**Dr. Blackwelder (AAFP President): AAFP update**

* Top priority payment reform
* Quadriple AIM
* No more old angry white guys model; happy…
* Payment reform
  + Pay for value not volume
  + Getting paid for asynchronous care- per member per month; improved outcomes; better satisfaction
* Payment risks
  + People have forgetten sequester
  + Medicare Medicaid parity ends at 2014
  + Primary care 10% bonus gone at end of 2015
* CME Changes
  + CME then and now, engage, challenge, in your face. Make people uncomfortable/ grace under fire.
* Change GME funding approach ($$ goes to hospital not program)
* Social mission?
* PMCH / **Community-based health**
  + [ ] **develop Far East “Care Community”**
* Support for members – MIG (member interest group)
* FamMedPAC California Donors
  + **[ ] donate to fam med pac**
* Family Medicie for America’s Health (FFM 2.0)
  + Comprehensive training
  + Team-based care including all roles
  + GME
  + Education
  + Advocacy
  + “Who We Are!”
  + Big splash in October at DC
* Resources
  + Aafp.org
  + Familydoctor.org
  + PCMH planner <http://bit.ly/QgHPF8>
  + Direct primary care: <http://bit.ly/1o94mm8>
  + Smart brief: <http://bit.ly/Rtq0DN>

**PCMH / ACO Panel discussion**

* PCMHC
  + Physician leads team/ everyone works to top of their license
  + Clinical pharm, dieticians, sw, pa, np, EHR, registries
  + Telemedicine, emails phone calls
  + “Right place, right way, right time” care delivery
* ACO
  + Hospital and health centers coordinate care
  + PCMH may cost more in the office, may be paid for in the back end.
  + PCMH is lower level, ACO is higher levels
* CIGNA’s view of ACO (Payor)
  + We’ve got to move away from RVU
  + Traditional model we sit in office and wait for people to get sick and wait for follow-up **no CPT code for proactive outreach**
  + **Information, opportunity, incentive**
  + Employers, health professionals, payors, customers
* HealthCare Partners Coordinated Care Model (AKA PCMH/ ACO) (Medical group)
  + Multispecialty medical group 700 providers, family practice 250
  + **Question**: Is there data that PCMH / ACO achieves any of elements of triple AIM (reduced cost, increased access, quality)?
  + **Comment**: I really like that CIGNA is worried about physician satisfaction- do the measure? How much of a priority is that or should that be?
  + Coordinate handoffs from discharge (DC summary, call PMD, make an appointment)
  + **PCP and providers are a precious and limited resource**
  + **Question:** What is an ACO? Payor? Facility? Physician group?
  + **Is ACO a destination or a pathway?** (Medical home = PCMH, ACO = Medical Neighborhood)
  + Change question from “how many patients do I have to see today” to “what can I do today to keep the patients for hom I’m accountable as healthy as I can?”
    - Does this degrade doctor physician relationship?
  + If we don’t move this way we will be left behind.
* Dr. Hornstein- should I join an ACO? (Solo practioner)
  + ACOs only taking care of 7% medicare right now, will go up to 30% in five years
  + Medicare Shared Savings ACO
    - Generated by CMMI: Engage doctors in payment innovation.
    - MSSP: just started in 2011, three year commitment
    - Accountable for quality and cost
      * If billings lower than benchmark AND if quality and satisfaction achieved, ACO can receive part of savings (several models)
  + All ACOs are different (Kaiser, HealthCare Partners, County)
    - But all are based on primary care physicians
    - Can be organized in different ways
      * Medical groups
      * Solo
      * Independent physician organization
      * Hospital
      * Insurance company based
  + Local hospital in community started an ACO (run by a board 8/11 physicians, 5 are primary care); one medicare beneficiary; one part time administrator; one part time medical director
  + Five reasons to join an ACO
    - Promotes better patient care
      * Need to think about populations and communities not just the patient in front of you
        + Need to risk stratify patients (high, rising, low risk patients)
        + **We need to tailor additional services to those patients who need it most**

How: Case managers in the hospital

Care coordinators / navigators

Other services

* + - Opportunity to grow your practice
      * Back referrals from specialists to PCPs due to Medicare attribution rules
      * Preferred provider status designation
    - Integration without loss of practice autonomy
    - Opportunity to increase physician satisfaction
      * Form a group
      * Assistance with quality metrics
      * Improve patient care
    - Opportunity for shared savings
      * ¼ first group of MSSP received shared savings

