AUTUMN 2013
VOLUME 80

The Official Publication of the Kentucky Academy of Family Physicians

Register today for the ANNUAL MEETING

NOVEMBER 14-17, 2013
CROWNE PLAZA-CAMPBELL HOUSE
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Colorectal Cancer Screening: A COMMUNITY-BASED EFFECT

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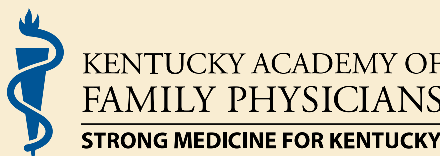

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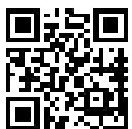

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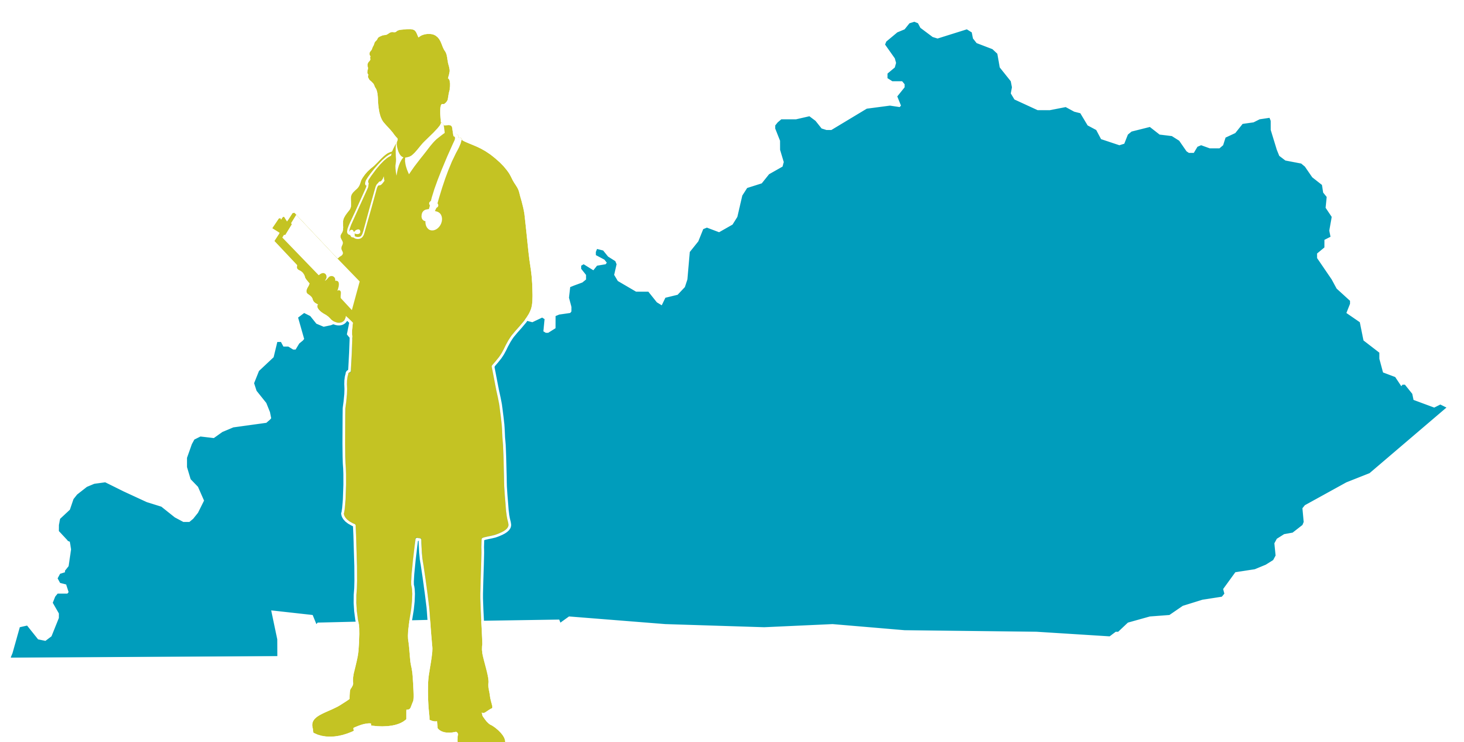
message from the PRESIDENT

Yes, I am still here! It has been the standing tradition that a KAFP President serves a 12-month term but I signed on for an additional 6 months. The reason I did it was to allow the KAFP to move its annual meeting from May to Nov 14, 2013 (at the Campbell House in Lexington). Our annual meeting in May was not drawing enough attendees and therefore, not financially viable for our organization. The KAFP Board is committed to keeping the state dues at the 2004 level and to do that we needed to make radical changes. Our annual meeting planning committee has identified topic areas that we know are needed for CME. Dr. Nancy Swikert will be doing a Federal Motor Carrier's DOT Medical Examiner training that will allow attendees to sit for the DOT Medical Examiner test. If you didn't know – CDL licensed drivers will be required in May 2014 to have their exam done by a certified DOT Medical Examiner. Also, The KBML has approved our Controlled Substance program for its mandatory training. For additional listings of courses -- you can download the annual meeting brochure by going to http://www.kafp.org/2013-kafp-annual-meeting/ . There may be minor changes to the program but the above two programs will not change. If you do attend our annual meeting, as I hope you will, then I encourage you to seek out one of your KAFP officers or me to discuss what we have done towards fulfilling our mission of 'Improving the health of Kentuckians, promoting the value of family medicine, and serving the needs of our members in a supportive professional community'. The Board decision to hire MML&K as our lobbyist has been the right decision at the right time. They have opened legislative doors for us. As the metaphor goes – either you are at the table or you are on the menu. We are not only at the table but we have achieved recognition for our contribution and leadership on key issues. Legislators want to know, "What does KAFP think …".

> I FIND THAT PCMH IS CATCHING ON AND AM EXCITED TO LEARN AT OUR ANNUAL MEETING ABOUT WELLPOINT'S PCMH INITIATIVE...

