THE MARYLAND

family doctor

SPRING 2010

The official journal of the Maryland Academy of Family Physicians

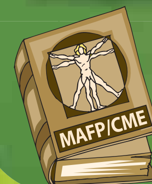
CARDIOVASCULAR HEALTH

Screening for Cardiovascular Disease

Aspirin for the Primary Prevention of Cardiovascular Disease

ALSO. . .

- Recognition and Treatment of Depression in Family Medicine, Part 2
- ACOs – Friend or Foe?
- Sexual Assault: The Role of the Family Physician
- "Solutions Through Interactive Learning:" See You in June in Annapolis!



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Spring 2010
Volume 46, Number 4

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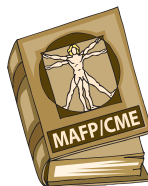

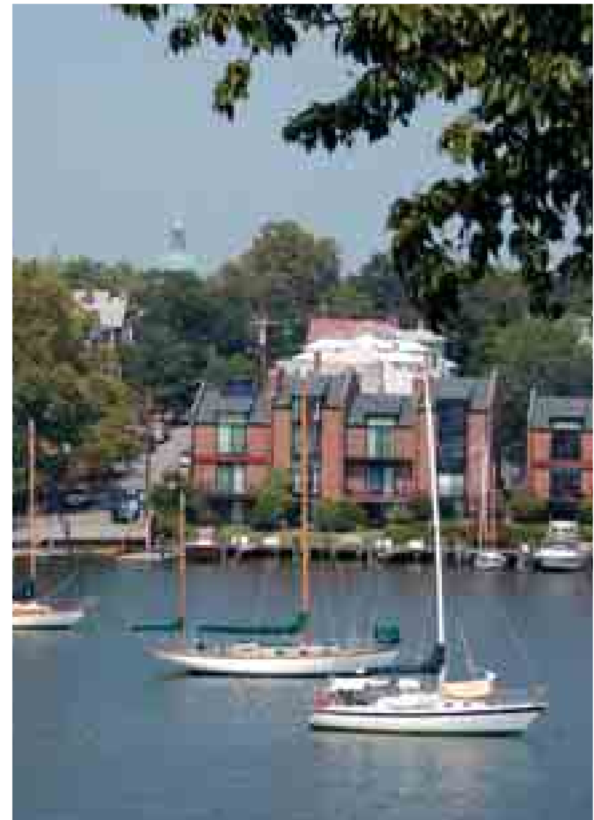

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THE MARYLAND
FAMILY DOCTOR

Spring, 2010
Volume 46, Number 4

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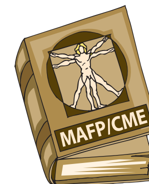
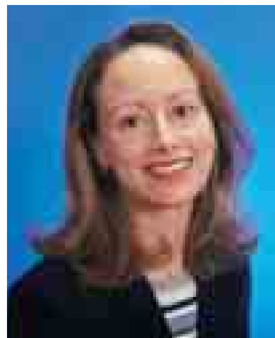
Published April 2010/MAF-Q0210/4041

editor

Focus on Prevention and Screening for CVD





by Tracy A. Wolff, M.D., MPH

CARDIOVASCULAR DISEASE (CVD) is a significant health burden in the United States, and it is becoming more and more important as the population ages and the number of overweight and obese Americans increases. While we have made great strides in reducing morbidity and mortality from CVD, this has come at a cost of increasing prescriptions and interventions. That should make us all focus more and more on prevention – counseling on preventive behaviors, screening for early asymptomatic disease and prescribing appropriate preventive medications.

In this edition, I have written an article on the epidemiology of first myocardial infarctions and strokes and on aspirin for the prevention of these events. You may have seen recent articles, editorials or media spots that have called into question the use of aspirin for the primary prevention of CVD events in asymptomatic adults. I think these authors have erroneously considered the data on benefit and harms.

Many authors and researchers have equated the benefits and harms of aspirin on a one-to-one basis in their calculations of overall net benefit; that is, the prevention of one myocardial infarction or one debilitating stroke is equivalent to the risk of a gastrointestinal bleed (GIB). As family physicians who have discussion with patients about benefits and risk, we likely agree that this is too simplistic a view of the benefits and harms of prevention. We must consider the whole patient, including risk of CVD over the next 10 years, gender, comorbidities and patient preferences. I think we need to consider that a patient with a very high risk of CVD and a low risk of GIB may make the decision that he is willing to risk a GIB (or even two GIBs) to prevent a heart attack. I would encourage you to take a look at the USPSTF recommendation on aspirin for the prevention of CVD (www.preventiveservices.ahrq.gov). The website has the USPSTF recommendation with detailed data tables and pamphlets that family physicians can use to facilitate shared decision making on aspirin therapy.

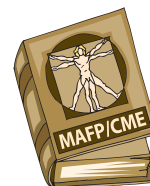
Another article, by family physician Mark Humphrey, describes the use of ultrasound to screen for CVD. I believe this could be very useful information for family physicians who may be approached by patients asking about the full-body ultrasound in vans coming to their churches and offered by for-profit companies. Dr. Kevin Ferentz has written a follow up article for this edition focusing on the recognition and treatment of depression by family physicians. While his article does not focus on CVD, there is mounting evidence that CVD outcomes are worsened by accompanying depression. Family physicians are uniquely qualified to focus on these two prevalent and often coincident illnesses.

Other articles in this edition include one by Dr. Zowie Barnes, resident director for the Board of the Maryland Academy of Family Physicians (MAFP) and our resident editor, on sexual assault with information specific to Maryland. Dr. Ken Bertka has written a very interesting and information article on Accountable Care Organizations.

I am very pleased to present this edition of *The Maryland Family Doctor*. In addition to the very informative articles there is information on members in the news and details on the Annual Assembly of the MAFP – "Solutions Through Interactive Learning" – to be held in Annapolis in June. I hope to see you there and I hope you enjoy this edition of *The Maryland Family Doctor.* ■

Dr. Wolff is a family and preventive medicine physician. A Western District director on the board of the Maryland Academy of Family Physicians, she is also a member of the MAFP editorial board, editing this, her 6th edition of *The Maryland Family Doctor.*

Screening for Cardiovascular Disease



by Mark E. Humphrey M.D., M.P. H.

MR. JONES, 68, is waiting in the next room. It has been months since his last appointment. As I brush up on his past medical history (30 pack year smoker, controlled hypertension and family history of lung cancer) I consider what cardiovascular prevention topics I should address during this visit along with his chief complaint.

The United States Preventive Service Task Force (USPSFT) has reviewed the evidence and made recommendations regarding abdominal aorta, carotid arteries and peripheral vasculature screenings. While most asymptomatic patients are not recommended for these screenings, the procedures are commonly performed.

The USPSTF does recommend a one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked. They found that screening and performing a surgical repair for large AAAs on men of this age group and smoking status significantly decreased the mortality associated with abdominal aortic aneurysms. According to the USPSTF, large is considered to be 5.5 cm or greater in diameter and ever smoked is considered to be more than 100 cigarettes in a lifetime. While there is risk involved in the surgical repair, the task force found that because of the significant frequency of AAA in this population the benefits outweighed the harms.

This is not the case for women and men who do not have a history of smoking. The potential harm versus benefit ratio for men without a smoking history is close to even and a recommendation was not reached in this population group. Screening should be considered on an individual basis, as a part of the doctor-patient relationship. Because of the rather low frequency of AAA in women, screening is not recommended for any age group or smoking status.

Major risk factors for AAA include being male, 65 years or older and a history of smoking. Having a first-degree family history of AAA that required surgical repair also elevates a male's risk for AAA. The Agency for Health Quality and Research has created a patient handout on the topic; it can be found at: http://www.ahrq.gov/clinic/cvd/aaapatient.htm.

Considering the carotid arteries, when no signs or symptoms are present, in the general adult population, the USPSTF recommends against the use of screening for asymptomatic carotid artery stenosis. This includes the use of duplex ultrasonography, magnetic resonance angiography or digital subtraction angiography as screening tools. Even though stroke accounts for one of the leading causes of disability and mortality across the United States, only a small proportion of unexpected and immobilizing strokes are directly linked to carotid artery stenosis.

This recommendation is only for patients without neurologic signs or symptoms, including transient ischemic attacks or strokes. When these symptoms are present, diagnostic testing may be indicated. Patients with a carotid-area transient ischemic attack, if otherwise eligible, should be promptly evaluated for possible carotid endartectomy.

Peripheral artery disease (PAD) is atherosclerosis of the arteries distal to the aortic bifurcation. The USPSTF recommends against screening for PAD in asymptomatic individuals. While the ankle brachial index can be used to detect PAD, there is little evidence that treatment at the asymptomatic stage of disease improves outcomes beyond treatment based on a complete cardiovascular risk assessment.

