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WHAT'S NEWS

Diagnostic promise for Alzheimer's? In a small study, PET plus a radiolabeled imaging agent detected beta-amyloid plaques with 93% sensitivity. **6**

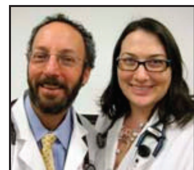
Intro to PCMH 101: Medical schools should start teaching students skills that prepare them to be part of the patient-centered medical home, primary care societies say. **8**

Open for EHR business: The feds are now offering bonus payments to physicians who successfully implement electronic health records. **11**

And a biomarker shall lead them: Using N-terminal prohormone brain natriuretic peptide levels to guide therapy in patients with systolic heart failure proved superior to standard approaches. **23**

Access without action: 40% of insured women who had access to the full range of preventive health care services didn't even get recommended biennial mammographic screening. **40**

Clinical Guidelines for Family Physicians: Know the basics of diagnosis, pain management, and symptom control for women with endometriosis. **42**



Tips for reaching the PCMH top: An expert offers primary care practices her advice for achieving patient-centered medical home recognition from NCQA. **58**

Osteoporosis Screening Guidelines Get an Update

There was insufficient evidence to form any recommendation about screening in men.

BY SHERRY BOSCHERT

FROM ANNALS OF INTERNAL MEDICINE

New federal recommendations on screening for osteoporosis provide more detail on when to screen women younger than age 65 years and – for the first time – point to a lack of data for screening decisions in men.

The U.S. Preventive Services Task Force updated its 2002 recommendations on osteoporosis screening to call for routine screening in all women aged 65 years or older and in any younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors (equivalent to a 9.3% or greater risk of fracture within 10 years). Previously, women younger than 65 years would be screened if they were at least 60 years old with risk factors for fracture.

The new recommendations were posted on the USPSTF Web site and published online by the Annals of Internal Medicine.

For the first time, the USPSTF evaluated the evidence for osteoporosis screening in men and found insufficient evidence to form any recommendation, Dr. Ned Colange, chair of the USPSTF, said in an interview. There's not enough evidence to recommend osteoporosis screening or treatment in men with no prior osteoporotic fractures, and "there's certainly not enough evidence to say, 'Don't' do it,'" he said.

"While there's not a call to action, that's an important call for research," added Dr. Colange, who is president and CEO of the Colorado Trust Foundation, Denver.

In women, the recommendations do not say to stop osteoporosis screening at any specific age, because the risk of fractures continues to increase with advancing age, and the minimal potential harms of treatment remain small.

Clinicians who are considering treating older patients with significant morbidity should take into account data showing that the benefits of osteoporosis treatment emerge 18-24 months after starting treatment.

To predict an individual's risk for osteoporotic fracture, the USPSTF used the online FRAX tool, developed by the World Health Organization and the

See **Screening** *page 11*

Primary Care Group Visits Cut Readmissions

BY M. ALEXANDER OTTO

FROM A CONFERENCE ON PRACTICE IMPROVEMENT SPONSORED BY THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

SAN ANTONIO – Group visits aren't just for diabetes patients.

At the Maine Medical Center in Portland, they also help – along with other measures – to keep recently discharged patients from being readmitted, according to Dr. Ann Skelton, chief of the center's department of family medicine, who presented the findings at a conference on practice improvement sponsored by the Society of Teachers of Family Medicine.

COURTESY HALLIE BIBEAU

The use of post-discharge group visits cut hospital readmissions, explained Mary McDonough, R.N., (in red) and Dr. Ann Skelton (second from the right).

Upon discharge from the Family Medicine Inpatient Service (FMIS) to the outpatient Family Medicine Center (FMC), patients are given the option of having their first follow-up visit with their primary care doctor, or in a group with other patients led by a team that includes an attending physician, a nurse, a social worker, a pharmacist, and a care manager, among others.