One legislative issue that we have spent a great deal of time on is working with our Nurse Practioner colleagues and others to promote the Patient Centered Medical Home (PCMH) model of care. PCMH returns the patient to the center of the health care delivery team in a collaborative model designed to meet better (and at reduced costs) that patient's health care needs. I just returned from some PCMH training last month and am beginning the PCMH transition process in my practice. During my last year as your President I have had the opportunity to meet with our colleagues from other states to discuss PCMH and other issues. I find that PCMH is catching on and am excited to learn at our annual meeting about WellPoint's PCMH initiative that they will be introducing in 2014.

Lastly, I want to offer you a challenge – "Get involved". Make a commitment to attend our annual meeting to learn more about the KAFP and how you can contribute. Our legislative team has a goal of identifying a family physician for each of our General Assembly's Senators and Representatives. We want to continue the momentum of, "What does KAFP think …" and to do that we need you. There is a lot more I can say but will leave it to you to answer that question.



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CALL FOR RESOLUTIONS FOR 2013 KAFP CONGRESS OF DELEGATES

Please note the following deadlines for submission of Resolutions to be presented to the 2013 KAFP Congress of Delegates: Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' handbook is November 1, 2013. If a Resolution is not received by the KAFP office prior to November 1, 2013, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on Saturday, November 15, 2013, any Resolutions pertinent to the objectives of the KAFP. Resolutions so offered shall be presented to the Congress of Delegates without debate at that time. Resolutions presented from the floor of the Congress are to be provided in triplicate form, with one copy to the KAFP Speaker, one copy to the KAFP Executive Vice President and one copy retained by the presenter.

OFFICIAL CALL FOR THE 2013 KAFP CONGRESS OF DELEGATES

Notice is hereby given of the 6nd Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held at the Crowne Plaza-Campbell House, November 14-17, 2013. Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 53rd Annual Meeting of the Congress of Delegates will be held Friday, November 15, 2013 at 7:00am to receive and act upon reports of officers and committees, to elect officers and to transact any and all business that may be placed before Congress.
All Officers, AAFP Delegates/Alternate Delegates, Regional/District Directors are requested to register in advance. Registration can be accessed from the KAFP web site http://www.kafp.org/2013-kafp-annual-meeting/. If you should have any questions please contact Janice Hechesky at 1-888-287-9339.

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2013 KAFP CALENDAR

KAFP ANNUAL MEETING
Nov. 14-17, 2013
Crowne Plaza
Lexington, KY

2013 AAFP ANNUAL MEETING
COD Sept. 23-25, 2013
Assembly Sept. 24-28, 2013
Westin Hilton Hotel
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GET INVOLVED

The Kentucky Academy of Family Physician's Executive Committee needs your involvement. A standing committee list with a brief synopsis is listed below. If you are interested in serving you can either send us your preference by faxing this page to (888)287-0662 or by emailing janice.hechesky@gmail.org.

We recognize your time is valuable and therefore, we structure our committee meetings as needed. Typically committees meet as directed by their chairs via conference call. The agenda is sent in advance of conference call with the objective of holding the meeting under 50 minutes. Delegates to the KAFP Congress typically meet annually at the Scientific Assembly for approximately 2 hours.

Advocacy Committee: Chaired by Nancy Swikert, MD and Brent Wright, MD; this committee identifies members' interests and use mechanisms to advocate for those interests, effectively and efficiently using the resources of the KAFP; identify the needs of our patients and advocate for those interests, effectively and efficiently using the resources of the KAFP; and, educate the public, public, private and governmental agencies about the importance of a "Medical Home".

Bylaws Committee: Chaired by Jerry Martin, MD and Robert Wood, MD. This committee is responsible for providing guidance to KAFP leadership on policies and procedures for Chapter Governance.

Communication Committee: Chaired by Bill Crump, MD with the assistance of Stevens Wrightson, MD and Eli Pendleton, MD; this committee is responsible for communicating the activities of the KAFP as it pertains to the present and the future via Journal, Website and e-mail.

Education Committee: Chaired by Patty Swiney, MD; this committee is responsible for developing CME that is targeted to the needs of membership.

Finance Committee: Chaired by John Darnell, Jr., MD, Treasurer; this committee is responsible for financial operations of the KAFP.

KAFP Foundation: Chaired by Nancy Swikert, MD and Baretta Casey, MD; this committee is responsible for the operation of the philanthropic organization that support undergraduate and graduate education in KY, and KAN's research initiatives that support private practice of family medicine.

Delegates to the KAFP Congress: Chaired by the Speaker Sam Matheny, MD; the KAFP Congress of Delegates meets annually or as called by the Board of Directors of the KAFP to review future and prior year programs and proposals; resolutions submitted by districts to be presented at the AAFP; and provide guidance to the KAFP Board of Directors on activities of the KAFP.

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Acceptability of fecal occult blood testing for colorectal cancer screening: A COMMUNITY-BASED EFFORT

ABSTRACT

BACKGROUND

Screening for colorectal cancer is an important preventive measure, often limited by patient acceptability of available screening tests to patients. Nine years of experience with a community-based screening effort using free Fecal Occult Blood Tests (FOBT) demonstrated that as many as half of the patients who took a FOBT kit did not return it. Our goal in this survey was to understand the reasons that patients made this choice, as well as to discern what would motivate them to have screening colonoscopy.

METHOD

Of the 110 participants who received free kits during the 2011 screening event, 56 participants were contacted and completed a detailed telephone survey administered by experienced endoscopy nurses. The survey included questions about motivation and concerns with the FOBT.

RESULTS

Returners of the kits did not differ in demographic variables from non-returners but the uninsured were more likely to return the kits. The strongest predictor of return was previous use of FOBT, and the returners were more likely to be open to physician advice on the need for screening colonoscopy. The non-returners reported a much higher concern with the process of the test itself.

CONCLUSION

There appears to be a group of patients who prefer repeat FOBT use despite the modification in dietary and medication use necessary as well as the unpleasant nature of the test. These motivated patients are also open to physician advice when considering screening colonoscopy. Included in this group are the currently uninsured who, if their FOBT is positive, may merit the use of scarce disproportionate share or charitable resources to arrange colonoscopy. In an attempt to increase the proportion of kits returned, the screening this year will use immunochemical-based (i-FOBT) methods that do not require any advance changes in dietary or medication routines.

