KAFP JOURNAL
SUMMER 2013
VOLUME 79
The Official Publication of the Kentucky Academy of Family Physicians

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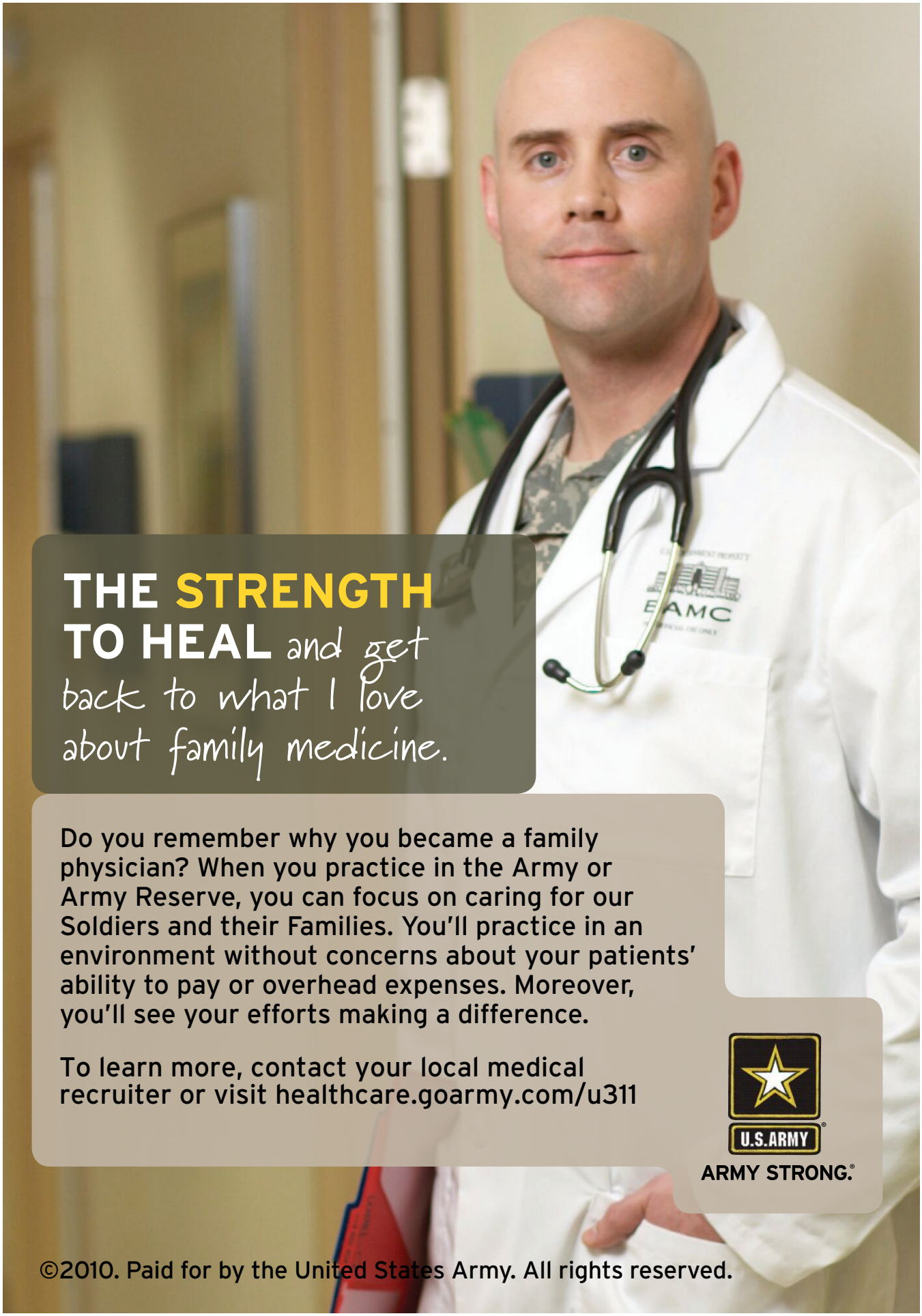

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STRONG MEDICINE FOR KENTUCKY

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MARK YOUR CALENDAR FOR UPCOMING MEETINGS!

2013 SOUTHEASTERN FAMILY MEDICINE FORUM
August 1-4, 2013
Marriott Griffin Gate Resort & Spa
Lexington, KY

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

2013 NCRSC
Aug. 1-3, 2013
Kansas City, MO

2013 AAFP ANNUAL MEETING
COD Sept. 23-25, 2013
Assembly Sept. 24-28, 2013
Westin Hilton Hotel
San Diego, CA

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In Memory of Francis Halcomb, Jr, MD

"When I stand before God at the end of my life, I would hope that I would not have a single bit of talent left, and could say, 'I used everything you gave me."

- Erma Bombeck

Francis Halcomb, Jr, MD (1918-2013) recently achieved his greatest reward as he passed into history and met the Great Physician on May 16, 2013, just 3 days before his 95th birthday. He died peacefully at home among his friends and family. Dr. Halcomb was a legend in the KAFP/AAFP and was truly one of God's healing angels. Those who knew and loved him will miss him.

Francis was born to a tobacco farmer in Franklin, KY. He attended Franklin Simpson HS, College at UK, and medical school at University of Louisville. He served in the U.S. Army as a Captain and worked in the 5th Auxiliary Surgical Group in operating rooms behind the front lines in Western Europe. He practiced full scope Family Medicine in Scottsville, KY for 40 years and then continued work part time for an additional 20 years, giving the community over 60 years of medical care. Francis volunteered in his community in businesses, church, team physician for sports, and was a Mason, Shriner and Rotarian. He loved fishing and remote controlled airplanes/boats.

