The Perspective

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"To promote excellence of the health care provided to all the people of Vermont."

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In This Issue:

Contact Us
PO Box 1457
Montpelier, VT 05601

800-640-8767 or
223-7898
Fax 802-223-1201

Online at:
www.vtafp.net

"I'm Sorry, Dave. I Can't Do That"

Many of us have been involved with and commented upon electronic medical records. Having been immersed in that experience for over three years, I would like to share some of my thoughts on the subject.

In 2011, we at times literally felt the ground shift beneath us as we endured personally, or witnessed, the effects of: record breaking snowstorms, floods, tornadoes, droughts, tsunamis, earthquakes, nuclear plant meltdowns, federal government meltdowns, the apocalypse (almost), global financial crises (still), and tentative steps towards health system reform. Not to be overlooked is a less obvious shift in the infrastructure of medical care last year. 2011 saw the advent of "meaningful use" criteria meant to stimulate the adoption of electronic medical record systems. EMR acquisition has been limping along for a decade or so, but predictions are that these next couple of years will see an acceleration as medical practices chase the federal dollars attached to the technology. .

If you have read, viewed, or listened to a presentation about EMRs, inevitably there will be an interview with a current user. Just as inevitably will come some variation of the question: "Now that you have been using a computerized medical record, would you ever want to return to the old paper chart?" The answer is always emphatically in the negative! I suggest that a more appropriate question would be: "If you knew everything you now know about adopting and using an EMR, but were still using a paper-based system, would you make the change to computerization?" The response to that question might be less emphatic and less favorable.

Knowing what I now know, I would start with a simplistic approach to evaluating the electronic system. Paper medical charts have a decent history. The format has changed over the decades, but it has maintained the same basic function and has performed pretty well. It is, after all, just one more tool to enable us to take better care of our patients.

Any electronic incarnation should, at the very least, carry out that function as efficiently as its paper counterpart. There are valid reasons to pursue computerization of medical practice, not the least of which is organizing and retrieving the escalating quantity of data acquired by individual patients as they age through our modern medical enterprise. Given the limitations of current EMRs, they may be a reasonable fit for the practices of the "limited" specialties where the conditions treated are fewer and the range of evaluation and management options is narrower. Family medicine, as we know, requires a high degree of versatility and flexibility, creativity and imagination, and some science. Most of these qualities are not highly developed in our electronic companions. Thus, at least some and probably all currently available EMR software is not up to the challenges of the average family medicine practice.

What on many occasions seems to my innate biological processor to be the most efficient way to input or manage information is not within the capabilities of my peripheral electronic processor. While not as overtly malicious as the the impassive but deadly computer HAL from 2001, A Space Odyssey, my little black tablet will just as impassively refuse to do what it is asked .... and it does not bother to say, "I'm sorry". I take some comfort in knowing that HAL was eventually defeated by a creative and courageous human being. Thus inspired, I search for the proverbial "workaround", so as to get the machine to perform more in line with my needs rather than vice-versa. Eventually, we will work out a compromise which should suffice while I wait for the machines to evolve.

Best of luck with your own electronic companions.

Rob Penney, M.D., President

Rural Ramblings: Paradigm shift

By Mark Lichtenstein, M.D.

Who out there is comfortable treating patients with chronic fatigue syndrome, fibromyalgia and similar syndromes that have little physiologic science to support the disease? Perhaps Lyme's disease is one of these syndromes. Perhaps many chronic pain syndromes are part of these syndromes. I would like to suggest a different way to think of these syndromes. A paradigm shift, if I may call it that. Instead of a body anatomic or metabolic problem I try to make it a body-brain communication problem. The circuits are crossed. The wrong circuits are being used. Like having atrial flutter of the brain-body circuits.

When a child or an elderly person has acute delirium with a trigger like high fever or severe illness we accept this as a brain malfunction. When a patient has regional pain syndrome with sympathetic dystrophy we accept this as a CNS dysfunction. Acute closed head injury and concussions cause profound deficits and cognitive changes and we accept these as well. MRI rarely shows evidence of anatomic injury but function is severely impaired. The stressor caused the patient to use abnormal circuits in their brain. Usually when the stressor is gone the deficits abate and all is resolved. Sometimes it lasts longer. Rehab includes encouraging adequate sleep, re-establishing regular rhythms of life, and pushing for gentle progressive rehab. Overdoing can set people back and so we warn to rehab slowly and notice their tolerance. We treat these maladies like they are circuit malfunction, miscommunication.