INTRODUCTION

To meet generally accepted criteria for disease screening, 1)the disease of interest must have a significant burden of suffering, 2) early detection must make a real difference in outcome, and 3) a reasonably easy and inexpensive screening test must be available. Colorectal cancer (CRC) is the second most common cancer, and it results in 10% of all cancer deaths.[1] About 1 in 20 Americans are expected to develop this disease within their lifetime and many of those will die from it.[2] For the years 2005 – 2009, Kentucky's annual mortality rate of 19.0 deaths per 100,000 placed the state at 3rd highest in the nation behind West Virginia and Mississippi.[3] While there is little agreement on screening for many cancers, there is consensus on CRC.[4]

The primary obstacle in CRC screening is patient acceptability.[4] All methods except the fecal occult blood test (FOBT) are invasive and uncomfortable and require a significant amount of the patient's time. Even first generation FOBT testing requires avoiding red meat and nonsteroidal anti-inflammatory agents (NSAIDs) for several days and is considered unpleasant by many patients. The use of fecal occult blood tests in the screening of colorectal cancer has traditionally had low patient compliance, ranging from 26-48% in large practice-based screening programs.[5] Inadequate payment for preventive counseling and difficulty working preventive issues into daily practice have also been identified as obstacles. While colonoscopy is considered the gold standard for colon cancer screening, randomized controlled trials have shown that screening with FOBT can reduce CRC mortality by 15 – 33 percent.[6] FOBT kits fit public screenings well as they can be handed out quickly to large numbers of people.

We reported previously the results of the first year of a community-based CRC effort using FOBT.[7] The effort was well-received, with patients expressing appreciation for both the education and the kit. One hundred eighty eight patients were seen, and 106 returned the kits (56%). Twelve patients had at least one positive result (11.3%), and were sent a registered letter and tracked to definitive diagnosis. Since

this initial free screening in 2004, the Baptist Health Madisonville (formerly the Trover Health System) Cancer Program has distributed 1,351 FOBT kits at annual screening events with an average return rate of 45.5 percent. We recognized the need for a greater understanding of screening motivation on the part of our service population.

Previously published literature provides some insight into the success of FOBT screening.[5, 8, 9, 10, 11, 12, 13, 14, 15, 16] These reports found that physician discussion, mailed reminders, and less change required in patient daily routines were associated with higher return rates. Several methods to improve patient compliance with fecal occult blood tests have been studied. An increase in FOBT adherence was seen with individual, 10-15 minute educational sessions by nurses focusing on the importance of CRC screening and FOBTs.[5] No study addressed the question of why patients did not return their FOBT kit obtained in a community event setting.

Our goal with this survey was to learn more about why some patients don't complete the FOBT screen despite attending the health screening event and secondarily to understand what would motivate these patients to undergo screening colonoscopy.

METHOD

The annual free screenings were advertised and open to all. Extended hours were provided to allow participants to avoid time missed from work. Participants could pick up a kit in person or have someone pick up a kit for them. Participants were provided general information on levels of cancer risk, tests available, and details of the use of FOBT kits. Anyone receiving a kit in person or by proxy was required to complete contact information. One hundred and ten kits were distributed at the screening in March, 2011 and form the basis for this survey.

Experienced endoscopy nurses were trained in telephone interview techniques by the survey evaluator (SF). This included a brief script to improve consistency from one call to another and to minimize interviewer bias, and a set of 18 questions was developed for participants who returned their kit and 17 questions for those who did not. The interview consisted of questions about participant motivation and demographics.

During initial field testing of the questionnaire, possible responses were developed for each question to facilitate recording and grouping participant comments and coding. As the interviews progressed, the survey evaluator worked with the interviewers to maintain consistency. All responses were separated from identifiers prior to data entry or review. Fifteen men and 41 women responded to the survey for a total of 56 interviewed. Others either could not be reached or declined the interview. Responses to the questionnaires were entered into a Microsoft Excel spread sheet and subsequently imported into SPSS 20. Simple frequencies were conducted followed by cross tabulations comparing respondents who returned their FOBT to those who did not. Chi-square or fisher exact tests, where appropriate, were used to examine statistical significance.

The Trover Health System Institutional Review Board (IRB) reviewed the protocol and determined it was exempt from further review.

RESULTS

The answers to the 17 or 18 questions were categorized using an iterative process by the survey evaluator and the project medical advisor (WC) until the categories shown in the tables captured most of the answers. Table One shows that there were no statistically significant differences in demographics between those who returned their kits and those who did not. As shown in Table Two, uninsured patients were more likely to return the kits, and among the insured, there were no differences among types of insurance.

Table Three shows that previous experience with FOBT kits was strongly associated with their repeat use, but time since last colonoscopy was not. The answer to the follow-up question

Table One: Demographics by FOBT Return

	Yes	No	Significance
Age			
<40	0	0	
41-49	2 (28.6%)	5 (74.4%)	
50-69	13 (44.8%)	16 (55.2%)	n.s.
70+	11 (57.9%	8 (42.1%)	
Gender			
Male	6 (40.0%)	9 (60.0%)	n.s.
Female	20 (48.8%)	21 (51.2%)	
Race			
White	23 (48.9%)	23 (51.1%)	
Black or African American	3 (37.5%)	5 (62.5%)	n.s.
Other	0	1 (100%)	

about colonoscopy showed that kit returners were significantly more open to advice from their physician than non-returners.

Table Four shows the reasons the non-returners gave for their choice, with issues with the process of using the kits being the most common, but avoidance and self-diagnosis were also almost 20% each.

DISCUSSION

Although the sample size was small, this survey provides a glimpse into the reasons why someone would expend the effort to attend a targeted screening event but then not complete the free screening test provided. We found no other publications that addressed this issue, although there are many publications that report that patients recruited in other ways found the FOBT testing unpleasant. Our finding that there seems to be a group of patients who prefer repeated FOBT screening to other tests was also reported previously.[5,8]

On first view of Table Two, it seems paradoxical that the uninsured would be more likely to return their kits, as the insured are generally assumed to have more resources required to complete any health task. In our selected group, this was not true. On reflection, it seems perfectly logical that those persons who have no other low cost option for screening but are still well-resourced enough to make it to the screening event would be more likely to take full advantage. Some authors have maintained that the greatest value of the FOBT, despite the false positives, is that it identifies a sub-group who should receive intensive advice for colonoscopy. In the uninsured, this may be particularly true. Scarce resources for disproportionate share and charitable application processes can be focused on these patients who have a positive FOBT, with the goal of earlier diagnosis of colorectal cancer resulting in long-term savings.