When an individual is symptomatic and PAD is suspected, an ankle-brachial index value of 0.90 or less is consistent with PAD. Often patients with this level of difference between their ankle and brachial arteries have limitations in lower extremity physical activity tolerance levels. Cholesterol-lowering agents and cessation of smoking have been demonstrated to improve the claudication symptoms associated with PAD. Further information on screening for PAD and carotid artery stenosis may be found at: http://www.ahrq.gov/clinic/cvd/vascprovider.htm.

In summary, for asymptomatic individuals, the USPSTF recommends:

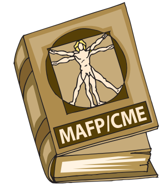
- Screening men ages 65-75 that have smoked more than 100 cigarettes in their lifetime for abdominal aortic aneurysm
- Against screening women for abdominal aortic aneurysm
- Against screening for carotid artery stenosis
- Against screening for peripheral artery disease

My conversation with Mr. Jones ended with a prescription to help him through his current bout of bronchitis and his deciding to get his aorta screened for an abdominal aortic aneurysm. ■

Dr. Humphrey is a preventive medicine resident at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland. His research interests include rural health disparities, global health and United States health care policy.

Note: References for this article are posted at www.mdafp.org; publications and news tab.

Aspirin for the Primary Prevention of Cardiovascular Disease



by Tracy A. Wolff, M.D., M.P.H.

CARDIOVASCULAR DISEASE (CVD) is the leading cause of death in the U.S.; it is the underlying or contributing cause in approximately 58 percent of deaths. Overall, one in three adults has some form of CVD. In adults ages 40 and older, the lifetime risk for CVD increases to approximately 66 percent for men and 50 percent for women. CVD was an underlying cause of death in one out of every 2.7 deaths, accounting for roughly 2.5 million deaths in 2003. [1]

The epidemiology of CVD events is different for men and women. Men have a higher risk for coronary heart disease (CHD) and tend to have these events at a younger age than women. Men have a lifetime risk of 49 percent for a CHD event after the age of 40: for women the lifetime risk is 32 percent. The median age is 66 years for first myocardial infarction (MI) in men and 70 years for women. Mortality is higher as a result of a MI for women; 38 percent of women die within one year of a first MI versus 25 percent of men. This is likely due in part to the older age in women at first MI.[1 2]

More women die of stroke than men because of their longer life expectancy, even though overall incidence is higher in men. [3] According to Framingham data, the 10-year risk for initial ischemic stroke at age 55 is approximately 2 percent for women and 2.5 percent for men; at age 65 the risk increases to approximately 4 percent in women and 6 percent in men. The lifetime risk for ischemic stroke is greater in women than men between the ages of 55–75 (approximately 17 percent in women and 13 percent in men). After age 75 the risk decreases: 14 percent in women and 8 percent in men.

Several effective preventive strategies for the prevention of CVD events are available. An important strategy is daily low dose aspirin. The practice of prescribing aspirin to asymptomatic women for the prevention of myocardial infarctions has been called into question after the publication of a recent large study in women and a meta-analysis that reported no benefit. [4 5] In the past, many organizations have recommended aspirin for the prevention of first myocardial infarctions in both men and women. These recommendations were based on studies primarily of men. The new evidence from the Women's Health Study and a recent meta-analysis with sex-specific calculations [4 5] help clarify the differing benefits of aspirin for men and women.

Evidence

A recent good quality meta-analysis suggests differential benefits of aspirin by sex: men derive benefit in the reduction of MIs and women derive benefit in the reduction of ischemic strokes.[5] Berger and colleagues' meta-analysis[5] reported on the sex-specific benefits of aspirin in 51,342 women and 44,114 men enrolled in six primary prevention trials.[5] This meta-analysis included the recent Women's Health Study [4] and five older RCTs: the British Male Doctors' trial[6], the Physicians Health Study [7], the Thrombosis Prevention Trial [8], the Hypertension Optimal Treatment trial [9] and the Primary Prevention Project[10]. Aspirin use in women was associated with statistically significant reductions in cardiovascular events (odds ratio [OR], 0.88; [CI, 0.79 to 0.99]) and ischemic strokes (OR, 0.76[CI, 0.63 to 0.93]); no statistically significant benefit was found in the reduction of myocardial infarctions or cardiovascular mortality. In men, aspirin use was associated with a statistically significant reduction in cardiovascular events (OR, 0.86 [CI, 0.78 to -0.94]) and in myocardial infarction (OR, 0.68 [CI, 0.54 to 0.86]); no statistically significant benefit was found in the reduction of ischemic stroke or cardiovascular mortality. Overall mortality was not significantly reduced by aspirin use in men or women.

There is consistent evidence that aspirin increases the risk for major bleeding events, primarily gastrointestinal bleeding (GIB), in men and women. The recent meta-analysis by Berger and associates reports that hemorrhagic strokes are statistically significantly increased among men, but not increased in women. Men seem to have about twice the risk for serious gastrointestinal bleeding from aspirin than women. [2 4] In women younger than 60 years without risk factors for GIB, aspirin is associated with 0.4 per 1000 person-years excess cases of serious GIB. In men younger than 60 years without risk factors, the excess number is 0.8 per 1000 person-years. [11] Other risk factors for bleeding include upper gastrointestinal tract pain, gastrointestinal ulcers and NSAID use. Nonsteroidal anti-inflammatory drug therapy combined with aspirin approximately quadruples the risk for serious gastrointestinal bleeding compared with the risk with aspirin alone. The rate of serious bleeding in aspirin users with a gastrointestinal ulcer is approximately two to three times the risk for those without an ulcer.

Recommendations

The United States Preventive Services Task Force (USPSTF) recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal

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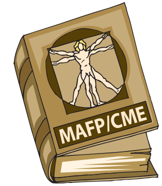
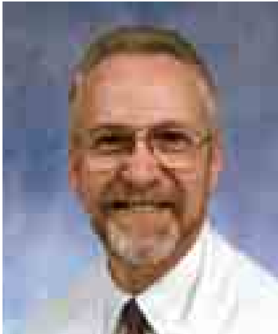


The Recognition and Treatment of Depression in Family Medicine **Part 2**



by Kevin Scott Ferentz, M.D.

The question I often ask when discussing this issue with residents and colleagues is "When was the last time you referred a patient with hypertension to a nephrologist or cardiologist?" The answer is usually "never."

Note: This is the second part of a two-part article regarding depression. Part 1 appeared in the Winter, 2010 Edition of The Maryland Family Doctor *and dealt with demographics, etiology, diagnostic criteria and differential diagnosis. Part 2 deals with treatment issues.*

DEPRESSION IS ONE of the most common illnesses seen by family physicians. The vast majority of depressed patients can be cared for by their family physicians. With the advent of SSRIs, antidepressant medications have become easy to prescribe and are quite safe. Given the wide range of complex medical conditions family physicians are comfortable treating pharmacologically, i.e., diabetes, hypertension, congestive heart failure, it is clear that family physicians should be as comfortable with prescribing antidepressants. This article will review the use of the available antidepressants.

The Hypertension Analogy

Despite the fact that antidepressants as a class are not particularly difficult to prescribe, family physicians often do not feel comfortable increasing doses and changing medications when patients do not respond to their initial therapy. The question I often ask when discussing this issue with residents and colleagues is "When was the last time you referred a patient with hypertension to a nephrologist or cardiologist?" The answer is usually "never." That is because we learn early on that if a patient with hypertension doesn't respond to a medication we increase the dose, change medications or add a second medication. The same strategy applies to the treatment of depression. When a patient seen by a primary care physician for depression is not responding to the initial dose of antidepressant and gets referred to a psychiatrist, the first intervention is usually to simply increase the dose of the initial medication. Family physicians should feel equally comfortable working with antidepressants.

Role of Psychotherapy

For most patients with anything more than mild depression, psychotherapy is an adjunct to drug treatment. It rarely replaces drug treatment. For patients with mild depression psychotherapy is as effective as antidepressants. While many different forms of psychotherapy exist, cognitive behavioral therapy (CBT) is the most studied and validated paradigm. Exercise is also effective in mild depression. The more significant the depression the more likely the patient requires antidepressant medication. The combination of medications and psychotherapy is usually required for severely depressed patients. Unfortunately, many patients choose not to see a psychotherapist because either they believe there is stigma associated with it or they cannot afford it. In patients who are unwilling or unable to undergo psychotherapy, family physicians are able to provide brief, supportive, interactive psychotherapy as part of our practices. Another excellent resource for patients is the book "*Feeling Good: The New Mood Therapy,*" by David Burns, which teaches patients how to do their own cognitive-behavioral therapy.

Non-pharmacological Treatments

Electroconvulsive therapy (ECT) has been used to successfully treat severe depression for decades. With a nearly 80 percent response rate, ECT is the most effective treatment for depression. While short term memory loss is a common side effect, ECT is safe for most patients. All family physicians should know of a psychiatrist they can refer to for ECT.

Transcranial Magnetic Stimulation (TMS) is an FDA-approved treatment

involving the use of magnetic pulses to stimulate nerve cells in the brain involved in mood regulation and depression. TMS is an outpatient procedure that doesn't require anesthesia. Patients usually have five brain stimulation treatments each week for up to six weeks. As many as 50 percent of patients respond to the treatment.

