but we desperately need a way to get our medical students interested in careers in primary care. One way to do this would be to level the playing field a bit as far as physician incomes are concerned.

So Mr. President, I am challenging you and Dr. Price to bring yourselves up to speed on the health care issues facing the country. I hope you will be persuaded that there is a powerful role for primary care, and family medicine specifically, to play as we attempt to address these issues moving forward. To paraphrase your predecessor Abraham Lincoln, "see what you can do". Thank you.

Sincerely,

Thomas J. LaClair, MD, MBA  
Partner, FamilyCare Medical Group  
Clinical Assistant Professor, Clerkship Director  
Dept. of Family Medicine, Upstate Medical University, Syracuse, NY





## Voting is a Vital Sign

Dear Fellow Family Physicians:

Like most family doctors, I have seen what happens when patients are denied access to primary and preventative care.

I have seen what happens when they have to decide between rent and insulin,

between food and anti-hypertensives,

between car payments and colonoscopies. And,

unfortunately, we are all looking at a situation in which many of our patients, once guaranteed access to insurance, now find themselves in a much less certain situation. These days, medicine and politics have, for good or for worse, become intimately intertwined, with far-reaching effects on your patients and mine. It is because of this that I have begun adding one new question to my social history: "Are you registered to vote?" If the answer is yes, then I thank them, and urge them to make sure they do vote, every election. If the answer is no, then I hand them a voter registration form, complete with postage, and ask them to fill it out, providing help if necessary. If they have a felony on their record, NY law allows convicted felons to resume the right to vote after they have completed their sentence and parole. If they have immigration issues, I get a social worker involved. And I would ask a favor of you, colleagues, that you try to do the same. It doesn't take nearly as long as you might think, and it has never been more important. If you would like me to mail registration forms to your office, I will do so (just e-mail me), though they're easy enough to find at your local town hall or post office. If you also want postage, I'll happily spot you (to a reasonable degree- family doctor, people- got bills, too). And because everything needs a stupid hashtag these days, here's this one: #VotingIsAVitalSign. Thank you for everything you do, and thank you in advance for everything you will be called to do in the coming weeks and months and years.

Sincerely,

Matthew J. Brown, MD, Rochester, NY

fairportdoc@gmail.com

(reprinted with permission from the author from NYSAFP Weekly eNews, 3/9-17)



Bassett Healthcare Network  
Bassett Medical Center

Opportunities at Bassett Healthcare Network

achieve **success** achieve **balance**



## Family Practice positions in Medical Home Recognized Practices

Bassett Healthcare Network, a progressive health care system in Central New York and major teaching affiliate of Columbia University has Family Medicine, MD or DO positions available for its NCQA Patient-Centered Medical Home, Level 3 Recognized practices.

Bassett Healthcare Network is an integrated health care system that provides care and services to people living in an eight county region covering 5,600 square miles in Central New York. The organization includes six corporately affiliated hospitals, as well as skilled nursing facilities, community and school-based health centers, and health partners in related fields.

- 8 AM – 5 PM Outpatient Monday – Friday
- No OB
- Group employed model with competitive salary
- Loan Repayment may be available to qualified candidates through Federal and State Loan Repayment Programs
- Comprehensive benefit package, including but not limited to medical, dental, CME, relocation assistance and paid malpractice insurance
- Excellent technology and subspecialty support at Bassett Medical Center
- Opportunity to receive faculty appointment from Columbia University

With its abundance of recreational and cultural pleasures, central New York provides a great place to live for both individuals and families. There is a strong feeling of community within this region, which attracts people from all over the country. This vast region offers the best of both worlds. The surrounding areas have an abundance of lakes, streams and mountains that form the Catskill Mountain Range and the Adirondack State Park.