**WHAT THE H?**

* HIV
  + Screening
    - **1/5 have not been identified- slides pages 157 and 159**
    - Opt out screening
    - Clinical sign, risk factors (zoster pna vulvovaginal)
    - **Confirm ora quick in commercial labs**
    - Informed consent is required in CA; pregnant women are opt out must document refusal
    - CDC has info about laws in state
  + Clinical signs
    - **Acute HIV is a mononucleosis like symptoms wihin a few weeks of infection page 164**
    - Fever, lethargy, myalgia, headache, LAD
    - Primary infection with high viral load takes a while for symptoms to show up
    - **Manifestations of immunodeficiency:** Severe refractory Seb derm, molluscum on the face (usually presents as STD in an adult localized in lower abdomen groin region); Kaposi sarcoma violaceous papules generally not painful- may just have a little purple spot (need a tissue biopsy); recurrent folliculitis; candidiasis (thrush = pseudomembranous; atrophic form); oral aphthous ulcers (canker sores); leukoplakia (hairy); KS just in the palate; shingles; primary syphilis; AFEBRILE PNEUMONIA THINK ABOUT PCP or atypical pneumoni**a 167-174**
    - **Meds: google HIV treatment guidelines**
      * Four areas where we can inhibit the virus
      * See slide for MEDS in RED (those are used most nowadays) **176, 177**
      * Three regimens are complete in a single tablet (atripla, stribild, complera)
      * See slide for treatment guidelines- basically once someone ready to commit, get them on the meds
      * **Always look for interactions:** antacids, hs blockers, ppi, Viagra
    - **Adherence** is so important, lack breeds resistance; **When’s the last time you missed a dose?**
  + What about PrEP? 44-73% decrease in HIV acquisition in PrEP group depending on adherence
    - For high risk groups, serodiscordant couples
  + Only 28% of patients completely suppressed viral load (lte 200 copies)
  + **See slide for Key points 182**
* **Hep B**
  + Becoming a chronic disease, complicated but let’s make it simple
  + **It’s important- geographic distribution broader than you think 185**
  + Endemic areas are pretty much everywhere except NA, southern SA, west Europe, Australia, Greenland
  + Long incubation, takes about three months
  + **Course depends on when you get infected 186**
    - Young about a 100% chance chronic infection, zero for acute (opposite if infected later in life but as high risk acute)
  + **Let’s go through the tests 188**
    - Surface antigen shows up within a month
    - Viral load shows up within a month
    - E antigen with rapid replication -> e antibody when they start to clear it
    - Core antibody stays positive forever IgG (IGM goes away)
    - Surface antibody = immune
    - Within six months of infection they should not have surface antigen anymore, they are now chronic
    - Recovered/ resolved: core antibody and surface antibody positive (no core if immunized)
    - **Chronic: immune system stuck, serology depends on WHERE it gets stuck**
      * **Surface antigen does not go away**
      * **E antigen may clear, antibody may show up**
      * **Core total may continue**
    - core antibody means natural immunity, shot only gives antibody
    - anti E means at least partial immune response
    - **anti hbs pos, anti hbc pos, hbs antigen neg: immune from natural infection 188, 189 (top)**
  + **Stages of chronic hepatitis B (189 bottom)**
    - Perinatal transmission (in utero) -> **fetus develops immune tolerance** blood tests show normal LFT, pos e antigen, normal ALT
    - Get a bit older 30-40**: immune system starts to wake up**, hepatocytes start to die off (e ag pos, VL high, ALT abnormal). If this keeps going: Cirhosis and HCC
    - 8-12% per year seroconvert and lose their e antigen: they still make surface antigen (still replicating) but e antigen is negative; VL is low; 20% may go back and forth into active hepatitis
    - Chronic carrier progresses to later phase: e antigen negative chronic hepatitis: virus is making mistakes. E antigen is negative but VL positive. ALT goes back up (Precore/ core mutation) (10-30%) leads to chronic hepatitis (known as HBEAG negative chronic hepatitis)
    - **WE CAN TREAT**
    - Higher viral load = higher risk liver cancer and cirrhosis
    - **KEY POINT:**
      * Find the patient
      * Anticipate development of cirrhosis by age 40
      * Inactive carriers may reactivate
      * Normal ALT 20 F, 30 M **190 bottom**
    - **Screening see slide 191**
      * From endemic areas
      * MSM
      * Multiple sexual partners; inmates, elevated LFT, close contacts of hep b chronic carriers
      * Initial eval
        + Look for cirrhosis (compensated or decompensated)