Deep Brain Stimulation is an experimental treatment which implants a device known as a "brain pacemaker." It is approved for the treatment of patients with essential tremor, Parkinson's disease and dystonia, but has not yet received FDA approval for the treatment of depression.

Pharmacological Treatment

A comprehensive review of antidepressants is beyond the scope of this article. Following are brief comments regarding the currently available medications.

Tricyclics (TCAs)

Tricyclics (amitriptyline, imipramine, nortriptyline, desipramine, doxepin) were for many years the only medications available to treat depression. TCAs are highly effective, with most of them acting as serotonin-norepinephrine reuptake inhibitors (SNRI's). Unfortunately, their side effect profile limits their usefulness when compared to the much safer newer medications. Only 10 days of an effective dose of a TCA can be lethal. TCAs are usually reserved to treat various chronic pain syndromes, and in much smaller doses than that required to treat depression.

Monoamine oxidase inhibitors (MAOIs)

MAOIs (phenelzine, tranylcypromine) have side effect profiles and dietary restrictions that have limited their use in primary care. Recently, a transdermal selegeline (Emsam®) was introduced which is somewhat easier to use and has an improved side effect profile.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Since the introduction of Prozac in the early 1980s, most patients with depression have been treated with an SSRI: fluoxetine [Prozac®], sertraline [Zoloft®], paroxetine [Paxil®], citalopram [Celexa®], escitalopram [Lexapro®]). The SSRIs are generally well tolerated, with nausea, diarrhea and headache being the most common early side effects. Sexual dysfunction, particularly difficulty in achieving orgasm, can be seen in as many as 40-60 percent of patients on an SSRI. Treatment options for the orgasm dysfunction include adding bupropion or mirtazepine. One great advantage to the SSRIs is their efficacy in treating the various anxiety disorders which often occur co-morbidly with depression.

Serotonin-Norepinephrine Receptor Inhibitors (SNRIs)

There are currently three SNRIs on the market: (venlafaxine [Effexor®], duloxetine [Cymbalta®] and desvenlafaxine [Pristiq®]). SNRIs have a theoretical advantage to SSRI's in that they have activity in both major neurotransmitter systems, so called "dual reuptake inhibitors." Indeed, SNRIs have been shown to get more patients to remission than SSRIs (see below). SNRIs also treat pain, with duloxetine having an indication for painful diabetic neuropathy. In addition, desvenlafaxine has data that shows it is effective in treating post-menopausal hot flashes, but has not yet received FDA approval for that indication. SNRIs are also effective in treating anxiety disorders.

Bupropion (Wellbutrin®)

Bupropion is a unique antidepressant in that it has no effect on serotonin. It appears to work by increasing levels of dopamine and norepinephrine. As such, while it is not indicated for anxiety disorders, it has the great advantage of not causing sexual dysfunction. As mentioned previously, bupropion is the most effective antidote to SSRI-induced sexual dysfunction. Bupropion is the most commonly used augmentation strategy for patients not completely responding to one antidepressant. Bupropion is also effective in the treatment of tobacco dependence (Zyban®).

Mirtazapine (Remeron®)

Mirtazapine increases activity in both the serotonin and norepinephrine systems, but not through reuptake inhibition. It has fewer sexual side effects than SSRIs, but it has more anticholinergic side effects (dry mouth, weight gain) than other newer antidepressants. It has anxiolytic properties, but is not officially indicated for the treatment of anxiety disorders. Mirtazapine is often used to augment the efficacy of SSRIs.

Trazodone (Desyrel®)

Trazodone has efficacy in the serotonin system through receptor antagonism. While approved for the treatment of depression for many years, sedation limits its usefulness as a primary antidepressant. It is, however, a useful sleep aid, in both depressed and non-depressed patients, usually at a dose of 50 to 100 mg.

Nefazodone (Serzone®)

Nefazodone also has efficacy in the serotonin system through receptor antagonism. Due to reports of liver failure, nefazodone has a black box warning concerning its use. Nefazodone generally has fewer sexual side effects than other commonly used antidepressants.

The dose ranges of the commonly used antidepressants are listed in Table 1. (See page 10.)

Efficacy of Antidepressants and Drug Selection

Clinical trials of antidepressants, and FDA approval, rely on the concept of "response" to the drug, defined as at least a 50 percent reduction in Hamilton Depression scores. Unfortunately, many patients that "respond" to a drug are

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Table 1. Antidepressant Medications

Medication	Dose (mg) Range in Major Depression
Bupropion	150-450
Desvenlafaxine	50
Duloxetine	60-120
Escitalopram	10-20
Fluoxetine	20-60
Mirtazapine	15-45
Paroxetine	20-50
Sertraline	50-200
Venlafaxine	75-375

not back to normal, or "non-depressed." Getting back to normal means remission, i.e., complete lack of symptoms. This is defined as a Hamilton Depression score of seven or less, or a PHQ-9 score of four or less (Readers are referred to Part I of this article which details the use of the PHQ-9.) It is important to get patients to remission because patients who do not get to remission are much more likely to relapse.

All antidepressants have the same response rates – roughly 70 percent. In studies looking at remission rates, it appears SNRIs are more likely to get patients to remission than SSRI's (45 percent compared with 35 percent). When patients are seen in follow-up it is appropriate to administer a PHQ-9 at each visit. In patients who do not reach remission, one should first consider increasing the dose of the medication. If remission is not achieved within six to eight weeks, consider switching medications or augmenting with a second medication, usually bupropion. A recent landmark trial examined patients who failed treatment with citalopram and were switched to either bupropion, sertraline or venlafaxine. The study showed that 25 percent of patients achieved remission no matter which drug they were switched to. This would indicate that patients who fail on one SSRI may do well on another.

A recent meta-analysis looked at 117 randomized controlled trials of bupropion, citalopram, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline and venlafaxine. The results showed that mirtazapine, escitalopram, venlafaxine and sertraline were significantly more efficacious than duloxetine, fluoxetine and paroxetine. The study also showed that escitalopram and sertraline showed the best acceptability with less discontinuation than duloxetine, paroxetine and venlafaxine. The overall conclusion was that sertraline might the be best initial choice, showing the best balance between benefits, acceptability and cost.

In choosing an antidepressant, consider prior anti-depressant treatment, including those used by family members. There is data that indicates that patients are more likely to respond to a medication that a family member has responded to.

St. John's Wort

Unfortunately, for some patients taking antidepressants is associated with stigma. People may resort to the use of St. John's Wort in order to avoid prescription medication. St. John's Wort has been shown to be ineffective in moderate to severe depression. It can induce hypomania, precipitate hypertensive crisis and delay emergence from anesthesia. Assays of products on the shelf have shown highly variable formulations. So while St. John's Wort is probably effective in mild depression, it is certainly no better than standard anti-depressants.

Stopping Antidepressants

There is a withdrawal phenomenon associated with most antidepressants, especially those with shorter half-lives. However, most patients stop their antidepressants without ever seeing their physician, so clearly the withdrawal syndrome does not affect all patients and it is usually not severe enough for patients to contact their physician. Patients on antidepressants for more than a month should be tapered from their medication, usually no faster than 50 percent every five days. This means taking about two weeks to taper. This will almost always avoid withdrawal. The only exception to this recommendation is fluoxetine, which has such a long half-life that tapering is usually unnecessary.

The "Black Box Warning" and Patient Follow-up

Several years ago the FDA mandated a black box warning for all antidepressants. The warning addressed the increased risk of "suicidality" in children, teens and young adults during the first months of treatment. There was no increase is suicidal thought in patients over the age of 24, and there was a decrease seen in patients over 65. The studies leading to the warning showed a doubling of suicidal thought when compared to placebo: 4 percent vs. 2 percent, with no suicides. Since the warning the suicide rate in adolescents is increasing. A more recent study has shown that higher SSRI prescription rates were associated with lower suicide rates in children and adolescents. While suicidal thoughts must be monitored in patients on antidepressants, clearly more depressed patients commit suicide when *not* taking antidepressants than when on antidepressants. It is important for patients to follow-up within one to two weeks of starting an antidepressant, and regularly after that, to track symptoms and response.

Phases of Treatment

Treatment of depression is divided into three phases: acute, continuation and maintenance. The acute phase begins

when the patient starts treatment and ends when the patient is in remission. Once the patient is back to normal, the continuation phase begins. Since an untreated episode of depression lasts approximately 14 weeks, patients who stop medication within that time are much more likely to relapse. Current guidelines recommend patients stay on their medication from four to nine months after they feel better.

For most patients, depression is a recurring disease. One half of patients will have a recurrence within one year of their first episode, and two thirds within five years. Patients who have had three or more episodes of depression have a greater than 90 percent chance of another episode and should be offered long term treatment, known as maintenance. The maintenance dose is the same dose that got them better, so there is no need to decrease the dose long-term. It is unknown how long maintenance should last, but some patients require life-long treatment. Patients who have been on long term treatment who wish to stop their antidepressants should be tapered slowly – over months – and clinicians should be watchful for signs of recurring depression. In addition, patients who have had multiple episodes of depression benefit from ongoing psychotherapy.