The slightly more than half who opt for the group find all of their hospital-to-home issues addressed at one time, in one place, and without delay, explained Mary McDonough, R.N., FMC practice administrator, who also presented the findings.

If a patient has trouble getting through to a specialist, for instance, the

See **Readmissions** *page 54*

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Feds' EHR Incentive Funds Are Now Available

BY MARY ELLEN SCHNEIDER

A new federal initiative offering bonus payments to physicians who successfully implement electronic health records has been launched, and early signs indicate it could help spur adoption of the technology.

Officials in the Office of the National Coordinator for Health Information Technology recently released two surveys showing that more than 40% of office-based physicians and 80% of hospitals plan to seek federal incentives for the adoption and use of EHRs under Medicare and Medicaid.

The incentive programs, which launched at the start of the year, offer payments to physicians for using health information technology (HIT) to improve patient care. The federal government recently issued regulations detailing how physicians and hospitals can meet standards for so-called "meaningful use" of the technology. Physicians who meet the criteria are eligible to receive up to $44,000 over 5 years under the Medicare program or $63,750 in 6 years under the Medicaid program. Eligible hospitals could receive millions of dollars, according to the Centers for Medicare and Medicaid Services (CMS).

The survey of office-based physicians, conducted by the Centers for Disease Control and Prevention, found that 41% plan to achieve meaningful use and seek federal incentive payments. Of those, about 80% said that they plan to enroll during first stage of the program, this year or next.

A separate survey, conducted by the American Hospital Association, found that 81% of hospitals plan to achieve meaningful use and apply for incentive payments, with about 65% enrolling in the same time frame.

While the federal government has promoting these incentives for more than a year, it was uncertain whether physicians would choose to participate.

Officials at the American Academy of Family Physicians said that while they do not have concrete data, but informal polls of their members show high interest in the incentives. Dr. Steven Waldren, director of the Center for Health IT at the AAFP, said that among physicians who attended lectures on meaningful use at the group's annual meeting last fall, about 80% reported that they currently use an EHR in their practice and about 90% said they plan to try to achieve meaningful use this year.

It's a biased sample, Dr. Waldren said, but it still paints a picture. "What it kind of tells us is that there are a lot of doctors out there, especially those that have adopted the technology, [who] are trying to figure out how to be meaningful users in 2011."

The big question is how many physicians will be able to convert their interest in the program into the ability to achieve meaningful use of EHRs, he added.

Dr. Waldren said most physicians will be able to meet the current thresholds for functions like electronic prescribing, which are outlined in the meaningful use criteria. However, the greater challenge will come in capturing and reporting that data to the government, he said.

Dr. Waldren recommended that physicians seek out the Regional Extension Centers set up by the federal government. These centers have been established around the country and are specifically charged with aiding small practices, primary care physicians, and those working in underserved areas. But he also cautioned that the level of expertise may vary by center.

While many of the barriers to EHR adoption remain the same, the financial incentives seem to be helping physicians who were "on the fence," move in the direction of purchasing a system, said Dr. Michael S. Barr, a senior vice president at the American College of Physicians.

The success of the program can't be judged, he said, at least until figures are available on how many physicians met the stage 1 meaningful use standards, said Dr. Barr, who also serves on the Health IT Policy Committee's meaningful use workgroup. ■

Osteoporosis Guides Refreshed

Screening *from page 1*

National Osteoporosis Foundation.

"The nice thing about the FRAX calculator is, the patient herself can determine that risk. It's available online. It uses measures that the woman should know," Dr. Colange said. "The clinician can do it, but the patient herself could do it as well."

The FRAX tool estimates 10-year fracture risk based on easily obtained information such as age, body mass index (BMI), parental fracture history, and tobacco or alcohol use. It asks about results of dual-energy x-ray absorptiometry scans but does not require this information to calculate fracture risk.

