The Perspective

A Publication of the Vermont Academy of Family Physicians

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

Winter 2012/2013

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

Past Presidents Post-Script: "The Value of Family Physicians"

In early March, there appeared briefly in the news media an account of a report in the *Archives of Internal Medicine* listing five tests and procedures, commonly ordered by primary care physicians, which are of questionable value in most circumstances. The report is part of the Choosing Wisely® campaign, an initiative of the ABIM Foundation focused on encouraging physicians, patients and others to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm.

Nine specialty societies, including the AAFP, representing 374,000 physicians developed lists of *Five Things Physicians and Patients Should Question* in recognition of the importance of physician and patient conversations to improve care and eliminate unnecessary tests and procedures.

The AAFP "Top 5" list has no surprises, and recommends that family physicians have conversations with patients regarding the efficacy of: imaging for low back pain, antibiotics for acute short-term sinusitis, DEXA screening for young patients, EKGs for asymptomatic, low-risk patients, Pap smears for young or low-risk women. It would not be difficult to think of several additions to this list.

Conversations with patients explaining why something should not be done are always difficult. The contemporary mind-set that "more is better" and "doing something" is preferable to doing nothing is difficult to overcome. Family physicians, however, are best positioned to have some influence in these areas by virtue of a trusting relationship with our patients developed over time and of our knowlege of their medical, family, and social conditions. The irony is, of course, that quality clinical evaluations and explanations require time, and the current environment necessitates a high patient volume through the office with diminishing time available to invest in each patient.

According to the Congressional Budget Office, as much as 30 percent of health care spending each year goes toward unnecessary tests and procedures. It is evident then why investment in educating and training more family physicians, and support for a more sane environment in which to practice, would go a long way towards slowing the rise in health care costs.

While the value of Family Medicine has never been so clear, addtional trends suggest that politicians and policymakers remain oblivious to this. In Vermont and many other states, there is a growing tendancy to address a perceived deficiency in access to medical care by expanding the scope of practice of optometrists, pharmacists, and other less comprehensively trained clinicians simply by a legislative or regulatory imprimature. This may seem like a "quick fix" for access, but not necessarily for more cost-effective care.

Another trend that diminishes the perceived value of primary care, is that it seems so much easier now to practice medicine. Just look up your symtoms on the internet and order a bunch of tests. That is certainly the preferred route for some patients. However, I worry at times that some of us are falling into that trap. Others have written about what appears to be an inclination to substitute testing for a careful history and physical exam; which, ideally, should inform decisions about diagnostic studies and procedures. I am as impressed as anyone by some of the hitech imaging and procedural gadgets that abound in the U.S. They do have their uses, but are often over or inappropriately used. They are all just tools, and determining how best to

Continued on page 7

Philosopher's Corner: Alphabet Soup and Change

By David Coddaire, M.D.

Here we go again with the alphabet soup: NCQA, ACA, ACOs etc etc. The one thing we know is that things are changing. We will either have a universal coverage type health care system with beefed up supports for primary care, or the same old . . . same old . . . with reimbursement cuts for all. Either way things will change and we should get involved.

The ACA (Affordable Care Act) may or may not be modified. NCQA is the agency which scores those who become Medical Homes and sets quality measures.

The Vermont Blueprint for Health looks like it is here for the immediate future assuming the politicians figure out how to pay for it. Did you notice that the Guv wants to wait until 2014 rather than present the financing plan in January 2013 as specified by law?

The establishment of Accountable Care Organizations (ACOs) is the latest non-clinical learning project for us to digest. My local hospital (Copley) and the organization I work for (a nonprofit separate from Copley) decided to work together and join the Medicare "One Care" ACO established by Dartmouth and Fletcher Allen . Our philosophy was to join and try to influence them rather than to compete. Incidentally, this is the only proposed state-wide ACO in the country. While we in primary care practices should be attractive to the ACOs because of our efficient care, the small Vermont hospitals (at least evidenced by Copley) seem to be shaking in their boots over the prospect of having ACOs redirecting care to the big dogs.