Conclusions

In these two articles I have tried to give a useful overview of the recognition and treatment of depression in our offices. There are many topics that have not been touched upon, such as the treatment of depression in pregnancy, switching antidepressants, treating comorbid disorders, augmentation strategies and many others. I would refer you to the many excellent review articles that are available.

Clearly, family physicians are capable of successfully treating the vast majority of depressed patients. The treatment of depression can be incredibly rewarding, giving patients relief from suffering that affects not only themselves, but their families as well. I can think of few disorders that belong more in the purview of the family physician - the physician that is best prepared to treat patients in the biopsychosocial model. ■

Dr. Ferentz was MAFP president in 1999. He is associate professor and director of clinical operations at the University of Maryland Department of Family and Community Medicine in Baltimore.

Note: References for this article are posted at www.mdafp.org; publications and news tab.

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hemorrhage. They provide several tables in the recommendation to help clinicians discuss the benefits and harms of aspirin in individual patients. The recommendations can be found at http://www.ahrq.gov/clinic/uspstf/uspsasmi.htm.

The USPSTF further concluded that the current evidence is insufficient to assess the balance of benefits and harms of aspirin for cardiovascular disease prevention in men and women 80 years or older and recommends against the use of aspirin in men younger than 45 and women younger than 55 years of age. The American Academy of Family Physicians has made similar recommendations. Along with the American Stroke Association, the American Heart Association recommends the use of aspirin for cardiovascular prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk for cardiovascular events of 6 percent to 10 percent). For the primary prevention of stroke, they recommend against aspirin in men and state that aspirin can be useful for primary prevention of stroke in women whose risk is sufficiently high for the benefits to outweigh the harms of treatment.[12]

Conclusions

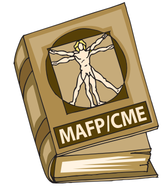
This evidence demonstrates that aspirin use reduces the number of CVD events in both men and women without known CVD. Men in the primary prevention trials experienced fewer MIs, and women experienced fewer ischemic strokes. CVD mortality or all-cause mortality does not seem to be reduced by aspirin in either men or women. Sex, baseline CVD risk and potential risk for GI bleeding are important factors to consider when discussing aspirin use with patients. Aspirin use for the primary prevention of CVD events likely provides more benefits than harms to men at increased risk for myocardial infarction and women at increased risk for ischemic stroke. The reason for the differences by sex is unknown.

The use of aspirin in primary prevention increases the risk for serious gastrointestinal bleeding events in both men and women. Men have an increased risk for hemorrhagic strokes with aspirin use, whereas a new RCT and meta-analysis [4] [5] suggest that the risk for hemorrhagic strokes in women is not significantly increased. Some factors, such as whether the patient is receiving proton-pump inhibitors, may modify the risk for gastrointestinal bleeding.

Recent studies on the use of aspirin in adults with diabetes have created uncertainty about the effectiveness of aspirin in this population.[13] This is an important area for further research and health policy. ■

Dr. Wolff is a family physician, preventive medicine physician, member of the Maryland Academy of Family Physicians and editor of this Spring, 2010 edition of *The Maryland Family Doctor*.

Note: References for this article are posted at www.mdafp.org; publications and news tab.



ACOs – Friend or Foe?

by Ken Bertka, M.D., F.A.A.F.P

THROUGHOUT THE HEALTH care reform debate in Congress, all of the proposed bills contained provisions for promoting development of Accountable Care Organizations (ACOs). So, what is an ACO? Will ACOs be good for patients? Are ACOs a positive step in the right direction for family physicians and other primary care physicians?

At the core, this proposed care model is a means by which physicians and other health care providers are part of a network responsible for quality and certain components of the cost of care for a defined patient population. An ACO is dependent upon a strong foundation of primary care. Ideally, this foundation is based upon the patient-centered medical home (PCMH) model of care. From this perspective, the ACO can be thought of as the "medical home neighborhood" aligning the goals and incentives of non-primary care physicians and other providers with those of a network of PCMH practices.

The main goal of the ACO model is to reduce health care cost, or at least "bend the cost curve" down while at the same time improving clinical quality and patient satisfaction.

Federal health care reform efforts in the U.S. are focused on increasing health insurance coverage, improving quality and controlling cost. From a health care reform perspective, the ACO model of care is aimed at cost and quality. The main goal of the ACO model is to reduce health care cost, or at least "bend the cost curve" down while at the same time improving clinical quality and patient satisfaction. An ACO is not a health maintenance organization (HMO) as it does not accept insurance risk – the risk of whether a patient who is part of the defined ACO population is sick or well.

Accountable care organizations can have various structures to fit the environment in which they function. These include:

- A collection of primary care practices working together through an Independent Practice Association (IPA) or some other organizational structure
- A collection of primary care practices and non-primary care specialists working together through an Independent Practice Association (IPA) or some other organizational structure
- A clinically integrated system of primary care practices, non-primary care specialists and hospitals working together though an integrated delivery system (all physicians employed) or through a physician-hospital organization (PHO) of independent providers who are clinically integrated
- Physician and non-physician health care providers, public health agencies, social service organizations and other community organizations working jointly to improve health care for a broad patient population.

Elliott Fischer, one of the pioneer proponents of ACOs, supports the concept of virtual ACOs as long as three key ACO elements are supported:

- Local accountability for quality and per capita cost for the local patient population
- Standardized performance in measurement
- Payment reform that transitions payments from encouraging volume and procedures to increasing quality outcomes and value (quality/cost)

The concept of a virtual ACO is particularly important for small- and medium-sized independent practices, especially those located in more rural areas. Formation of virtual networks of practices with infrastructures that can support data sharing and the collection of quality measures across practices will be a requirement for ACO formation.

ACOs will not happen overnight. Just like PCMH practice transformation, the medical home neighborhood transformation to an ACO model will require well-organized planning, decision making and implementation under strong physician leadership. Most importantly, the foundation of the ACO care model is effective family medicine (primary care) emphasizing access to care, continuity of care, comprehensiveness and coordination. Harold Miller, in his white paper *How to Create Accountable Care Organizations,* identifies eight prerequisites for primary care practices to participate in ACOs:

- Complete and timely information about patients, including the services they are receiving

- Technology and skills to support population management and coordination of care
- Adequate resources for patient education and self-management support
- A culture of teamwork in the practices
- Coordinated relationships across all practices, specialities and providers
- The ability to measure and report on quality of care
- Infrastructure and skills for management of financial risk
- A commitment by senior leadership to improving value as a top priority backed by a system to drive improved performance.

Effective and sustainable accountable care organizations cannot happen without significant payment reform. Since primary care is foundational to the ACO, the blended payment model – fee-for-service, care management fee and outcomes-based payments – is critical to the support of primary care within the ACO model. In addition to the blended payment model for primary care, the overall ACO payment structure should support several goals:

- Baseline payment that adequately covers the expected costs of the defined population
- Avoidance of penalties for taking on sicker patients or experiencing "adverse selection"
- Flexibility to deliver the right services at the right time in the right place
- Enhanced ACO profitability if it keeps its population healthier (relative to baseline) or reduces unnecessary services
- Enhanced payments for higher quality care and encouragement of patients to become engaged and seek out higher quality care.

Table 1

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires 'lock-in' of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

Source: Engelberg Center for Health Care Reform at Brookings. The Dartmouth Institute. Issue brief: Accountable care organizations. Reforming provider payment. 2009.

Although a mature ACO system might thrive under a global payment model, as long as it avoids the pitfalls of traditional capitation, developing ACOs should avoid global payments and look toward transitional payment models, including combinations of shared savings, episode-of-care payments and hybrid models (partial comprehensive care payments with bonuses based on quality outcomes and savings). Most importantly for primary care physicians, the ACO payment model must effectively set levels of "internal" physician payments that recognize the dependence of ACO success on a strong foundation of primary care and PCMH practices. (See Table I for a comparison of payment models).

In late summer 2009, the American Academy of Family Physicians Board of Directors appointed a task force to study ACOs, especially from the perspective of small- and medium-sized family

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medicine practices. The ACO Task Force defines an ACO as "a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the quality and cost of care provided to a defined patient population." The task force developed a series of ACO principles aimed primarily at small- and medium-sized family medicine practices considering participation in or development of an ACO. Key principles include:

- The core of an ACO is accessible, team-based primary care such as the PCMH.
- ACOs require strong physician leadership and a true partnership among all participants.
- A clinically integrated information system for point-of-care decision making is ultimately required.
- The ACO encourages continuous innovation to identify and implement best patient care practices.
- Organization structure and payment reform should be implemented in an incremental manner and monitored closely to prevent "unintended consequences."
- ACO should strive to incentivize active patient participation in health and wellness decision making.
- Changes to antitrust regulations and to Stark self-referral regulations likely will be needed to allow full participation of physicians, especially those in small- and medium-sized independent practices.
- Payment models must align mutual accountability and evolve over time as the ACO model transitions.
- The ACO should be financially rewarded based upon a combination of absolute standards, relative performance and improvement.
- Primary care and the PCMH model should be supported by blended payments – fee-for-service, care management payments and quality outcomes payments.