Among those considering colonoscopy who returned their kits, physician advice was rated the most important variable. This reinforces the importance of the doctor-patient relationship in screening. This is also consistent with data published from the

Table Two: Insurance Coverage by FOBT Return

	Yes	No	Significance
Insured	17 (38.0%)	28 (62.0%)	P=.018
Uninsured	8 (80.0%)	2 (20.0%)	
Any Commercial Insurance	11 (36.7%)	19 (63.3%)	n.s.
Medicare without Commercial Insurance or Medicaid	5 (47.7%)	7 (58.3%)	
Any other insurance	1 (33.3%)	2 (66.7%)	

Table Three: Predictors of FOBT Return

	Yes	No	Significance
Previous FOBT Experience			
Once	3 (30.0%)	7 (70.0%)	P=0.0005
2 or more	14 (87.5%)	2 (22.2%)	
Time since last colonoscopy			
< 5 years	9 (47.4%)	10 (52.6%)	n.s.
5 or more years	5 (50.0%)	5 (50.0%)	
What would it take to get you to get a regular colonoscopy? §			
Advice of MD	10 (76.9%)	3 (23.1%)	P=0.042
Other reasons	10 (41.7%)	14 (58.3%)	

§Respondents provided a total of 19 different answers to this question which were collapsed into the categories shown above. "Advice of MD" includes: "MD recommendation", "MD recommendation and knowing when to do it again", "MD recommendation and not due yet", and "MD said after age 80 risks outweigh the benefits." "Other reasons include: "reach 50+ years of age", "reason I need to have a colonoscopy", "insurance coverage", "affordable cost", "ease of scheduling", "I do [get regular colonoscopies]", "next one due 5 years", "not due yet", "already scheduled at time of interview", "making an appointment'", "if I feel bad I will get one", "finding time to do it", "next colon due soon", "reason I need to have a colonoscopy and change in bowl function/habits" and "I do get regular colonoscopies".

Pennyrile region where citizens who reported that they did not get a colonoscopy made this choice because it was not recommended by their doctor.[17] When individual physicians are interviewed, they often report that so few patients follow through with screening that they may not mention it during an otherwise busy visit. Physicians may be well advised to take the time to discuss colonoscopy screening with the patient who demonstrates commitment to screening by completing a FOBT kit, even if the FOBT test is negative.

The reasons for not returning kits shown in Table Four are those expected. It takes a particularly motivated individual to obtain the kits, avoid red meat, vitamin C and anti-inflammatory agents for three days, collect three sequential stools and smear them on the cards, and return the cards on time. Modification of this FOBT routine may make the test a little more acceptable. Some authorities question the need for the 3-day preparation, and immunochemical-based stool testing does not require diet modification because it measures only human blood. This immunochemical-based test (the i-FOBT) also does not detect small amounts of upper gastrointestinal bleeding, so usual doses of aspirin and NSAIDs can be continued during testing. "Drop in the bowl" testing avoids the most unpleasant aspects of the FOBT, but the ability of the patient to detect and record the color changes accurately is not yet proven.

Table Four: What caused you to not return your FOBT kit? ¥

Lost kit	2 (6.9%)
Avoidance	6 (20.7%)
Self diagnosis	6 (20.7%)
Issues with process	13 (44.8%)
Other reasons	2 (6.9%)

¥Respondents provided a total of 18 different answers to this question which were collapsed into the categories shown above. "Lost kit" is self-explanatory; "Avoidance" includes "did not really want to do it", "fearful of positive results", "just did not do it", 'procrastination", "did not have time"; "Self Diagnosis" includes "I recently had a checkup [and] everything was o.k.", "read results [myself]", "results read at another office", "bleeding stopped", and "I know I was fixing to have a colonoscopy"; "Issues with process" included "unsure of how to return kit", "waited too long to return [kit]", "forgot", "health issues right after picked up kit and did not follow through", "did not follow through with eating instructions/restrictions";
"Other" included "can not remember" and "never received the kit".

CONCLUSIONS

After careful consideration, our group has decided to continue our community-based screening with modifications. Because each i-FOBT costs about $7 compared to the older FOBT kits that are currently about $3, we will provide careful counseling to each patient on all their cancer risks and give the free i-FOBT kit only if there is a high likelihood that the patient will return it. To facilitate compliance, we will recommend no change in dietary or medication routines during testing. Future surveys will give us feedback on these changes.

ACKNOWLEDGMENTS

This survey could not have been successful without the hard work and attention to detail shown by the nursing staff in the Baptist Health Madisonville Merle Mahr Cancer Center and Endoscopy services. These include Diana Jackson, RN, M.S.N., OCN, Audrey Thompson, RN, CGRN, Denise Winstead, RN, CGRN, and Amy Forker, RN, CGRN.

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“NINE YEARS OF EXPERIENCE WITH A COMMUNITY-BASED SCREENING EFFORT USING FREE FECAL OCCULT BLOOD TESTS (FOBT) DEMONSTRATED THAT AS MANY AS HALF OF THE PATIENTS WHO TOOK A FOBT KIT DID NOT RETURN IT. OUR GOAL IN THIS SURVEY WAS TO UNDERSTAND THE REASONS THAT PATIENTS MADE THIS CHOICE, AS WELL AS TO DISCERN WHAT WOULD MOTIVATE THEM TO HAVE SCREENING COLONOSCOPY.”