We in primary care should get involved. I do think we can influence some of these organizations at the state level. Whether we join an ACO or not, we should work together to strengthen primary care. Whether practicing for a hospital, for a group or solo we should look out for one another. Primary care docs have a unique view of the whole health system and how it (dys)functions. Join the Vermont Medical Society, get on one of those clinical review committees if you join an ACO, work with your local hospital or keep an eye open for the next "Physician Leadership" program that Cy Jordan is organizing.

Change is coming. Let's not be the tail wagged by the big dogs.

AAFP Chapter Spotlight: Vermont

America's smallest states face special challenges when it comes to providing access to health care services for their populations. Ditto for membership organizations such as the Vermont AFP, which relies on a small pool of family physicians to spearhead the chapter's advocacy efforts.

Thanks to a dedicated core of FP leaders, however, the chapter has made its voice heard on numerous pieces of state legislation -- especially those affecting children's and adolescents' health. One measure, in particular, sparked testimony by a Vermont AFP Board member during the 2011-12 legislative session: a bill that proposed to eliminate Vermont's "philosophical exemption" clause from the state law requiring that all children enrolled in school and child care facilities receive immunizations specified by the department of health.

The full article can be read at: *http://www.aafp.org/online/en/home/publications/news/news-now/chapter-of-the-month/20120731vermontchapter.html?cmpid=em-29506-0*

Vermont AFP Wins AAFP Membership Awards

It seems that the Vermont AFP's high visibility in the Vermont statehouse keeps members tuned in and ultimately may have contributed to the chapter winning two membership awards at the AAFP's 2012 Annual Leadership Forum held in April in Kansas City, Mo.

According to Vermont AFP Executive Director Stephanie Winters, the chapter won first place among small chapters for retention of active members and came in second among small chapters for the highest percentage increase in active members.

Winters said an immunization bill generated a lot of chapter communication with members, as did health care reform efforts at the state level.

"There are a lot of health care issues going on the state, and when members see that their specialty has a voice, they see the value of belonging to their AAFP chapter," said Winters.

VTAFP 2012 Family Physician of the Year
Mark Lichtenstein, M.D.

Presented by Fay Homan, M.D.

Many of you know I used to work with Harry Rowe, who practiced until age 92, and held all sorts of records for longevity in the medical community. Our recipient for Family Physician of the Year appears to be taking a shot at some of those records. Mark Lichtenstein has cared for residents of the Northeast Kingdom for 33 years. After a four year stint in the public health service, he has practiced at the same site in Hardwick for his entire career. That alone is remarkable – statistically, a family physician changes employment every 5 -7 years. But Mark's effect on his community reaches far beyond the walls of the Hardwick Health Center and his long tenure there. He is a family physician in the venerated Vermont tradition, a doctor who practices in his own community and "does everything" – clinic, hospital, nursing home and house calls. Oh and he's also the regional medical examiner as well. He has served for many years on the board of the Vermont Academy of Family Physicians. His colleagues on the board describe him as a consistent and vocal advocate for rural interests and the underserved. Last year, he took his medical skills to a new underserved population, taking a 4 month sabbatical and working in Nepal. Mark has a subspecialty in Geriatrics, and for 31 years, he has been the medical director and sole medical provider of the Greensboro Nursing Home. Even Dr. Rowe would have been impressed with that. A coworker at the nursing home, who has worked in long-term care for 35 years, told me that Mark is the "best advocate for the elderly I have ever seen. I don't even want to begin to think of the day we'd have to get by without him." Another described him as "dedicated to the nth degree" and told me a story of Mark showing up on his bicycle once when he didn't have a car and was called about a patient in need.

Mark has taught decades of UVM students, exposing them to the depth and richness that a career in Family Medicine can provide. His students' comments say it all: "Dr. Lichtenstein always made sure that I realized the emotional impact of medical intervention, along with the physical impact," said one. Another said: "Mark gets you to think like a Family Practitioner" and "He really stressed how to improve the overall quality of his patient's lives". And, my favorite: "His compassion is contagious". Compassion is a word that comes up time and again when people talk about Mark.

Mark is the only physician providing Suboxone treatment in his region of Vermont. It takes a very special person to take on this challenging population. Mark's office nurse described his interactions with his Suboxone patients like this: "They are such tough patients. And Mark always treats them with dignity and trust." She spoke of the depth of his involvement in his patients' lives. She described a bed bound, reclusive patient who let only Mark into his dilapidated home. Mark facilitated him moving to a safer location, and that that was literally the first time the man had seen the light of day in 15 years. She called Mark "the most compassionate physician I have ever worked with." I winced a little when I heard that --- she used to be my nurse. . . . .