So, is the ACO family medicine's friend or foe? The simple answer is "Yes, ACOs can be friend or foe." The real life answer will depend upon the details of ACO structure and operation. The greatest ACO strength for family physicians is that ACO success requires strong physician leadership and strong primary care. The physician leadership must be characterized by true knowledge-based decision making in an environment of mutual support, collaboration and transparency by all ACO participants. This cannot be the façade of physician leadership characteristic of the many independent practice associations (IPAs) and physician-hospital organizations (PHOs) seen during the heyday of managed care. True collaboration and mutual trust, supported by data and transparency and across diversity of geography, demographics, processes of care and technology will be challenging. If done without an intense commitment to patient care and health care value, the ACO model could swallow up primary care into an ambiguous medical neighborhood of "more of the same by a different name." Most family physicians espouse the need for true, meaningful health care reform that supports and rewards access to primary care, comprehensive care and coordinated care. These should be the goals that guide family physicians in the exploration of ACOs as friend or foe. ■

Dr. Bertka is a family physician in Toledo, Ohio, and a member of the AAFP Board of Directors. He served as chair of the AAFP Accountable Care Organization Task Force.

Note: Printed with permission Ohio Academy of Family Physicians. References for this article are posted at www.mdafp.org:publications and news tab.

A Message for Healthcare Providers Who Diagnose and Treat Patients with High Blood Pressure

From

The Maryland State Advisory Council on Heart Disease and Stroke

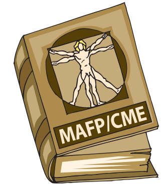
More "Simple Strategies" to Help Your High Blood Pressure Patients Achieve and Maintain Recommended Levels of Control

Patients with high blood pressure will do better if they become actively involved in their own care. You can help by providing them with some very simple and very focused "tools."

- Tell your patient what his/her blood pressure reading is at each visit.
- At each visit, give your patient a GOAL blood pressure to aim for... but make it a relatively small, achievable goal. Success will breed success and provide motivation for reaching the **next** small goal.
- Provide your patients with a blood pressure wallet card, which researchers have found to be an excellent tool for getting them involved.

Watch for More "Simple Strategies" Next Edition
Volume 1, Number 4, September 2009

Sexual Assault – The Role of the Family Physician



by Zowie S. Barnes, M.D.

IMAGINE THIS SCENARIO: A third-year medical student is rotating in a community office during his/her clerkship. The day has run long. The medical assistants have left the preceptor, student and patient in the office. At the end of the visit, the patient leaves. The student stays to discuss the case. As preceptor and student leave the office, the student feels a touch…

Sexual assault happens everywhere. It can happen to women or men, young or old, rich or poor, educated or not. Sexual assault is broadly defined as non-consensual sexual contact. The legal definition of sexual assault varies from state to state and in Maryland the specific definitions are according to criminal law § 3-301 (See Table 1 on page 16). In this article, I will discuss some epidemiology of sexual assault, sexual assault related post-traumatic stress disorder and the family physician's role in interactions with adult patients who present at a time removed from the acute incident (how to deal with the long term effects).

Almost 18 percent (17.7 million) women and 3 percent (2.7 million) men in the United States have been victims of rape or attempted rape sometime in their lives, [1] as reported in 1998. That is one in six women! From the same study, we see that 302,091 women (0.3 percent) and 92,748 men (0.1 percent) were victims in a 12 month period (1995-6). According to the Bureau of Justice Statistics Criminal Victimization [2] (2008), there was a 52.6 percent decrease in rape/sexual assault from 1999 to 2008. Between 2007 and 2008, there was a 18.5 percent decrease (248,280 [2007] to 203,830 [2008]). In Maryland, there were 1,127 rapes in 2008, which is a marginal change from 1,179 in 2007) and 1,178 in 2006 [3]. Rates of reporting have recently decreased (48 percent reported to authorities in 2000 [14], whereas 41.4 percent reported in 2008 [2]). When evaluating the data on age and sex of victims, it is evident that more women are raped than men and that adolescents and young adults are more likely to be victims. The National Institute of Justice published a report in 2006 that highlighted the age discrepancies of victims: "More than half of female victims (54 percent) and three-quarters of male victims (71 percent) were first raped before their 18th birthday. In comparison, 29.4 percent of female victims and 16.6 percent of male victims were 18-24 years old when they were first raped, and 16.6 percent of female victims and 12.3 percent of male victims were age 25 or older" [5].

Feelings of shame, fear, anger, confusion, distrust and abandonment all permeate through the tears, smiles and expressionless moments of victims, who often do not report it to authorities (and do not present as such to their office visit). The consequences of sexual assault are vast and can include both physical (such as disfiguring scars, infections, such as HIV, or unintended pregnancies) and psychological damage, such as post-traumatic stress disorder (PTSD). *Rape in America- A Report to the Nation (1992)*[2] found that "almost one-third of all rape victims developed PTSD sometime during their lifetime, and more than one in 10 still had PTSD." In brief, PTSD is a common anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm or violation of personal integrity has occurred or was threatened. The diagnosis of PTSD requires specific criteria defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (See Table 2 on page 17). It includes reliving the events (intrusive thoughts, nightmares and flashbacks), avoidance, sleep disturbance and hypervigilance. These symptoms last for more than a month and cause impairment in work and social life.

Referring back to the scenario, this student may relive this event every time the student meets a new preceptor or is in a hierarchical situation. Avoidance. How do you avoid what you have worked so hard to achieve? Sleep disturbance and hypervigilance may occur. With the rigors of the medical field, the degrees of separation may be blurred. It would be hard always living on the edge, cautious of every patient that you meet.

As family physicians, we are primary caregivers serving both women and men, both of whom can be affected by sexual assault. The medical student in the scenario – male or female – could easily be a patient. Expanding on the scenario, this

continued on page 16

SEXUAL ASSAULT from page 15

third-year medical student presents for his/her yearly exam. You start a conversation about rotations as you do the physical exam. As you begin the genitourinary exam, the patient starts to cry. Our first job is to identify patients who are victims of sexual trauma. It is appropriate to ask all patients – especially women before performing a pelvic exam – if they have ever been physically or sexually abused. Patients rarely present this information spontaneously and, unfortunately, physicians rarely ask these questions. Ensure that you have enough time to respond to the answer and the reaction.

From the very first interaction, it is important to establish an open and honest relationship with patients, letting them know that they are in control. It is important to empower these patients as much as possible because empowerment is something that has been lost. Once you do have this information, record it inconspicuously so that you and other health care providers do not need to repeatedly ask the patient. Additionally, be gentle and maintain dignity while doing the physical exam, especially when examining sexual organs, i.e., breast, vagina, penis, rectum, but also consider that any area could have been involved, i.e., neck, abdomen. Lastly, remember that this is a recurring and intrusive process that only you may know about. Be patient with your patient.

The PTSD checklist (PCL) has been extensively used in research and is a validated screening instrument [3]. Patients who screen positive should have confirmation of the diagnosis through clinical interview by a trained professional. A combination of psychotherapy and pharmacotherapy should be considered. Various psychotherapeutic modalities have been shown to be effective in PTSD. A key component of success with cognitive behavioral therapy and other modalities is exposure to traumatic memories. The therapeutic goals of psychopharmacologic therapy are to reduce symptoms. Drug therapies have been most effective in decreasing positive symptoms such as arousal and re-experiencing and generally less effective for the negative symptoms such as avoidance, numbing and withdrawal [8]. Overall, selective serotonin reuptake inhibitors (SSRIs) have been shown to be an effective first-line drug and can be started by primary care physicians [4]. Sertraline and Paroxetine are FDA-approved for PTSD. Several other classes of drugs have been studied in the treatment of PTSD, such as non-SSRIs (second-line treatments), tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) (third-line treatment), mood stabilizers, anticonvulsants, antipsychotics and alpha blockers. These may be needed for patients with more severe symptoms and can be used in conjunction with a comprehensive PTSD treatment plan. Of note, anxiolytics are generally ineffective in PTSD and, with the high prevalence of comorbid substance use, benzodiazepines should generally be avoided.