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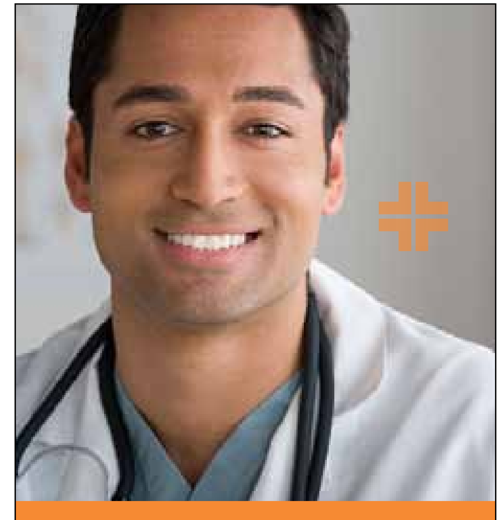

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BENJAMIN COURCHIA, M.D.

Reflections– HAZARD, KY

Introduction by : Samuel C. Matheny, M.D., MPH, Assistant Provost for Global Health Initiatives, University of Kentucky

We are pleased that the editors of the KAFP Journal have included a paper by Ben Courchia, a medical student who participated in a family medicine elective in his final year of medical school with our department at our East Kentucky site in Hazard. A bit of explanation is in order to give some perspective about this student's paper. Ben and his wife were students at Ben-Gurion University Medical School for International Health in Beer-Sheva, Israel. Both natives of France, they pursued a desire to learn more about rural communities and health care in the United States.

Ben-Gurion is a unique institution, drawing students from all over the world who have an interest in global, community and preventive medicine, as well as primary care for underserved populations. The University of Kentucky has had an exchange agreement with Ben Gurion for a number of years, and our students in turn have an opportunity to work with Bedouin populations in the Negev desert where the school is located.

Ben participated in all aspects of our clerkship experience, including writing a reflection paper which was required for all of our students. This paper is the result of that assignment. His unique perspective, seeing our part of the world through a different lens, and the universality of his patient experiences we felt was important to share with you.

I have always been fascinated by the United States. Growing up in the south of France, television distilled the American culture through every outlet possible: TV shows, basketball games and interviews with American actors such as Will Smith. Every presidential election felt like we were electing our own chief in command. No matter how hostile French politicians pretend to be towards the United States, the truth of the matter is that any French teenager wishes to live the American dream. Our understanding of U.S culture and geography is dictated by five television shows, that being in no way educationally optimal. Friends depicts the Northeast, Beverly Hills 90210 covers the west coast, Texas = Chuck Norris, Miami is the city with the coolest forensic cops and anything else is pretty much the Little House on the Prairie.

In 2002, as a fresh high school graduate, I was fortunate enough to have the opportunity to study at Yeshiva College in New York City.

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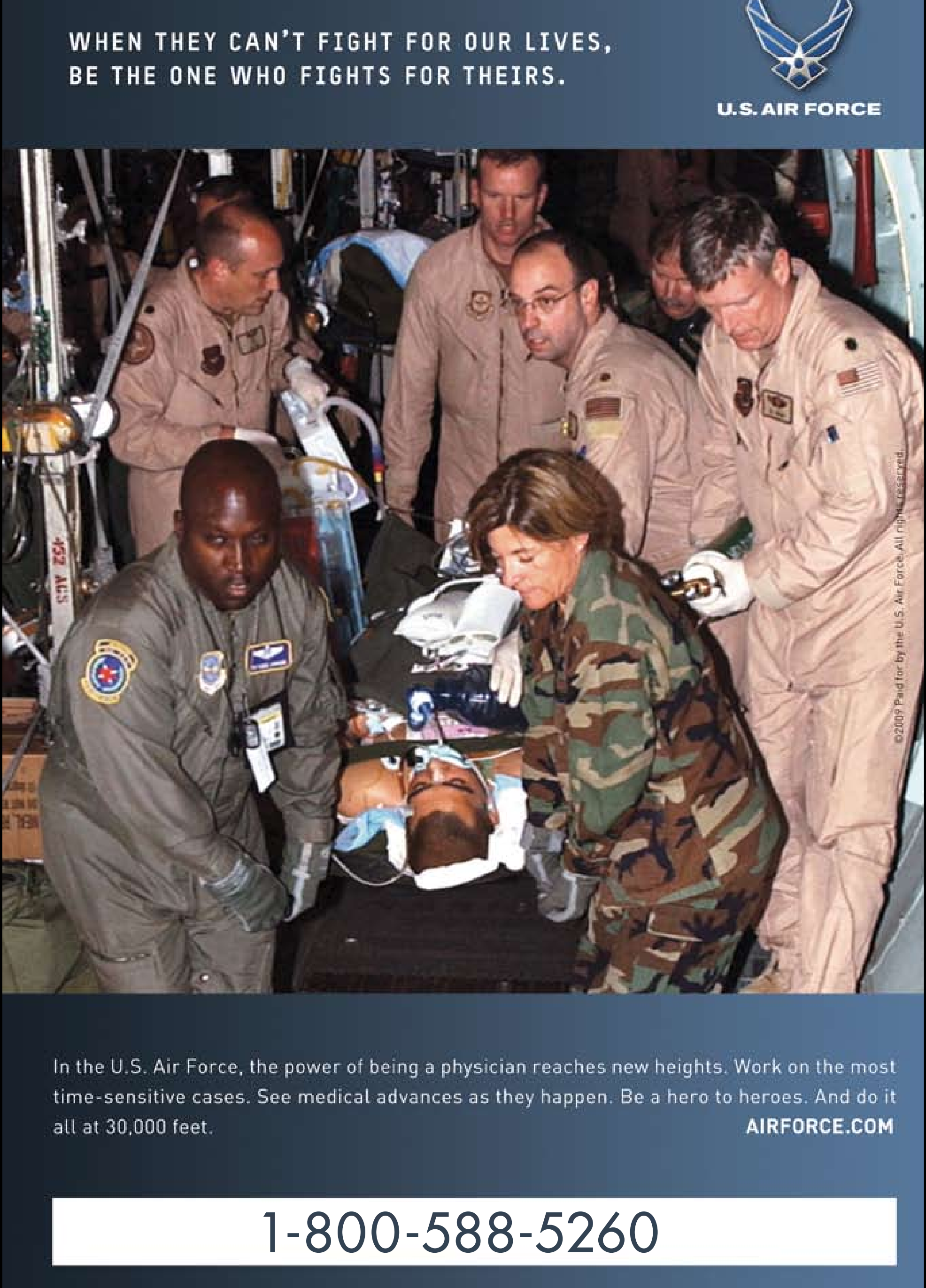
In the six years that followed, my outlook on this country got more realistic but not yet objective. I then embarked on another adventure: Medical School in Be'ersheva, Israel. This medical school has a strong focus on international and rural health and all that really matters for the purpose of this essay is that as a fourth year student I chose to rotate in Hazard, Kentucky for my elective in international and rural medicine. Many friends and classmates picked sites that were much more "exotic" than rural southeast Kentucky. My best friends went to lend a hand in Nepal, others traveled to the Philippines, Vietnam, Argentina, South Africa, Papua New Guinea, and the list goes on. The little French boy in me could not pass up on the opportunity to live 8 weeks in what would surely be exactly like the set of "a little house on the prairie"! As I told my wife Sarah and 2 year old daughter Raphaelle, it was going to be awesome. On December 31st, we filled our rental car to its breaking point, and left sunny Miami for a two day drive toward Hazard. Ten hours to Atlanta, where we spent New Year's Eve at the Holiday Inn, we woke up at dawn to complete the second, 8 hour long, leg of our trip to Kentucky. We made it to Hazard around five o'clock in the evening, and settled in our new home kindly rented out to us by Ms. Castleman.