His office manager, who has worked with him for 32 years, calls him "a wonderful teacher and mentor, an old school doctor who still does house calls. With Mark, the patient is always the priority."

Mark has served his community as more than a family doctor for more than three decades. As we move towards transforming healthcare in Vermont, the Green Mountain Care Board would be wise to look into cloning him. He has lived and practiced "patient-centered care" long before it became an industry buzzword. And if he continues in Dr. Rowe's footsteps, the residents of the Northeast Kingdom may be able to look forward to his dedicated care for another 30 years.

Please congratulate Mark Lichtenstein, Vermont's Family Physician of the Year.

VERMONT ACADEMY OF FAMILY PHYSICIANS

Leadership

Allyson Bolduc, M.D.
President/Delegate

Carol Blackwood, M.D.
President - Elect/Delegate

Michael Sirois M.D.
Treasurer

Robert Penney, M.D.
Immediate Past President

Thomas Peterson, M.D.
UVM Rep.

Fay Homan, M.D.
Member-At-Large

Mary Dill, M.D.
Member-At-Large

Mark Lichtenstein, M.D.
Member-At-Large

Andrea Regan, M.D.
Member-At-Large
Alternate Delegate

Stephanie Winters
Executive Director

Horse Trekking Across Iceland

By Carol Blackwood, M.D.

The last few years have been filled by a lot of "nose to the grindstone". I retired from the Navy, moved, earned back money lost in the recent stock market crash, built a house and barn, and cared for my dying mother. So this past spring I decided it was time for some fun.

I signed up for week of horse trekking across eastern Iceland. The ride was advertised for fit riders capable of being in the saddle all day. Icelandic horses are known for their willing spirit, and comfortable fast gaits. Never mind it has been years since I spent a day in the saddle.

Iceland is one of the youngest land masses on Earth, formed from volcanic rock. It has an area about four times the size of Vermont, with one half the population. Most of the population lives in the immediate Reykjavik environment, leaving 100,000 people sparcely spread out around the 3,000 mile long coastline. The interior is volcanoes and glaciers, and very inhospitable for homes; but good for sheep grazing, and sure footed horses.

The night before the ride, there was a supper meeting to hear the details of the trip and meet my fellow participants. We were all women, two mother/daughter combinations, some single, some married, all of us shared a desire for adventure. The others haled from France, Germany, Sweden, and Belgium and of course the leaders were Icelandic. As the only native English speaker, I became the official English expert while everyone else practiced their already quite good English. I did manage to educate them on a few slang phrases and explain some Queen's English vs American English differences.

In the morning, we flew to the east coast, and bused to the farm. The farmer has a flock of 500 sheep and borrows 100 horses from his own herd and his neighbors to cull 70 of the best horses to use for tourist rides like ours during the short summer. Around noon, we headed up into the mountains, 20 of us riding and pushing the herd of 50 horses along with us.

Up and up. After 4hrs of riding, we strung a line around the herd to make a corral with human fence posts. We changed horses inside the fence line and ate our lunch standing up holding the line, bathroom breaks were behind a 1ft tall shrub. After lunch, we climbed higher to the plateau, and crossed over to descend into a different valley. Nothing seemed to phase the horses. Slippery rock scree, rushing streams, where I would be nervous walking, they zipped across with nary a misstep.

After several hours of descending, I was too exhausted to appropriately brace my weight with each down step, I started holding the back of the saddle to hold my weight steady. Through it all, my horse was kind and steady. I fell in love. I asked to ride her each afternoon for the rest of the trip. I knew when I was tired and not at my best, she would take care of me.

When we got into the valley floor at dusk, after 9PM. We were sore and exhausted and worried how to survive 5 more days of the same. But then the horses started Tolting and it was magic. We flew along the river in the moon light , over a rough trail, at the speed of a canter, with just a small side to side sway (Tolt is fast, smooth walk, that only Icelandic horses do) for several miles to the corral where the horses spent the night. Glorious.