I believe that the syndromes we can not easily measure all have something in common. There is miscommunication between the brain and the body. There is exaggeration of the post-rehab fatigue. The brain is not interpreting signals from the muscles or the sensory input properly. The brain sees pain when there is no obvious reason. The brain feels fatigue because there is poor brain body integration. Stressing the brain with too vigorous rehab sets people back for days sometimes. I see this in closed head injuries and in chronic fatigue and fibromyalgia patients.

So I have come to describe the illness as a miscommunication between brain and body that produces the feelings and disability. I focus on the integrity of body and brain and push the patient to see the illness as a mind-body disconnect rather than a muscle problem, toxicity, or some missing magical substance. With the paradigm change the counseling can then focus on how the patient can recover good brain body communication. Medicine becomes secondary. Rehab becomes primary. Comparing the illness to things like closed brain injury or delirium helps the patient come up with some strategies of their own.

I tell the patient that I do not know why they have this problem but I think I know what is causing the problem. I ask them to think of times in their life that they have overcome mind-body disconnects. What skills do they have to help these symptoms disappear? I may offer mood drugs, meditation or counseling. CBT can be helpful.

Perhaps this approach can help some of us deal with the mysterious maladies that impair many patients. If causes of these maladies are elucidated in the future then we can use specific interventions. Until then this may be a helpful strategy.

Vermont Academy of Family Physiicans
2012 Annual Meeting

Saturday, November 10, 2012

Capitol Plaza Hotel
Montpelier, VT

Save the Date!

Registration information to follow later this fall! Watch your mail/email!

Report from VMS: Legislative Wrap-Up

H.559 Passes – Establishes an ACA-Mandated Health Benefit Exchange - The General Assembly passed H.559, legislation establishing state-specific characteristics for the federally-mandated health benefit exchanges required under the Accountable Care Act (ACA). Under the bill, individuals and employer-sponsored groups with less than 50 employees will be required to purchase their health insurance from private sector qualified health plans (QHPs) through the exchange beginning Jan. 1, 2014. Premium tax credits are available to individuals and families below 400 percent of the federal poverty level (FPL) ($89,808 for a family of four) and above 133 percent of FPL ($29,861 for a family of four) purchasing coverage through the exchange. In addition, individuals and families with incomes below 250-percent FPL are also eligible for cost-sharing subsidies to reduce their out-of-pocket exposure. Vermonters under 133-percent of FPL will be enrolled in Medicaid and those 65 years and older would continue to receive Medicare. Beginning in 2014, VHAP and Catamount would be repealed with individuals covered under VHAP or Catamount having income over 133-percent of FPL enrolling in the exchange.

H.745 – Prescription Drug Abuse Bill Fails to Pass - Notwithstanding a great deal of consensus on numerous provisions in the bill to prevent prescription drug abuse, the House and the Senate failed to reach a compromise on H.745 and the issue of state police access to information on an online prescription drug database, thus the bill's failure. VMS intends to actively encourage the DOH to improve the functionality of the VPMS and provide Vermont physicians with information and support in registering and using the VPMS in order to help prevent prescription abuse in the state.

S.199 Passes – Bill Preserves Exemption for Immunizations - S.199, a bill that would have eliminated the philosophical exemption allowing parents to enroll children in public school without immunizations, passed the last day of the session with heavy amendments and in the end left the philosophical exemption intact. While the Senate voted to eliminate the philosophical exemption; the House voted 93-36 to keep it. Efforts to strengthen the bill in conference committee by giving the Commissioner of Health authority to remove the philosophical exemption if rates for MMR, DTaP, and Tdap dropped below a 90-percent threshold were unsuccessful.

H. 777 - Fails to Pass - Would Have Required Insurers to Reimburse Homebirth, but Insurers May Not Require Liability Insurance Until 2014 - The House of Representatives approved H.777 -- a bill that would by law exempt licensed midwives and certified nurse midwives from carrying medical malpractice insurance for home birth until 2014. The bill would have required insurers to reimburse licensed midwives and certified nurse midwives for homebirths, and at the same time, would not permit the insurer to require that midwives be part of the insurer's network until 2014. Because the bill was referred to the House Judiciary Committee it did not make the legislative crossover deadline, and could not be considered as a separate bill in the Senate. An attempt was made in the House to attach H.777 to an insurance bill that had already been passed by the Senate, but H.777 was found not to be germane to the insurance bill, and the legislation died.