The next day was dedicated to orientation and I was due to start the following day on January 3rd. Until then, I had the chance to meet a great bunch of people, all more welcoming than the previous one even if in some cases I was just getting a urinary toxicology screen. As a medical student, my job description was fairly straight forward; see the patient, get a history and physical exam, present your findings to one of the residents, see the patient with the resident physician, and present your findings to the precepting physician. At this stage of my medical career, I was well qualified to perform those tasks. During my first week, it seemed to me that my patients were competing for the craziest story ever told. One patient back-flipped out of the bed of a pickup truck when his friend suddenly jammed on the accelerator leaving him with a broken patella; another crashed his monster truck while driving through hurricane Sandy in the New York area. Last but not least was the patient complaining of leg pain six years after his mother shot him and his then wife leaving her dead and him with a bullet permanently lodged in his brain. In complete honesty, these stories were sad yet entertaining. As I progressed through my rotation I started to be less entertained by my patients' stories and more worried about their future prospects. For many, those entertaining stories meant life with a permanent handicap and trying to obtain disability benefits. I then started to see my fair share of people with "low back pain" trying to score some pain medications after being kicked out of their pain clinic. It would be criminal to forget patients without health insurance and extremely limited financial means. I may not have been in a remote location in India but it surely felt like it when I had to advise a patient of mine to buy her omeprazole (heartburn medication) over the counter at the dollar store rather than at our pharmacy, just so that it would be easier for her to make ends meet on her $124 check she draws every month. My love of this beautiful country has not wavered one inch but I



was starting to see a reality not depicted on TV shows and that the great city of New York failed to show me.

I am rational enough to understand that something may not be apparent but yet still exist. However, when one patient explained to me that a free colonoscopy at the health department would not be of any benefit because she would not be able to afford the cost of treating a potential cancer, it became clear to me that poverty was not the same as misery. I understand poverty; as a student, poverty is my daily bread and butter. Misery, the true lack of positive prospect/outlook, is something I was not cognizant of. Was I ever taught, during medical school, to treat misery? Is it really my job to address such an issue? After all, I am in the business of treating health issues. Got palpitations? I can tell you how to fix that. Got headaches? I have pills for that. Feel short of breath? I have a solution to that as well. Can't pay for your meds? Well, talk to some finance person who can "balance your budget" or talk to a social worker. One thing is certain, I am not your guy (after all, I am the one with $150,000 in loans to repay.) The Merriam-Webster dictionary defines misery as "a circumstance, thing, or place that causes suffering or discomfort". As a healthcare provider, that sounds very much like misery should be in my repertoire. I am ashamed to say that at the time, it was not. "What am I supposed to say to a patient who cannot pay for his medications? A social worker would be much more competent than I ever would," I told Dr. Atkins, precepting me one day. His answer was the turning point of my rotation in Hazard; "Well, Ben, we don't really have a choice, do we?" Indeed, we did not. Patients did not give their physicians the luxury to pick the issues that would be taken care of during a particular visit; in some cases it meant being a physician, social worker and therapist all at once, in twenty minutes mind you.

By the end of my rotation, I found myself comforting patients crying after the loss of a loved one, while helping them choose which medication they absolutely needed versus the ones they could live without. "Definitely buy your heart medication; I can give you some samples for your constipation, you should get your aspirin over the counter at the dollar store and your heartburn can wait for the time being." There I was, trying to make this person's burden a bit lighter, one dollar at a time. It felt good. This was not standard New York City "care." That city is merciless, and physicians are most of the time, not your friend. Hazard taught me differently; to be your patient's friend in a time of need is what is expected of you and should be the norm. Across the medical hierarchy, interns, resident, chief resident, and attending, each one is willing to do whatever is necessary to make a patient's life better. For that reason, when leaving this city after 8 weeks of life changing experiences, I was not worried for the welfare of the patients at the UK Center for Excellence in Rural Health because of what its physicians were willing to do. Les Brown, in Live Your Dreams said it best: You must be willing to do the things today others don't do in order to have the things tomorrow others won't have. Thank you, Hazard.

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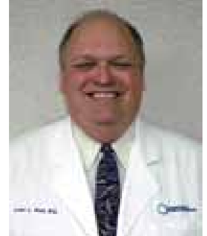
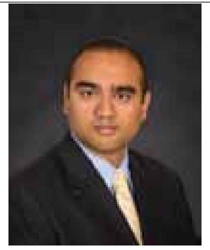
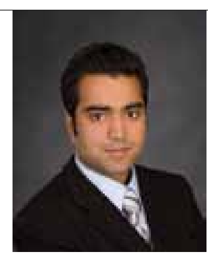

First Steps Toward a PATIENT CENTERED *Medical Home in a Family Medicine Residency Practice:* THE HUDDLE

BACKGROUND

The transformation of primary care practices to an environment that is truly patient centered is based on the four goals shown in Table One.[1] When describing the Patient Centered Medical Home (PCMH), the elements shown in Table Two are considered core principles or components.[2] Physicians who have completed this transition report higher personal satisfaction and better patient outcomes, and both federal and private insurers are beginning to pay higher amounts for this service. The process of an individual practice change often takes 2-3 years and often begins with development of a formal "huddle." The huddle is a brief meeting among physicians and support staff, usually just prior to a patient care session. The goal is to increase communication, teamwork, efficiency and patient safety.[3]

While much has been written about the effectiveness of the huddle in practice [4-6], little attention has been paid to its implementation in a residency practice. A recent publication addressed the perceptions of participants in a family medicine residency in New Jersey [7], and we used their instruments to assess our situation.