In conclusion, sexual assault can and does happen to anyone. Although physical scars may heal, emotional scars may be long lasting. Family physicians can make a difference by working to decrease iatrogenic effects of exams on assault victims, and by improving the health and functioning of patients who may not ask for help. ■

Table 1 – Definitions [5]

TERM	DEFINITION (ACCORDING TO CRIMINAL LAW § 3-301)
Mentally Defective Individual	One who suffers from mental retardation or a mental disorder, which temporarily or permanently makes him or her incapable of understanding the nature of his or her conduct, or resisting or communicating unwillingness to engage in vaginal intercourse, a sexual act, or sexual contact.
Mentally Incapacitated Individual	One who is incapable of understanding the nature of his or her conduct or resisting vaginal intercourse, a sexual act, or sexual contact due to: (1) the influence of a drug, narcotic, or intoxicating substance; OR (2) an act committed on him or her that occurred without his or her consent or awareness.
Physically Helpless Individual	(1) One who is unconscious OR (2) One who does not consent and is physically unable to resist or to communicate unwillingness to submit to vaginal intercourse, a sexual act or sexual contact.
Sexual Act	Any of the following, regardless of whether semen is emitted: (1) oral contact with the anus; (2) oral sex; (3) anal sex, including penetration of the anus; (4) an act in which an object penetrates one's genital opening or anus; and (5) an act that can reasonably be construed to be for sexual arousal or gratification or the abuse of either person. Sexual Act does NOT include vaginal intercourse or an act in which an object penetrates one's genital opening or anus for an accepted medical purpose.
Sexual Contact	An intentional touching of any part of one's anal or genital area or other intimate parts for the purpose of sexual arousal or gratification or for the abuse of either party and includes the penetration, however slight, by any part of the person's body, other than penis, mouth or tongue into the genital or anal opening of another person's body if that penetration can be reasonably construed as being for the purpose of sexual arousal or gratification or for the abuse of either party. Sexual contact does NOT include acts commonly expressive of familial/friendly affection or acts for accepted medical purposes.
Vaginal Intercourse	Genital copulation, regardless of whether semen is emitted, including penetration of the vagina.

Table 2 [6] - DSM-IV-TR criteria for PTSD

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). The diagnostic criteria (Criterion A-F) are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance

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

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders DSM-IV-TR (Fourth ed.). Washington D.C.: American Psychiatric Association.

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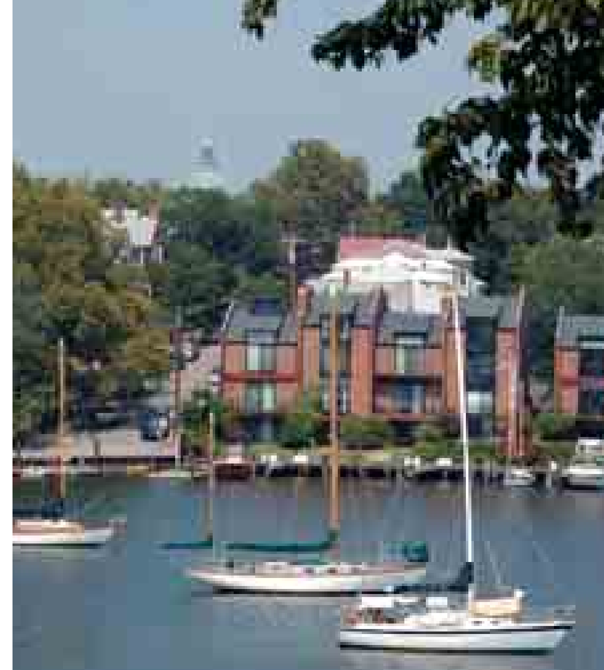

From the President

Hello readers! We enthusiastically invite you and welcome you to MAFP's 2010 Annual CME Assembly. The theme of the conference is "Solutions Through Interactive Learning." Attendees will participate in the learning process leading to a greater retention of information. Also, members of our planning committee, your peers, have developed this conference with YOU in mind. We have a terrific CME program and know that you will be pleased to receive the latest information available on selected topics presented by an expert faculty – a large number of whom are family docs! Plan to have some fun, as well, in Annapolis, Maryland's beautiful, historic capital city situated on the scenic Severn River. I personally look forward to the meeting and to seeing you there!

Yvette L. Rooks, M.D.

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Glimpses of Topics and Faculty

Complete Program Schedule at www.mdafp.org

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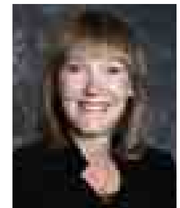
American Board of Family Medicine (ABFM)
Maintenance of Certification (MC-FP)
Self Assessment Module Session (SAM) – Health Behavior
Adebowale G. Prest, M.D., Facilitator
Limited to 30 eligible participants. Pre-Registration Mandatory.
Request separate flyer for fees/schedule and other details.

- meet Part II requirement for ABFM MC-FP
- go through the 60 core competency questions
- get CME credit upon completion of the Clinical Simulation
- lunch included

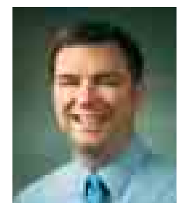
Special Guests and Honorees

Lori Heim, M.D.
President,
American Academy of Family Physicians
To Present Keynote Address and Install Officers



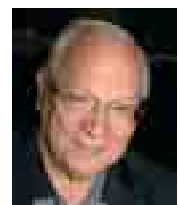
Yvette L. Rooks,
M.D.Outgoing President,
Maryland Academy of Family Physicians

Eugene J. Newmier, M.D.
Incoming President,
Maryland Academy of Family Physicians



Joseph W. Zebley, III, M.D.
To receive MAFP Lifetime Achievement Award

William D. Hakkarinen, M.D.
To receive MAFP Award of Special Recognition



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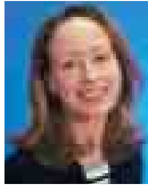
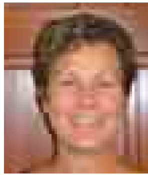
Topics on Common Problems

Update on Preventive Services Task Force Recommendations
Tracy A. Wolff, M.D.



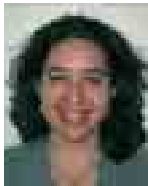
Prevent Abuse and Neglect Through Dental Awareness
Neuthan S. Rao, D.D.S.

and
Susan M. Camardese, F.D.H., M.S.



Topics on Pediatrics

Vaccines for Kids
Sharon Feinstein, M.D.



Gender Development: Recognizing and Helping the Gender Variant Child
Eva S. Hersh, M.D.

Pediatrics in Pictures
Paul Berman, M.D.

Topics in Men's Health

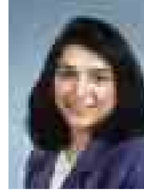
Depression in Men
Glenn J. Treisman, M.D.

Preparedness for Extreme Sports
John Castellani, Ph.D.
and
Paul A. Donaher, M.D.

Topic on The Fertile Female

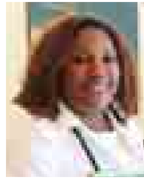
AIM-HI and Ready, Set FIT!
Yvette L. Rooks, M.D.

President Contraception Prescribing
Netra Thakur, M.D.



First Trimester Prenatal Care
Nancy Beth Grossman, M.D.

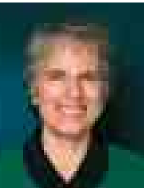
The Peri-Menopausal Patient
Vivienne A. Rose, M.D.



Topics in Mental Health

Alcohol Dependence
Aliya Jones, M.D.

Eating Disorders: Binge Eating
Susan Z. Yanovski, M.D.

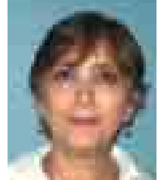


Physician Wellness
Adrienne Williams, Ph.D.

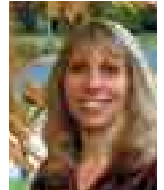
Potpourri Topics

Assessment and Care Coordination for People with Intellectual and Developmental Disabilities
Kim A. Bullock, M.D.

Marisa C. Brown, M.S.N., R.N.



Identifying and Treating Sexual Abuse Survivors
Lisa Ferentz, L.C.S.W.-C, D.A.P.A.



Adult Vaccines
Kevin S. Ferentz, M.D.

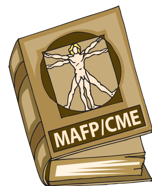
Getting to the "Root" of Alopecia
Ronald Goldner, M.D.

Special Meal Sessions

Keynote Luncheon
AAFP Update: PCMH and Health System Change
Lori Heim, M.D.

Nutritional Evaluation: Understanding Your Patient's Nutrition & Supplement Needs
Patrick J. Hanaway, M.D.

journal CME quiz



Articles

1. Focus on Prevention and Screening for CVD p. 5
2. Screening for Cardiovascular Disease p. 6
3. Aspirin for the Primary Prevention of Cardiovascular Disease Events p. 7
4. The Recognition and Treatment of Depression in Family Medicine, Part 2 p. 8
5. ACOs – Friend or Foe? p. 12
6. Sexual Assault: The Role of the Family Physician p. 15

The Maryland Family Doctor has been reviewed and is acceptable for Prescribed credits by the American Academy of Family Physicians (AAFP). This **Spring, 2010 edition (vol. 46, No. 4)** is approved for 2.5 Prescribed credits. Credit may be claimed for two years from the date of this edition.

AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 credit toward the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as Category I.

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Instructions: Read the articles and answer all questions by circling the correct answers. Mail, fax or email the quiz form within two years (by April 30, 2012) to:

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Questions Article #1:

1. Risk of CVD over the next 10 years and risk of GIB are the only factors to discuss with patients when considering aspirin for the primary prevention of CVD.
   A. True
   B. False

Questions Article #2:

2. Which is (are) true regarding current USPSTF recommendations for asymptomatic screening of abdominal aortic aneurysm?
   A. Women age 65-75 years old who have smoked greater than 100 cigarettes in their lifetime should be screened.
   B. No women should be screened.
   C. Women age 65-75 years old who never smoked should be screened.
   D. Men age 65-75 years old who have smoked greater than 100 cigarettes in their lifetime should be screened.
   E. Both b and d are true
3. Which is (are) true regarding peripheral vascular disease?
   A. It primarily impacts the upper extremities.
   B. An ankle-brachial index score of 0.93 is considered severe disease.
   C. Definitive treatment is available that improves mortality beyond treatment determined by a standard cardiac assessment
   D. Smoking cessation and anti-lipid medications can help to improve symptoms.
   E. Easy fatigue of lower extremities and decreased physical activity is rarely a symptom.
4. Cardiovascular screening in asymptomatic individuals as recommended by the United States Preventive Service Task Force includes:
   A. Men aged 65-75 years old who have smoked, for aortic aneurysm
   B. Women who have smoked, for abdominal aortic aneurysm
   C. Men 65-75 years old who have smoked, for peripheral artery disease
   D. Women who have not smoked, for carotid artery stenosis
   E. Men who have smoked, for carotid artery stenosis
5. Carotid artery duplex scan should be considered
   A. When a 65-year-old woman who smokes presents to her family doctor with no neurological signs or symptoms
   B. When a 72-year-old man who does not smoke presents to his family doctor with new neurologic symptoms in the area of the right carotid artery distribution
   C. When a 45-year-old man who smokes and has a family history of cardiovascular disease presents to his family doctor
   D. When a 55-year-old woman who does not smoke presents to family doctor
6. Mr. Reagan, who is 74 years old and a former smoker, comes to your office after his wife heard about vascular screenings on the radio. You suggest:
   A. a duplex doppler ultrasound on his carotid arteries
   B. an ankle-brachial index to screen for peripheral vascular disease
   C. a one-time abdominal ultrasound to screen for an abdominal aortic aneurysm
   D. All of the above
   E. None of the above

Questions Article #3:

7. Which of the following is true regarding the epidemiology of cardiovascular disease (CVD) in men and women in the U.S.?
   A. Men are more likely than women to die after a first myocardial infarction.
   B. After age 75, the risk of ischemic stroke in women is greater than the risk for men.
   C. The 10-year risk of initial ischemic stroke at 55 years of age is 10 percent for women.
   D. Women tend to be younger than men at first myocardial infarction.
   E. After age 40 the lifetime risk for CVD is greater for women than men.
8. Regarding the evidence for aspirin for the primary prevention of CVD events, which of the following is true?
   A. Aspirin consistently reduces mortality from stroke in women without a history of neurovascular disease.
   B. Men benefit from aspirin in the reduction of all-cause mortality.
   C. Women benefit from aspirin in the reduction of myocardial infarctions.
   D. Men benefit from aspirin in the reduction of overall CVD events.
   E. Men experience a reduced risk of hemorrhagic stroke associated with aspirin.
9. Which of the following statements is true concerning the harms of aspirin?
   A. Aspirin consistently increases the risk of gastrointestinal bleeding (GIB) in men and women.
   B. Aspirin consistently increases the risk of hemorrhagic stroke in men and women.
   C. Women have a higher risk of GIB from aspirin than men.
   D. Drugs like ibuprofen given with aspirin increase the risk of GIB approximately two-fold.
   E. Age is not an important risk factor for GIB associated with aspirin.
10. Who of the following should take aspirin, according to the U.S. Preventive Services Task Force recommendations:
    A. A 42-year-old man with an average 10 year risk of MI and GIB
    B. A 42-year-old woman with an average 10 year risk of MI and GIB
    C. A 50-year-old man with an increased 10 year risk of MI and average risk of GIB
    D. A 60-year-old woman with an average 10 year risk of MI and average risk of GIB
    E. A 50-year-old woman with an average 10 year risk of MI and an average risk of GIB
11. Which of the following is true regarding the epidemiology of CVD in the U.S.?
    A. CVD accounts for approximately one million deaths per year.
    B. CVD is the underlying or contributing cause in 58 percent of deaths.
    C. CVD is second to cancer as a cause for death in adults in the U.S.
    D. Overall, 1 in 5 adults have some form of CVD.

Questions Article #4:

12. Which would be the most accurate statement about anti-depressant medications?
    A. SSRIs work better than tricyclics.
    B. Tricyclics are very safe.
    C. All anti-depressants work in about 70 percent of patients.
    D. Anti-depressants should start working within two days.
    E. Fluoxetine has a short half-life.
13. Which is correct?
    A. Stop medication at end of acute phase.
    B. Continuation phase should last 3 months.
    C. Maintenance may be lifelong.
    D. Lower dose during continuation phase.
    E. Stop medication when achieve remission.
14. Which is true?
    A. St. John's Wort is highly effective in severely depressed patients.
    B. Psychotherapy is as effective as medication in severely depressed patients.
    C. Adolescent suicide has declined since the "black box warning."
    D. Bupropion is the most effective antidote for SSRI-induced sexual dysfunction.
    E. A recent meta-analysis showed escitalopram to be the best first antidepressant.

Questions Article #5:

15. Which one of the following factors is a fundamental requirement of the accountable care organization (ACO) model of care?
    A. The ACO accepts insurance risk.
    B. Payment to physicians is based primarily upon a capitation model.
    C. Goals and incentives of physicians and other providers of clinical care are aligned.
    D. Participating primary care doctors are employees of the ACO.
    E. Participating non-primary care doctors are employees of the ACO.
16. All of the following payment models incentivize hospitals to participate in coordination of care EXCEPT:
    A. Accountable care organization
    B. Patient-centered medical home model of blended payment
    C. Bundled payment for episodes of care
    D. Full capitation
17. The accountable care organization model of care promotes all of the following EXCEPT:
    A. Local accountability for the quality of care of a defined population
    B. Standardized performance measurements
    C. Payments that incentivize the volume of care performed
    D. Local accountability for per capita cost of care of a defined population
    E. A culture of teamwork in the practices

Questions Article #6:

18. Which of the following is true regarding the epidemiology of sexual assault?
    A. There was a 53 percent decrease in rape/sexual assault between 1999 and 2008.
    B. There are approximately 5000 rapes a year in Maryland.
    C. There are approximately 500,000 rapes a year in the U.S.
    D. About half of Americans will experience rape/sexual assault in their lifetimes.
19. Age and sex are important risk factors for sexual assault/rape; which of the following is true?
    A. The elderly are at highest risk.
    B. Three percent of men and 18 percent of women will be victims during their lifetimes.
    C. Approximately 75 percent of female victims were first raped before their 18th birthday.
    D. Approximately 25 percent of female victims were first raped after their 25th birthday.
20. Regarding the consequences of sexual assault, which of the following is true?
    A. Approximately 10 percent of rape victims will develop post-traumatic stress disorder (PTSD).
    B. Drug therapies for PTSD are most effective for negative symptoms, such as numbing and avoidance.
    C. Selective serotonin reuptake inhibitors have been shown to be an effective first-line drug.
    D. Psychotherapy has been shown to be ineffective in the treatment of PTSD.

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News For and About MAFP Members

Members to Vote for New MAFP Officers and Directors

MEMBERS ARE ENCOURAGED to attend the 2010 Annual Business Meeting scheduled for June 25, 2010, during the Annual CME Assembly at the Westin Hotel in Annapolis, Maryland (see pp. 18, 19); all details at www.mdafp.org). A major order of business will be elections of officers and directors for 2010-11/12. In accordance with MAFP Bylaws, Chapter XVI, Section 1, the 2010 Nominations Slate is recommended by the MAFP Nominating Committee. Nominations from the floor will be accepted. Members must be present to vote. Newly elected officers will be installed by AAFP President Lori Heim, M.D. at the Installation Ceremony that day during the Installation and Awards Luncheon.

Directors
2010-11; one year terms

Central District
Jocelyn M. Hines, M.D.
Mozella Williams, M.D.

Eastern District
Paul Donaher, M.D.
Rosaire Verna, M.D.

Southern District
Kari Alperovitz-Bichell, M.D.
Ramona G. Seidel, M.D.

Western District
Kwame Akoto, M.D.
Matthew Hahn, M.D.