Decompensated: ascites, encephalopathy, variceal bleed

* + - * + See slide for oher labs bottom 191
      * Follow-up
        + **Labs (ALT and AFP) and US every six month**
        + **Every 12 months e antigen**
        + If ALT becomes abnormal in an inactive carrier: Evaluate for reactivation of hepatitis B HBV DNA, HBeAg, Liver U/S, consider biopsy
    - Prevention
      * Vaccine
    - **Treatment: Question now is not whom to treat but when to treat**
      * See LOK ARTICLE FOR TREATMENT algorithm (looking at viral load and ALT) **slide on page 194 bottom**
      * Tenofovir or entecavir. 70% response rate even in people with normal ALT. lifelong treatment as low seroconversion rate; higher response rate in e antigen negative
      * Checking for fibrosis
        + Fibroscan shoots a sound wave into the liver and pretty well correlated with fibrosis
        + Fibrosure multiple biomarkers
      * Interferon can be used if e antigen, young; not a great medicine but can lead to cure (for young people with high levels of ALT)
      * Hep B is hiding in the nucleus (proviral DNA remains) thus hep B is a chronic disease
      * Need to screen patients for hep b prior to immunosuppressive therapy
      * Sceening see page 45
  + Hepatitis C
    - Silent epidemic of hepatitis C: not identified until 1990
    - High risks nonhisp blacks, income lt 2x poverty level, baby boomers
    - We are losing more people yearly from Hep C now than HIV
    - Boomers are 5 times more likely to be infected, 75% born bw 45 and 75
    - Injection, sexual and transfusion
    - Infection 85& chronic 20 % cirrhosis 10% cancer
    - CDC everyone 1945 and 65 screened at least once
    - **Serology is a lot easier: antibody and viral load (ab = infection but not immunity)**
    - **Monitoring- see slide**
    - **Treatment- telaprevir and bocepravir are already obsolete**
      * **Going to be primary care based, algorithmic based treatment**
      * **Look up** [**www.HCVguidelines.org**](http://www.HCVguidelines.org)
      * See slide for treatment options by genotype- probably interferon free regimens for all genotypes coming up within a few years (multiple by 2015) cost liver transplant $600 K; cost of treating patients with cirrhosis $270K
      * **Cost $84 K for 12 weeks (cheaper than a liver transplant) drug maker has a patient assistance program which will pay for sovaldi; have to select patients because people can get reinfected**
      * **Key points**
      * **See educational resources: CDPH.CA.GOV toolkit for hep B**
      * **HCVGUIDELINES.org**

**Parkinson’s in family medicine clinic 220**

* Parkinson’s is not just a movement disorder
  + See iceberg slide
* **HOW DOES THIS DISEASE START**
  + **By the time someone presents they’ve lost 50-75% of striatal dopamine** likely to have started many many years before (**How early can it be detected)**
  + Kind of irrelevant right now because treatments are all symptom related, not disease modifying
  + LEWY BODY is either marker or cause of cell death. Substantia nigra
  + **T**REMOR at rest
  + **R**IGIDIT
  + **A**KINESIA
  + **P**OSTURAL INSTABILITY
  + Look at posture, tremor **(usually starts on one side**); hand flexed at MP and extended at fingers, pill rolling tremor
  + Do they have to push to stand up; watch them walk
    - Gait small shuffling late; early arm doesn’t swing (posturing). Affected sided just “keeps up”; **they don’t turn easily, take several steps; stopping and starting they get stuck**
    - Facies: poker faces, don’t blink (used to be called serpentine stare) or flexed simian posture
    - **Nonmotor symptoms: olfactory dysfunction antedates disease by a long time, REM sleep behavior disorder PD patients have frightening dreams, shout scream, etc. depression and anxiety are not comorbidities a part of disease see slide for other**
  + **STEP 1: DIAGNOSIS**
    - BRADYKINESIA (hand slaps, finger taps, open and closing fisting for 15 seconds at least)
    - AND AT LEAST ONE
      * Muscular rigidity
      * 4-6 Hz resting
      * Postural instability not caused by primary vsual, cerebellar or proprioceptive dysfunction
  + STEP 2: EXCLUSION
    - Several see slide; more than 1 affected relative, sustained remission, strictly unilateral features after three years
    - Can’t rule it in. can do things to rule it out
      * MRI, avoid if possible in classic case where they respond; do perform if vascular risk factors, rapid progression
      * DaTscan is a PET scan that if normal can rule out PD; if abnormal
  + How does it all start. Motor and nonmotor symptoms with nonmotor symptoms antedating
    - Caused by loss of dopaminergic neurons
    - BRAAK hypothesis
      * Starts in lower brainstem and olfactory tubercule, myoenteric plexus (nerve supply to the gut); final stage begins to involve the cortex.
      * Dementis is an almost inevitable part of development if patient survives for long enough
      * Slowness In processing of information
  + Treatments
    - You have to think about dopamine
      * First you make it
      * Then it crosses synapse
      * Some taken up by producing cell
      * **MAO-B inhibitors** push plug back in the sink
        + Good thing:

they are very different to MAO A, you do not have to modify diet. They are safe and very effective

may not have to take anything else for two years

* + - * **dopamine agonists**
        + better for the young because they can cause confusion etc in older patients
        + **major side effects: sleep attack (drop off while you’re driving); impulse control disorder (compulsive behavior gambling, sex, shopping, eating); least with the new kid on the block (patch)**
      * **levodopa: the best drug for parkinsons**
        + converted to dopamine in the brain; dopamine is used all over the body so there were a lot of side effects
        + carbidopa blocks conversion in the periphery
        + comtam (sp?) combined with above, prevents metabolism by a different pathway
      * it’s important to manage carefully- long term side effects
        + levodopa wears off, peak dose dyskinesia so you try to delay starting levodopa
        + levodopa does not lose effectiveness after five years
      * game plan: maob first, add dopamine agonist if they’re young; levodopa if over 70; can add maob if the med is wearing off
      * **nondrug: physical therapy; working out; speech therapy; swallowing therapy; bronchitis pneumonia cough === send for dysphagia eval and then modify their diet (thin liquids are the hardest things to swallow); balance and fall prevention**
      * deep brain stimulation very good for tremor and rigidity; not so great for older patients or patients with severe dementia and depression

**Asthma**

* **use action plan; teach inhaler use; follow symptoms; how is asthma interfering with your life**
* there’s an app for that: assist me with inhaler
* take home points;
  + asthma management more than the sum of meds
  + shared decision making
  + patient engagement
* see resources

**Family Medicine Update 264**

* Access recent study about Massachusetts
  + Increased utilization but better outcomes
* Most people who go on disability don’t go back to work
* **JNC 8 age over 60 BP guideline is relaxed, everyone else 140/90 see good slide for summar**
  + **Nonblack: thiazide, ace, arb, ccb**
  + **Black: thiazide, ccb**
* Lipid guidelines
  + Four groups (hx cad, ldl gt 190, dm, 10 yr risk 7.5)
    - Cad- high intensity
    - Ldl – high intensity
    - Diabetes 40-75
      * Risk above 7.5 high
      * Risk below 7.5 moderate
    - Just risk above 7.5 – moderate or high intensity
  + No more treat to target
  + Know your risk
  + Risk calculator
  + Ldl ok for adherence don’t use as a performance indicator
  + Role of low intensity statins is dramatically diminished
* Microscopic hematuria
  + **Cytology not recommended, CT urography is imaging of choice, cytology not recommended (2012 AUA guidelines)**
* **Chest**
  + Annual low-dose CT age 55-80 with 30 pack-year hx and currently smoke or quit within past 15 years
  + NNS 577 to prevent one death
* Diabetes guidelines
  + See good slide
  + 2009: add bariatric surgery
  + 2010: a1c diagnostic for DM (point at which retinopathy develops
  + 2011: strategies for restructuring chronic care systems
  + 2012:
  + 2013: hep b vaccination; have patient on a statin
  + 2014: add a second agent after 3 months, don’t just use insulin sliding scale, retinopathy screening every two years
* Sunshine law
  + Disclosure of payments and gifts to physicians
* Tdap for pregnancy
  + New guideline as of 2011
  + More aggressive now every pregnancy 27-36 weeks maximize passive transfer of transplacental; cocooning;
* Cervical cancer screening
  + 3 years for cytology, 5 for HPV + cytology (30-65)
  + Don’t screen for less than 21
* HTN research
  + 2002 ALLHAT: thiazides are good they work they’re cheap (chlorthalidone)
  + **2013: Kaiser; how do you take care of hypertension in a population**
    - Registry
    - Metrics
    - EB guidelines
    - MA visits for BP measurement
    - Single-pill combo
  + Closing the gap between what we know and what we do
* **Social networks** 
  + **predict gun violence**
  + **Obesity spreads across social networks (spouse, sibling, friend)**
* **Whitehall study (18K males in british civil service)**
  + **Men in higher grade positions lived longer**
* **Built environment**
  + **Where you live is one of the most important factors**
    - **Weight 8 lbs less if you live in a less walkable area**
* **These last three bits are going to be where we need to focus on as we move into the accountable care stuff (we need to stop thinking beyond patients, clinics and hospitals)**