We previously reported our first impressions of implementation of PCMH in our residency. [8] Our first step was to begin and optimize huddles, to be followed next by clear determination of patient panels for each resident and faculty, and then hiring of a nurse care manager to facilitate patient access between visits. Here we report participants' views three months after beginning the huddle process.

Table One

KEY QUESTIONS FOR PRACTICE TRANSFORMATION

How does this effort:

1) Make it easier for patients to get access to care and obtain continuity?

2) Provide ways to increase the patient's participation in their care?

3) Provide the skills necessary for patient self-care?

4) Coordinate care among different clinical settings?

METHODS

Most PCMH huddles are comprised of front office staff who know about appointment availability, medical assistants (MA) who know the individual patients and the clinical processes, and the physicians who act as the patient's primary care provider. In a residency, this can be a fairly large group that includes 4-8 residents, 1-2 faculty and the support staff. Often then a leader, usually a faculty member, "runs" the group, with this transitioning to a senior resident over time. Early on, we determined that in our staff-lean system with only 2 front office staff for 6-10 resident and faculty physicians in a session and 23 physicians in the practice, they were better deployed continuing to answer the phone and schedule patients during the huddle time. Also, with our computerized appointment system, the medical assistants could manage appointments, so the huddle developed into just MAs and physicians.

Our practice is divided into two "ends of the hall," with all faculty and their MAs

Figure 1

Patient Flow Form

DATE: ______________
Huddle Time: ____________
1st Pt Pulled Time: _________
Time Last Pt Left: _________
Physician Name:

____

Planning for Today:

1. Review Schedule

2. Any Patients who require additional resources/forms/reports?

3. Who will need more time than scheduled? Who will need less?

4. What can make today run smoothly for everyone?

at one end and all residents and their MAs at the other end. Rather than a group of participants at each end, what developed was a small meeting of the individual resident with the MA assigned to that resident for that session. This usually occurred at the work desk of the individual resident about 10 minutes before the session began. Supervising faculty could move among the meetings and observe the process. Since there were only 3 MAs at any time, a more junior resident might share an MA with another junior resident, meaning that that MA would need to do two shorter meetings. The focus was on the schedule for that session, and if the resident arrived soon enough to log in and open the EHR, they could review previous visits, lab, and imaging.

We used the huddle surveys reported previously [7] as well as their interview outline for faculty to obtain the perceptions of the participants. In addition, a process improvement form completed after each session by the MAs was developed to focus the huddles and to track changes in patient flow. (See Figure one.)

RESULTS

Table three shows the survey responses by category of job responsibility, with generally positive responses, but some uncertainty. Follow up discussions with those surveyed reported that the negative ratings on improving continuity were because the resident system already places a very high premium on continuity of physician, and they couldn't imagine how huddles could improve it any further. Table four shows the comments, and again reflects that the definition of the MA/physician roles was still in transition. In the faculty interviews, they reported few new opportunities for resident evaluation provided by the huddles, largely because the faculty could not be present at each huddle. Most of the faculty also admitted that because of conflicting multiple responsibilities, they were often not present in the office at the time of the huddles.

DISCUSSION

Although most participants were positive about huddles as a method to increase practice efficiency, it was hard to see how they would address the four key goals shown in Table one. Most just saw huddles as a necessary first step to a team-based care process that hopefully would then address the other aspects shown in Table two. To allow everyone to "work at the top of their license," a successful PCMH must allow considerable autonomy by well-trained MAs. Studies have shown that this change alone increases quality in a PCMH. [5] Huddles are designed to bring this need into focus, but the training takes initiative on the part of the physicians. One resident reported that he began "mini-training" during his huddles, with his MA beginning to provide self-care skills to his patients including dressing changes and blood sugar checks. For our PCMH to succeed, more MA training and support for their autonomy is necessary.

Our system still has some challenges on the coordination of care among different clinical settings. Our residency outpatient EHR cannot access lab and imaging ordered in the hospital or any other outpatient site, requiring a manual review of other EHR systems. For patients recently hospitalized, this can be a problem if the dictated discharge summary is not yet available even in the hospital EHR, and the daily hospital progress notes are still paper-based. Our residency outpatient EHR also cannot provide the kind of automated preventive maintenance and evidence-based chronic care prompts that are required for a successful PCMH. Active planning is underway to address these issues, and it may require change to an entirely different EHR vendor, with all the inefficiencies that come with the required learning curve for a new system.

All the physicians were aware that they previously did a mental "pre-review" of each patient. This might be as the schedule

Table Two

AAFP/AAP/ACP JOINT PCMH PRINCIPLES 2007

1) Easy access (virtual or in office)
2) Team care (physician led, care coordination)
3) Chronic Disease Registry
4) Good EHR (evidence prompts and reminders)
5) Group visits
6) Patient centered (goals set by patient, e.g., A1C)
7) Efficiency (everybody works to the limit of their license, tight coordination with pharmacy)
8) Quality/safety (ongoing performance improvement, national guidelines)
9) Payment for coordination (roughly twice the fee for service rate)

was viewed for the first time or sometimes just prior to entering the exam room. This review generated a mental list of needed preventive services or lab, based on the patient's active problems, as well as administrative things like the need for a urine drug screen (UDS) or Kentucky All Schedule Prescription Electronic Reporting (KASPER) report. What changed with huddles was that this pre-review was verbalized to the MA and the MA was able to make suggested modifications. This was really the beginning of true team-based care.