Younger women can reach the new threshold for screening because of various risk factors. For example, a white woman would qualify for screening if she is 50 years old, smokes, drinks alcohol daily, has a BMI less than 21, and has a parental history of fracture. A 55-year-old white woman would need only a parental fracture history to warrant osteoporosis screening. A 60-year-old white woman who smokes and drinks alcohol daily would fit the 10-year risk profile for screening (Ann. Intern. Med. 2011 Jan. 18. [Epub ahead of print]).

White women are more likely than women of other races or ethnic backgrounds to develop osteoporosis and fractures. Although there are fewer data on nonwhite women, the USPSTF recommended screening all women at age 65 years because the consequences of failing to identify and treat low bone-mineral density are considerable, the potential risks of treatment are small, and it's unclear if there's a better strategy for screening nonwhite women.

There are not enough data to recommend when to rescreen women without osteoporosis on their initial screen, the USPSTF stated, but at least a 2-year interval would be needed to assess a change in bone density and perhaps longer for better prediction of fracture risk.

The new recommendations are based on a 2010 review of studies published since 2002 by a team at the University of Oregon Health and Science University's Evidence-Based Practice Center in Portland.

An estimated 12 million Americans aged 50 years or older will have osteoporosis in 2012. Among postmenopausal women, 15% will develop a hip fracture during their lifetime, 25% will develop a vertebral deformity, and osteoporotic fractures of any kind will affect 50%.

In a new effort at transparency, the USPSTF first published a draft of the new recommendations online in the summer of 2010 and invited public comment.

They received more than 50 comments from individuals, professional organizations, advocates, and pharmaceutical companies, Dr. Colange said, which led the USPSTF to clarify its approach to fracture risk assessment in the final version.

The USPSTF "has been criticized in the past for not being more transparent," Dr. Colange explained. "We're an independent panel, and everyone is a volunteer. It was never our intent to do stuff in secret. It was our intent to make sure that we deliberated and evaluated evidence free from the impact of advocacy, politics, and special interests. I think that was translated to a sense of 'outside the public eye.' "

The USPSTF plans to use the new public-comment process for future statements. "Transparency is always good," he said.

Dr. Colange said he has no pertinent conflicts of interest. ■

VIEW ON THE NEWS

Assess Fracture Risk in Younger Women

For clinicians, the biggest change in the new screening recommendations may be the need to calculate the 10-year fracture risk in women aged younger than 65 years, two experts suggested in interviews.

"They will need to know what tools are out there to be able to figure out whether a younger person is at equal to or greater risk than a 65-year-old woman with no addition risk factors," Dr. Carolyn J. Crandall said.

The online FRAX calculator that was used by the USPSTF is a "really good tool" for this purpose, said Dr. Crandall. "Clinicians will have to access that tool in their clinics, which means they will either need Internet access at some point, or else they can download versions that are available for iPhone, or print versions that are available."

Dr. Edward S. Leib also commended inclusion of the FRAX tool in the guidelines, but cautioned that it has some weaknesses that were discussed at a November 2010 "position development conference" conducted jointly by the International Osteoporosis Foundation and the International Society for Clinical Densitometry.

Some important risk factors that could affect the 10-year fracture risk would not necessarily be reflected in the FRAX calculation, he said. Also, the FRAX tool is based on an international model, and although it included U.S. databases, the calculations may not reflect risks in regional populations.

"For example, in a retrospective review of our population of 15,000 postmenopausal women having bone density studies over the past 10 years, we did not find a correlation between history of fracturing and parental history of hip fractures," he said.

Both Dr. Crandall and Dr. Leib also commended the USPSTF for acknowledging the need for more research in men, but Dr. Leib had hoped for more guidance. "It is known that the fracture risk in men who are age 75 is about equivalent to women who are age 65. I would have hoped that the USPSTF would have recommended screening at that age" despite the lack of primary prevention trials, he said.

DR. CRANDALL *is professor of medicine at the University of California, Los Angeles. She said she has no pertinent conflicts of interest.* DR. LEIB *is professor of medicine at the University of Vermont, Burlington. He said he has no pertinent conflicts of interest.*