**Prescription drug abuse in teens**

* 24% have misused or abused a prescription drug at least once in lifetime (up from 18% in 2008)
* 12 – 17 yo abuse prescription drugs more than other illicits combine
* 1/5 start before 14
* Every day abou 2000 kids use rx drugs without a doctor’s guidance for the first time
  + Usually starts with a prescription that doctors have given
  + 70% get from friends and family
  + **20% say parents don’t care as much as with other drugs**
  + Other drugs are stable; rx drugs are going up; alcohol going up
  + 90% of adolescents that need help with a drug or alcohol problem aren’t getting help
  + 1/3 parents believe that stimulants enhance performance even without ADHD
  + Willpower alone is often insufficient; just say no is not enough
  + Teens are wired to take more risks
  + Talk about family and what’s going on at home
  + Dispel cool factor myth
  + Wha’ts abused
    - Opioids, CNS depressants, stimulants
* Treatment
  + Early recognition
  + School programs are largely ineffective

**Insomnia (60% of primary care complaints)**

* Insomnia is a SYMPTOM of a lot of potential problems
* See slide for definition poor sleep plus dysfunction
* REM is not deep sleep, body tries to catch up REM sleep so don’t sleep as deep if you’re missing sleep
* NON REM: brain repair from oxidative stress
* REM sleep: memory, receptor sensitivity is upregulated bc NTs decrease
* ACUTE v CHRONIC (less than 3 months v more than 3 months)
  + Acute: try to help them associate it with an event / change / situational/ occupational / financial stress
  + Chronic: is there daytime impairment, co-morbid conditions
* Almost any med can cause
* Sleep diary
* Epworth sleepiness scale
* Neuro exam, MMSE

**Covered CA (Dressner)**

* Covered CA is the marketplace not the payor
* Three paths medi-cal (below 139 fpl), subsidized plans (139-400 ), regular plans (abov 400 fpl)
* Adult students highest uninsured
* Medi-cal enrollment continues year round, covered California open enrollment for 2014 has ended
* Metal tiers bronze = low premium but high cost (good for low utilizer); platinum high premiums but only pay 10% if you get into the system
  + 139-200% need to buy a silver plan if want extra benefits
  + **Question: what are the extra benefits?**
* Next open enrollment 10/15/14 can also sign up if life event (birth, marriage, adoption, citizenship, error in enrollment or non-enrollment, misrepresentation or inaction, lose your job
* [www.coveredca.com](http://www.coveredca.com)

Advocacy

* Covered CA are not taking responsibility for contracts b/w physicians and health plans or adequacy of networks (falls to dept of insurance)
* **SEE SLIDE FOR ACCESS PROBLEMS- report access problems**
* also can report to CAFP staff
* **some special rules apply to covered California patients (will have logo on their card)**
  + EPO = exclusive provider organization (no out of network benefits) if patients sent to wrong hospital could end up covering 50% of their cost
* Grace period: 3 months after last payment until being kicked off; after month two they are now suspended and we will be notified
* Issues
  + Who’s on what network?
  + Broad networks
  + How to manage (deductibles copays referrals)
  + **WEBINARs (see slide)**
  + Can have someone come and talk to you

Transgender

* Most underserved population
* What gender were you assigned at birth?
  + Male, Female, Other
* And how do you identify now?
  + Male, female, transman (female to male), transwoman (always name for where your heading), gender nonconforming, gender queer, other
  + Starting to work with EPIC
* Are you or any of your sexual partners thinking about getting pregnant in the next year?
* Change to gender neutral signage in bathrooms.
* Ok to apologize to patients: “I’m so sorry, I’m still learning.”

Life

* Stones and sand analogy

Force of Family Medicine

* Be there and give a damn

Scabies **372**

* Make sure patient covers all body (behind ears, belly button between fingers)
* Infant all over- consider in ddx eczema in infants
* Sulphur treatment for infants and pregnant women
* Handouts
* Retreat in a week
* Itch and nodules last long after infestation
* Treat everyone in the house even if they are asymptomatic
* Permethrin for everyone
* Ivermectin 200 MCG/KG (max dose 18 mg)
* Usually just one dose unless severe exczemantous repeat in a week

Tinea capitis

* Can cause hair loss in kids (usually 3-7 yoa)
* Variable clinical manifestations

Molluscum

* Beetle juice

Perioral derm

* Steroids may worsen it

Granuloma annulare

* NO SCALE
* Biopsy to confirm, cause unknown, 73% disappear in to years

ER/LA opioid jeopardy