There was also consensus that even though there was not a continuity one-to-one pairing of MA and resident, with the huddle process, they began to know and understand each other as persons. As a result, the residents learned the name of their MA much earlier than previously, and the MAs felt comfortable communicating with the physicians via texting. Overall, faculty saw a more collegial process between residents and

Table 3
Survey Response by Job Category

Statement	Front Desk n=3			Med Asst n= 3			Residents n=18			Faculty n=5		
	Agree	Disagree	Unsure	Agree	Disagree	Unsure	Agree	Disagree	Unsure	Agree	Disagree	Unsure
1. Our office huddles help provide good patient care.	100%	0%	0%	33%	33%	33%	78%	6%	16%	60%	20%	20%
2. Our office huddles improve patient flow	100%	0%	0%	0%	33%	67%	72%	6%	22%	60%	0%	40%
3. Our office huddles facilitate communication among all staff caring for patients.	100%	0%	0%	33%	33%	33%	100%	0%	0%	60%	20%	20%
4. Our office huddles improve patient continuity with providers (help ensure patients see their primary doctor by exchanging appointments when possible).	100%	0%	0%	0%	67%	33%	50%	11%	39%	20%	20%	60%
5. Our office huddles take up more time than they are worth.	33%	67%	0%	33%	0%	67%	6%	83%	11%	0%	80%	20%
6. Our office huddles improve patient safety.	67%	0%	33%	0%	33%	67%	39%	0%	61%	60%	20%	20%
	Harder	**Easier**	**Unsure**	**Harder**	**Easier**	**Unsure**	**Harder**	**Easier**	**Unsure**	**Harder**	**Easier**	**Unsure**
7. Overall, our office huddles have made my job:	0%	100%	0%	33%	33%	33%	6%	67%	27%	20%	60%	20%

staff than previously. Also, communication among the residents improved in the faculty view. Where previously the residents would focus on patient flow and efficiency only during scheduled “gripe sessions,” during the huddle process these discussions happened nearly every day. Also, these discussions provided an immediate practical opportunity to implement solutions.

The strongest consensus of a positive effect of the huddles was getting residents and staff to the office on time. Historically, because of hospital responsibilities, residents and faculty might arrive late for a clinic session. This then resulted in staff feeling less pressure to get the initial patients of a session in a room on time. Staff, physicians, and even patients become accustomed to this pattern that sets up a light schedule for the first 30-60 minutes of the session but ultimately results in more pressure to complete it on time. There was also consensus that the addition of an administrative staff member with no clinical responsibilities whose role was to watch patient flow and bring issues to the attention of faculty was very effective.

The MAs were the least positive about the early experience with the huddles. If they already perceived themselves as too busy, sometimes responsible for more than one resident’s patients in a session, the additional workload could make their job harder. It may take some time for the MAs to perceive that shifting some of the workload to the period before the patient sees the resident might actually save time and work overall, if in fact it does. Their responses also must be interpreted through the lens of a recently implemented EHR that only a year ago began to require them to do full medication reconciliation and confirmation of medical history during their intake. For the effort to implement full PCMH to be successful by having these MAs work up to the limits of their capabilities, they will have to be convinced of its effectiveness. If funding would allow for one MA to each resident at each session, and continuity of the pair, this would be more easily accomplished.

For the full potential of huddles as evaluative opportunities for faculty to be realized, faculty must arrive in the office at the beginning of huddle time and listen in to the discussion, and then remember to ask the resident whether important issues arising in the huddle had been addressed during the patient visit. For faculty with multiple responsibilities, including caring for their own hospitalized patients, this is an ongoing challenge. With multiple huddles going on simultaneously, faculty may need to focus on one resident’s huddle process in a given session, rotating to be able to evaluate all the residents over time.

The next step for us is to automate the patient flow form shown in the figure so that we can see a summary of our process and focus on individual MA/resident pairs. Once a care coordinator is hired, training and morale-boosting among the MAs will be an important goal. The primary purpose of this position is managing patients between visits, but in our staff-lean environment, he or she will also have to work very closely with the MAs to optimize the care during patient care sessions. Time must also be found for these MAs to get this training, which will require either intermittent float MA coverage or closing some clinic sessions. A particularly educationally rich strategy

Table 4

Survey Comments by Job Category

Clerical	no comments
Medical Assistant	no comments
Residents	"I have not used this to its fullest potential." "Helps ease the transition." "Provides some good background info on the Pt." "Should have more staff than what we have." "I feel as though the huddles provide a brief summary over the physician's schedule to look over the day and what may be needed to do prior to MD seeing the patient. It's not necessarily making it easier on the MD but I don't think it makes it more difficult either. It also depends on the nurse/staff overall and how efficiently they work. Preventative medicine questions are rarely asked, which is not helping the MD. "Huddles are supposed to help provide good patient care, but so far this hasn't worked in all situations. For instance, a pt with several comorbidities and taking several medications will take a longer time to check in because their med list should be reviewed prior to seeing MD. The med list is not always updated. Also, having a brief overview of why the pt is here for visit would be helpful, instead of just writing 'recheck'; often times pt has other concerns that they may want addressed." "Some nurses are excellent in following up on what we planned during the huddle but not all of them. Many things are still not done as discussed." "Useful if MD has time to review pts prior to Huddle if time permits." "It helps facilitate the ease of patient care."
Faculty	"Helpful." "I think huddles provide an opportunity for physicians to involve nursing staff more directly in patient care. Also allows physicians to communicate concerns more directly and vice versa with nursing." "There is some misunderstanding with staff as to the use of the huddle. We need to work on it as it is the preamble to the PCMC model."

would be to remove the MAs for a few sessions for training and during that time have the residents serve as their own MAs with a half-volume schedule. During this time, some reward for the "most effective resident/MA" may be needed to avoid resident unhappiness.

We, along with our other Kentucky Family Medicine residencies, will continue periodically to report our perceptions of the transition to a true PCMH. Huddles have been a good place for us to start.

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ACKNOWLEDGEMENT

We would like to thank the leadership of Baptist Health Madisonville for supporting the consultation from TransforMed® that is leading us through the transition to PCMH and Michelle Gunn for collecting the survey data and designing the patient flow form.

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