Continued on page

Horse Trekking

(Cont'd from pg. 4) The next few days alternated between hugging the coast and going inland for short stretches. Views of the ocean and sea fog, alternated with harsh mountain passes. Clusters of 2-3 Sheep grazed loose on the high rocks and their "baa" could be heard for long distances across the valleys between. The half grown lambs stayed near their mothers. Each day we changed horses mid-day. Everyone developed their favorites.

The last day was spent following Route 1, the main round that circumnavigates the entire country. We rode on a 6ft wide path, beside the road right of way, with official road signs designating it as a horse path. The flat footing of the path allowed the horses to Tolt the whole day, we easily covered about 30 miles. When stopped for lunch, we became a tourist attraction and had 3 buses stopped to take pictures of us, "a bit of old Icelandic past". We started to take pictures of them, taking pictures of us…

Turning into the drive of the last corral where we would part with the horses was sad. My body was just getting used to riding all day, but it was time to get back to my other life. I took my bridle off for the last time and gave my girl a kiss on her forehead. I and several of the other riders are planning a trip next summer to the American west…

Experiences from a Rural Family Practice

By Fay Homan, M.D.

Althea

Althea was a bony 80 year old with aortic stenosis. She'd had the Echos and the cardiology consults, and, when the valve area was the size of a pencil eraser, finally decided to have it replaced, "but not til spring". In December, she was in and out of heart failure regularly, winded just stepping up to the exam table. I talked to her about scheduling the surgery sooner, but she said that would be impossible. She heated with wood, and had to keep the stove going or the pipes would freeze. How in the world, I asked, did she manage a woodstove? Oh, it wasn't so hard, she said. Her nephew stacked wood on the porch in the fall, so all she had to do was bring it inside. She could only manage one stick at a time with her breathing, but it worked out fine as long as she made a couple of trips an hour. She only needed to stoke the stove once at night. She made a plan for surgery in March.

Mid winter, she came in to the ER in pulmonary edema. When she was moved to ICU, she told the nurse there was an envelope in her pocket, to open in case she didn't make it. In it was $3,000 in cash to cover her funeral expenses, and instructions on who was to care for her cat. Who knows what would have happened if she'd had the surgery earlier – perhaps the outcome would have been the same. She died in our ICU the next day, and if nothing else, you could certainly say that things went according to her plan.

Fitness

It's entertaining to hear patients' excuses for not exercising. There's one for every season, weather pattern, and whim. Too icy, I understand, particularly for seniors, but there are many more; too muddy, too windy, the black flies have hatched, my road is too busy, my road is too empty, I feel dumb walking alone, someone once saw a bear on my road.

Once when I asked an older woman if she exercised, she said yes, for several hours per day, and in fact she proceeded to demonstrate for me. "I sit in my rocker and push off with my legs." I looked hard for a glimmer of sarcasm, but saw none. Another woman said she'd read that taking deep breaths was just as good as exercising, and she had adopted that as her current regimen. On another occasion, a woman told me that she used to walk several miles every day, but had fallen out of the habit. When I asked her why, she said, "Well, I started watching television a lot when President Kennedy was shot, and I just never got back to walking." This was in 1997.

Now, I've been working on my motivational interviewing skills, but I can see that for some patients, I still have a lot of work to do.

Vermont Academy of Family Physiicans

2013 Annual Meeting

Saturday, November 2, 2013

Capitol Plaza Hotel
Montpelier, VT

Save the Date!

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

Past President's Post-Script

(Cont'd from pg. 1) use them is part of what that expensive education should give us. Despite the technological advances I have seen over the last 30 years (or so), nothing has altered the validity of some of the basics I learned at dear old UVM.

This is some of the information that politicians and policymakers need to hear. My impression from conversations with some of them is that they have a genuine interest in hearing our concerns and suggestions. It has been said that the best route to healthcare reform is to allow family physicians the freedom to do what we have been trained to do. That is a simple message that sums it up pretty well.

On a personal note, it has been a pleasure and an honor to serve as your Chapter President these past two years. Family Medicine has the potential for a brighter future in Vermont than in most other states. I look forward to that outcome.