Delegate to AAFP
two year terms, 2-terms limit
Howard E. Wilson, M.D.
2010-12; two year term

Alternate Delegate to AAFP
two year terms
2-terms limit
Yvette L. Rooks, M.D.
2010-12; two year term

In Mid-Term
Howard H. Bond, M.D.
Vice President, Eastern District

William P. Jones, M.D.
AAFP Delegate

Adebowale G. Prest, M.D.
AAFP Alternate Delegate

2010 MAFP Nominating Committee

Joseph W. Zebley, III, M.D.
Yvette L. Rooks, M.D.
Eugene J. Newmier, D.O.
Trang M. Pham, M.D.
Yvette Oquendo, M.D.
Zowie S. Barnes, M.D.
Kisha Davis, M.D.

2010 Nominations Slate

President-Elect
2010-2012; two year term
Yvette Oquendo, M.D.

Secretary
2010-2012 ; two year term
Kisha N. Davis, M.D.

Treasurer
2010-11; completion of term
Joseph W. Zebley, III, M.D.

Vice Presidents
2010-12; two year terms

Central District
Eva S. Hersh, M.D.

Southern District
Trang M. Pham, M.D.

Western District
Tracy A. Wolff, M.D.
2010-2011; completing term

In Memory

The Maryland Academy of Family Physicians is saddened by the passing of its members **Robert J. Lyden, M.D.** of Baltimore and **Charles R. Mock, M.D.** of Bowie. Memorial contributions have been made to the MAFP Foundation in their honor.

continued on page 24

Snapshots from MAFP's Winter Conference

A capacity crowd attended the general sessions.

Technical exhibits generated much interest!

Program Chair and moderator Dr. Ramona Seidel welcomes the group.

"Issues in Treating Special Populations" was the theme of MAFP's Winter Regional Conference in Columbia, Maryland, February 20, 2010. In addition to timely and informative topics, wonderful speakers, an array of exhibits and a beautiful facility in a good location, folks seemed to be happy to get out so soon after Maryland's two blizzards of the Winter of 2010!

Several lingered after the luncheon presentation to ask questions of speaker Dr. Bob Phillips, deputy director for the Graham Center for Policy Studies in Family Medicine.

MEMBERSHIP from page 23

Congratulating MAFP Members for Special Appointments, Honors, Features, Achievements

Richard Colgan, M.D. of Annapolis presented "A Quest to Learn the Art of Medicine: From Hippocrates to Woodward" at Davidge Hall/University of Maryland at Baltimore on February 4, 2010, as part of the Alpha Omega Alpha History of Medicine Lecture Series. He also authored "The skin disorders of pregnancy: A family physician's guide," (Bremmer M, Driscoll MS, Colgan R), .J Fam Pract. 2010 Feb;59(2): 89-96. Dr. Colgan is MAFP editor in chief and associate professor and director of undergraduate education in the University of Maryland Department of Family and Community Medicine and author of "Advice to the Young Physician on the Art of Medicine (available at Amazon and Barnes & Noble).

Stacy Garrett-Ray, M.D. of Baltimore was quoted in "Debate ensues after U.S. panel discourages breast self-exams," appearing in the November 21, 2009, edition of *The Baltimore Sun*. She is medical director, Baltimore City Cancer Program.

Richard Lamson, M.D. of Baltimore was featured in the Ask the Expert column entitled, "Cause of (Metabolic) Syndrome Isn't Known" in the December 28, 2009, edition of *The Baltimore Sun*.

David McClure, M.D. of Bel Air wrote "No sympathy for those 'exhausted' U.S. senators," a letter to the editor appearing in the January 1, 2010, edition of *The Baltimore Sun*.

James P. Richardson, M.D. of Ellicott City was listed as one of only two specialists in geriatric medicine (and the only family physician) in the "Top Docs" in the November, 2009, edition of *Baltimore Magazine*. He gave a talk at the Howard County 50+ Expo entitled, "Being Good to your Heart is Good for your Brain" on October 16, 2009. He was part of a panel discussion at the Alzheimer's Association conference, "Living with Alzheimer's Disease: Optimize Strengths/Maximize Function" on December 3, 2009, where he spoke on the challenge of managing multiple medical problems for the individual with dementia. He announces his availability for in/outpatient consultations at St. Agnes Hospital for geriatric patients, specifically those with memory loss to determine if they have dementia and patients with a diagnosis of dementia whose families are requesting additional advice/help.

Yvette L. Rooks, M.D. of Ellicott City has been appointed to a four-year term to the AAFP Commission on Health of the Public and Science. She is current MAFP president and vice chair and program director at the Department of Family and Community Medicine at the University of Maryland School of Medicine.

The following MAFP members are among those selected 2009-2010 Best Doctors® in America, from a peer-review of physicians in more than 40 specialties and 30 countries taken every two years. Only 5 percent of U.S. physicians are chosen:

Janet Ciarkowski, M.D.
Richard Colgan, M.D.
Mel Daly, M.D.
R. Scott Eden, M.D.
Kevin S. Ferentz, M.D.
Kevin M. Gill, M.D.
Robert J. Ginsberg, M.D.
Maryellen R. Goodell, M.D.
Erica C. Isles, M.D.
Joyce King, M.D.
Ursula McClymont, M.D.
Michael A. Moskewicz, M.D.
Sallie Rixey, M.D.
Kellie B. Smaldore, M.D.
David L. Stewart, M.D.
Patricia Tomsko-Nay, M.D.
Cheryl E. Winchell, M.D.
Joseph W. Zebley, III, M.D.

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AAFP/MAFP CME Requirements for Active/Supporting Members

Active and Supporting Family Physician Members must accrue at least 150 hours of AAFP Prescribed and Elective credit within each 3-year reporting period, of which:

- At least 75 must be AAFP Prescribed credit; of which at least 6 of those being obtained from MAFP sponsored programs every 3 years (eg. CME conferences and journal CME)
- At least 25 are from live learning activities
- Not more than 25 are from enrichment activities

- not more than 30 are from presentation or publication of an original scientific or socioeconomic paper pertaining to medical care
- Not more than 45 are from publication in a state or national "refereed" journal
- Not more than 15 are from preparation and presentation

Members are encouraged to review the document *AAFP Continuing Medical Education Requirements for Members* at http://www.aafp.org/PreBuilt/cmea_memberrequirements06.pdf or contact the MAFP office to request a copy; office @mdafp.org

The AAFP will send Maryland Chapter members, at regular intervals, correspondence showing each member's reported number of hours and reminding members of what is required. All details about the AAFP/MAFP's CME records, reporting and information can be obtained through the AAFP web site at www.aafp.org/cme, toll free at 800-274-2237 (ask for the CME Records Department) or the MAFP at 410-747-1980; office@mdafp.org (e-mail).

Other Aspects of MAFP CME Policy

The MAFP Board of Directors has approved the following:

1. MAFP members who are faculty members at MAFP conferences may claim the credits for those sessions (even if they are not registrants) for the MAFP CME requirement.
2. MAFP members who are authors of CME articles published in *The Maryland Family Doctor* may claim those credits (according to AAFP policy; www.aafp.org) for the AAFP and MAFP CME requirements.
3. MAFP CME credits will be waived for those Active and Supporting members who relocate to the Maryland Chapter within 6 months of the end of their cycle of AAFP reelection.
4. Active and Supporting members who have not met the chapter requirement to report at least 6 chapter credits within their AAFP reelection cycle may receive a waiver for that cycle, to be made up in the subsequent AAFP Reelection cycle, by following the process noted below:

1. Member must contact the MAFP office submitting a request (written, email, phone call) for a one-time waiver for the chapter requirement indicating a desire to continue membership, pledging to acquire the credits during the next AAFP reelection cycle. There is a waiver request administrative fee of $50.
2. Member *must make up* waived credits in the subsequent AAFP reelection cycle (in addition to the required 6 credits).
3. If failing to acquire the required chapter hours in the subsequent AAFP reelection cycle, MAFP will not accept another waiver request from member.
4. The MAFP Board of Directors will consider, on individual bases, each member failing to meet the chapter CME requirement. The Board will determine the course of action for each member in this category. ■

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Medical Director

calendar

2010

October 28-31 — Northeast Regional STFM Conference Hershey Lodge and Convention Center
Hershey, PA

June 23-26 — MAFP Annual CME Assembly & Trade Show
Solutions Through Interactive Learning
Westin Hotel
Annapolis (see p. 18)

July 29-31 — AAFP National Conference of Family Medicine Residents and Medical Students
Kansas City

2011

October 20-23 — Northeast Regional STFM Conference
Crowne Plaza North Shore
Boston, MA

February 12 — MAFP Winter Regional Conference
Sheraton Center City Hotel
Baltimore

June 23-26 — MAFP Annual CME Assembly & Trade Show
Clarion Resort Fontainebleau Hotel & Conference Center
Ocean City

AAFP Scientific Assembly Schedule

2010	September 29-October 2	Denver
2011	September 14-17	Orlando
2012	October 17-20	Philadelphia
2013	September 25-28	San Diego

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• Focus on Healthcare Reform

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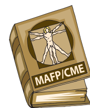

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2. E	7. B	12. C	17. C
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