H.524 – Office of Professional Regulation (OPR) Bill Expands Naturopaths Prescription Authority. VMS Proposed Study on Naturopaths' Education and Clinical Training Added - H. 524 authorizes the Office of Professional Regulation (OPR) to eliminate the naturopaths' formulary, the list of drugs that naturopaths have authority to prescribe, and instead will permit naturopaths who pass a qualifying test to prescribe any prescription drug that they believe is consistent with their scope of practice. These changes to the naturopaths' prescribing authority were proposed by the Director of OPR with the concurrence of the Commissioner of Health. The current formulary would

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The Residents Corner:

I'm pleased to introduce in this issue the Residents' Corner. Our FAHC University of Vermont Family Medicine Residents impress me daily with their enthusiasm in applying the best available research to practice. I am constantly learning new approaches and nuances of patient care from their information mastery work and hope that these tidbits will help inform your daily practice as they do mine. If you are interested in receiving more frequent such information delivered directly to your email, and are not already signed up to our list serve please email me at *jgking@uvm.edu.*

John

John G. King, MD, MPH FAHC/University of Vermont Residency Program Director

Lyme Disease Prophylaxis: IDSA guidelines

To provide antibiotic prophylaxis for Lyme disease ALL of these criteria should be met:

- Tick identified as an adult or nymphal deer tick
- Attached for > or = 36 hours (by engorgement or time of exposure)
- Treatment started within 72 hours of tick removal
- Local rate of infection of ticks with B. Bourgdorferi >=20% (assumed in Vermont)
- Doxyclycline is not contraindicated, patients this applies:
    - o <8 years of age
    - o pregnant
    - o lactating
    - o Amoxicillin is not recommended in these groups because of lack of data on efficacy, effectiveness of treatment of lyme disease if it does develop, and higher incidence of side effects with multi-day antibiotic regiments.

Recommended prophylaxis is a single 200 mg dose of doxycycline (4 mg/kg in children over age 8)

Strength of Recommendation: B (estimate based on description of IDSA grading compared to AAFP)

References:
From the Infectious Diseases Society of America
http://www.idsociety.org/uploadedFiles/IDSA/Topics_of_Interest/Lyme_Disease/IDSALymeDiseaseFinalReport.pdf

From the Vermont Department of Health:
http://healthvermont.gov/pubs/IDB/documents/IDB_2010_Spring_Supplement_lymedisease.pdf

By Kristine Cruz, MD PGY-2

(Cont'd from pg. 3) remain in effect until 2015. After 2015, naturopaths who have not passed the test would not be able to prescribe prescription drugs. VMS opposed this expansion of prescribing for naturopaths, due to concern about the potential risk to patients when dangerous drugs are prescribed by naturopaths without sufficient training. Naturopaths' education and training is very different from physicians' education and training. Their naturopathic college curricula generally appear to include only one or two courses in pharmacology that are typically taught by naturopaths. A review of their education and training done in 2007 by the Vermont Department of Health and a work group that included physicians, pharmacists, naturopaths found that naturopaths were not qualified to prescribe all prescription drugs, and proposed a limited formulary for naturopaths that would be contingent on passage of a rigorous test.

Vermont Board of Medical Practice (VBMP) Approves Proposed Rules Requiring Physicians to Have 30 Hours of AMA Category 1 CME Every Two Years - The Vermont Board of Medical Practice (VBMP) has approved proposed rules that will require physicians to have 30 hours of AMA Category 1 CME every two years for license renewal. Of those 30 hours, 1 hour of CME must address palliative care, hospice or pain management and 1 hour of CME must address prescribing controlled substances. In connection with their license renewals, physicians will be required to certify that they have completed the CME requirements, listing the courses and hours. The VBMP will have the ability to audit licensees for compliance for four years after the certification is submitted. VMS currently tracks CME as a membership benefit. The rules include provisions for make-up plans and exceptions for physicians serving in the military. After the formal rulemaking process is completed, the CME rules are expected to be in effect for the license renewal period that begins Dec. 1, 2012, and physicians will first need to certify that they have taken the required CME when they renew their licenses in the fall of 2014. VMS is seeking comments from members on the proposed rules and will comment formally to the VBMP as the rules go through the administrative rules process.

S.103 – Physician Assisted Suicide Bill Fails
Legislation that would allow physicians to assist terminally ill patients to take their own lives failed to pass the General Assembly. VMS testified before the Senate Judiciary Committee in opposition to the bill, based on its policy of not supporting laws for or against physician-assisted suicide. VMS recognizes the need to continue to work on these issues.