Rob Penney, M.D.
Immediate Past President

References:
- The "Top 5" Lists in Primary Care; ARCH INT MED/ VOL 171 (No. 13) 2011, pp.1385-1390 WWW.ARCHINTERNMEDCOM
- Choosing Wisely web page: http://choosingwisely.org/

Hot Topics for Primary Care

- VTAFP signed on to a letter to Congress to express strong opposition to proposals that would eliminate the Medicaid primary care payment increase that was finalized in a final rule issued by the Centers for Medicare and Medicaid Services (CMS) and scheduled to be implemented on January 1.

- **Child Mental Health Blog for Primary Care** – from the UVM College of Medicine and the Vermont Center for Children, Youth and Families designed to enhance child mental health assessment and treatment for Vermont primary care clinicians. *The blog can be found at http://blog.uvm.edu/drettew/.*

  If you would like email notification of new postings, please email Dr. David Rettew at david.rettew@uvm.edu and just put "Blog email list" in the subject line.

- **Coughing up the Facts on Pertussis – Emerging Trends and Vaccine Recommendations**
  Description: This course reviews the clinical presentation of pertussis, how to test and treat appropriately, and who to vaccinate and when. Participants will also learn about emerging trends in pertussis reporting across the U.S. The course is presented as a web-on-demand video. Credit available until Nov. 26, 2014

  Audience: Immunization Providers (Physicians, Nurses, Nurse Practitioners, Pharmacists, Physician's Assistants, DoD Paraprofessionals, Medical Students, etc.)

  The course can be found at *http://www.cdc.gov/vaccines/ed/pertussis/default.htm.*

The Residents Corner:

I'm pleased to present 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

Does screening baby boomers for Hepatitis C decrease mortality and/or save money?

Bottom Line Answer:

- Age-based screening for hepatitis C is cost effective ($4900 per QALY gained) for those born between 1945 and 1965.
- When 15% of the population was screened in their model, reductions were seen in
  - Decompensated cirrhosis events (2%)
  - Hepatocellular Carcinoma (1.7%)
  - Liver-related deaths (1.1%)
- When 60% of the population was screened in their model, reductions were seen in
  - Liver-related deaths (3.8%)
  - Deaths attributable to poor referral and treatment (4%)
  - Deaths attributable to poor viral response (6.9%)

Case: 65 y/o male presents for routine physical. Current problems include HTN, GERD, L-sided Sciatica. PMH with depression, appendicitis (s/p appy), acute cholecystitis (s/p cholecystectomy), and BCC (s/p excision). SH reveals married, retired smoker with 10 pack-year smoking history who drinks two servings of alcohol per night. No history of IVDU. Without allergies; currently taking Lisinopril and Omeprazole. Flu and Tdap are up to date. Last colonoscopy four years ago was normal. In addition to AAA and depression screening, shingles and pneumovax vaccines, should he be screened for Hepatitis C?

Background and Supporting Evidence:

This past spring, the CDC issued draft guidelines recommending one-time screening for Hep C in all baby boomers. Our patient, and others born between 1945 and 1965, should be screened because

- Hep C is important – it leads to the more liver transplants and liver cancer than any other diagnosis. The rate of death from Hep-C attributable HCC due is increasing faster than the rate of death from any other cancer.
- Hep C infection is common especially in this age group that was exposed prior to universal screening of blood.
  - ~1% US Citizens are affected, ¾ of those are boomers
- Hep C has a high cure potential
  - Up to ¾ may be cured with current therapies.

References:

Coffin PO, Scott JD, Golden MR, Sullivan SD. Cost-effectiveness and population outcomes of general population screening for hepatitis C. Clin Infect Dis. 2012 May;54(9):1259-71. *http://www.ncbi.nlm.nih.gov/pubmed?term=Coffin%20PO%2C%20Scott%20JD%2C%20Golden%20MR%2C%20Sullivan%20SD.%20Cost-effectiveness%20and%20population%20outcomes%20of%20general%20population%20screening%20for%20hepatitis%20C.%20Clin%20Infect%20Dis.%202012%20May%3B54(9)%3A1259-71.*

From Centers for Disease Control and Prevention. Hepatitis C: Proposed Expansion of Testing Recommendations, 2012. 2012 May. http://www.cdc.gov/nchhstp/newsroom/docs/HCV-TestingFactSheetNoEmbargo508.pdf

Julia Hunter, MD, Second year Family Medicine Resident