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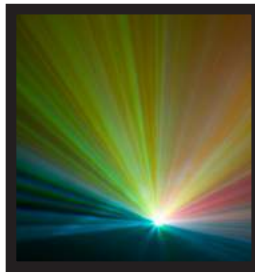
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## Official Notice of NYSAFP Congress of Delegates

June 24-25, 2017 (Saturday and Sunday)

The 69th annual Congress of Delegates of the NYSAFP will meet June 24-25, 2017 at the Renaissance Albany in Albany, NY. All members are invited and encouraged to attend the Congress, to participate in discussions of current issues and to debate Academy policy. Delegates to the Congress include delegates elected by county chapters and family medicine residency program chapters, members of the board of directors, past presidents, delegates selected by resident and student members, and delegates selected from counties that do not have a component chapter. County chapters are entitled to two delegates and alternates. Counties with more than 100 members have an additional delegate and alternate for each additional 100 members. In counties where there is no component chapter, any member(s) interested in becoming a delegate must provide written notice to the Speaker of the Congress. If more than one member in a county where there is no component chapter want to be delegates, the Speaker will conduct an election not less than 30 days prior to the Congress and will limit participation in that election to members in good standing of that county. Although all members may participate in the Congress, only delegates may vote.

The Congress is an annual meeting of the membership of the NYSAFP. This is the forum wherein active members voice their opinions on Academy positions and operations and present suggestions for Academy programs and positions.

Resolutions which have been submitted in advance and reports of commissions and officers are presented at the Congress. Reference committees meet and hear testimony regarding resolutions and reports. The reference committees make recommendations regarding resolutions and reports. Any member may submit a resolution.

Resolutions should be submitted to the NYSAFP no later than 60 days (by April 24, 2017) prior to the Congress to be published in the delegates handbook. Resolutions may also be submitted at the Congress, but the Congress may decline to consider resolutions, which were not presented 60 days prior to the opening of the Congress.

### Guidelines for writing resolutions are:

1. Staff assigns numbers to resolutions
2. The author of the resolution is responsible for identifying the subject of the resolution
3. The resolution must include name of the member, commission or organization presenting the resolution
4. Each justification for the resolution should be included and should begin with the word "Whereas"
5. After the various "Whereas" paragraphs, the "resolves" paragraphs should clearly establish the purpose of the resolution such as a change in Academy policy, amendment of the bylaws, referral to another organization or individual

Additional information is available at the NYSAFP website.

The Congress also conducts elections. Elections will be held for the following offices at the Congress: president-elect, vice president, secretary, treasurer, director (3 positions), delegate to the AAFP Congress, and alternate delegate to the AAFP Congress, speaker and vice speaker. The three director positions are for 3-year terms. The AAFP delegate and alternate positions are for 2-year terms. The New Physician position is a 2-year term. All other offices are for 1-year terms. There will be a Dinner and Installation Ceremony (Black Tie Optional).

If you are interested in becoming a delegate and you live in a county that does not have an organized county chapter, contact EVP Vito Grasso for information regarding how you can become a delegate. You may reach Vito at [vito@nysafp.org](mailto:vito@nysafp.org) or 518.489.8945.



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## ReMEMBER your BENEFITS!

### NYSAFP Membership Provides:

#### Advancing our Specialty, Saving Members Time, Maximizing Values of our Dues

- Representation at the AAFP
- Representation of the local county chapters at the NYSAFP Congress of Delegates
- Promotion of family medicine in the medical schools and support of student programs
- Support of family medicine residency & fellowship training programs
- Representation of family medicine in the federal & state legislatures and policy makers through the PAC

#### Saving Members Time

- Hosting of relevant and interactive CME workshops
- Hosting of ALSO instructor and provider courses
- Opportunity to interact with fellow family physicians throughout the state
- Reliable source of relevant and current events
- Weekly e-NewsBrief
- Quarterly peer reviewed journal – *Family Doctor*
- Timely access to current events of Academy via social media (NYSAFP Facebook | NYSAFP Twitter)

#### Maximizing the Values of our Dues

- Sponsorship of students and residents to Academy meetings (Winter Weekend, Regional Family Medicine) and the Congress of Delegates
- Cultivation of the next generation of family physicians by offering scholarships and awards to pre-medical students, medical students, and residents to participate in family medicine conferences and programs
- Support of residents and new physicians in development of leadership skills and practice opportunities

#### AAFP Member Services: <http://www.aafp.org/online/en/home/membership/resources.html>

- A list of the AAFP professional resources
- A list of the AAFP "Member Advantage"
- Additional Partnerships: <http://www.nysafp.org/index/resources-6/partner-programs-106.html>
- Jobs Board