Francis was a true believer. He believed in Family Medicine and young physicians. He was a mentor to hundreds of students/residents/young physicians, always with encouraging words and lobbying in both Frankfort and Washington for patient and physician rights in healthcare. He attended every KAFP meeting with enthusiasm and ideas until his health deteriorated. He was a charter member of the AAFP and was very proud of attending every annual meeting until well after age 85. He always had a smile and a twinkle in his eye that attracted people to him and made them feel better just for knowing him. Francis was very supportive of his fellow FM peers, always with positive ideas and hard work. He made us be better doctors.

Erma Bombeck said: "When I stand before God at the end of my life, I would hope that I would not have a single bit of talent left, and could say, 'I used everything you gave me." Francis Halcomb, Jr, MD, we believe this can be said of you. Francis used every single bit of talent and then some.

We hope Francis will continue his work as he advises The Great Physician on behalf of us Family Medicine physicians here below. We need his help now as much as ever. Work hard, our friend. We love you.

Visitation will be on June 15, 2013 at 2:00 PM at White Plains Baptist Church, 329 Franklin Road, Scottsville, KY. A funeral service will follow at 3:00 PM with burial in the Crescent Hill Cemetery in Scottsville.

** Family has requested donations in memory of Francis may be made to the Kentucky Academy of Family Physicians Foundation, P.O. Box 1444, Ashland, KY 41105 or to White Plains Baptist Church, Scottsville KY.

NEW KAFP MEMBERSHIP BENEFIT

Your Kentucky Academy of Family Physicians has arranged a group purchasing agreement for "The Core Content Review of Family Medicine" 2013 CD ROM version.

The Core Content of Family Medicine is a unique educational resource for family physicians and other primary care professionals who desire a comprehensive, practical and affordable home-study program for earning CME credit or preparing for Board examination.

This self-evaluation program can be used anywhere, anytime, at your convenience. Whether you are preparing for Board examination or want to update and improve your clinical skills, Core Content Review provides a comprehensive review of the core curriculum of family medicine.

A comprehensive collection of Core Content Review Question/Discussion sets and Clinical Set Problems, updated from the Review's July 2012 through May 2013 print versions, is now available on the 2013 CD-ROM version. This interactive electronic reference resource addresses 45 different subject categories and provides a practical means to refresh and strengthen your knowledge base in preparation for Board Certification and Maintenance of Certification. **The CD-ROM is approved for 60 Prescribed credits by AAFP.**

The AAFP Review Course costs AAFP members $895. A Subscription rate for the Core Content CD-ROM costs AAFP members $199. KAFP is offering it to our paid members who are in attendance at the 52nd Annual Scientific Assembly on Nov. 14-16, 2013 at the Campbell House in Lexington, KY for $160.

Please fax this form to 1-888-287-0662 in order to reserve your copy of the 2013 Core Content Review CD-ROM version by October 15, 2013 and you must register for the meeting in order to receive this discount. The 52nd Annual Scientific Assembly Registration Brochure will be mailed out to all members. The CD-ROM will be available for pickup on Nov. 14-16, 2013 at the Crowne Plaza-Campbell House in Lexington, KY and check/Visa/MC will be accepted.

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KAFP & KAFP Foundation
Annual Meeting

Crowne Plaza-Lexington, KY • Nov. 14-16, 2013
21 CME, 12 CME SAMs & 2 Non-CME

Nov. 14, 2013 - Thursday

7:30am-8:00am Registration & Continental Breakfast
8:00am-5:00pm Exhibit Set-up & Resident Set-up with option to exhibit
8:00am-5:00pm DOT Training Program and Patient Center Medical Home Workshop
8:00am-1:00pm Working Lunch: DOT Training Program for National Registry of Medical Examiners, Instructor: *Nancy Swikert, MD* ($250.00 Registration Fee for DOT Training)
1:00pm-5:00pm Patient Center Medical Home (PCMH) Workshop
Topic 1-Collaborating Physician Training for RHC/RHC Look-a-Like
Topic 2-CPCI-St. Elizabeth PCMH
Topic 3-PCMH Initiative
Topic 4-How to set-up a Quality Improvement Plan for RHC/RHC Look-a-Like
7:00pm-10:00pm Board of Directors Dinner Meeting
9:00pm-12:00am Hospitality Suite

Nov. 15, 2013 - Friday

7:00am-8:00am Registration/Continental Breakfast/Exhibits
7:00am-11:00am Congress of Delegate Breakfast
8:00am-11:00am SAMs Prep Session (12 CME for eligible attendees) Pain Management-*Rick Miles, MD*
11:00am-12:00pm Lunch/Exhibits/Product Theater-Type 2 Diabetes Disease Awareness (1 non-CME)
12:00pm-1:00pm AAFP Chapter Lecture Series: Human Papillomavirus (HPV) (1 CME)
This CME activity is funded by an education grant to the AAFP from Merck.
1:00pm-2:00pm Improving the Identification & Management of Osteoporosis: A Curriculum for the Primary Care (1 CME)-France Foundation
2:00pm-3:00pm Allergic Rhinitis (1 CME)-National Jewish Health
3:00pm-3:30pm Break/Exhibits
3:30pm-5:30pm Part IV Performance in Practice (2 CME)-Robert Wood, MD
12pm-1pm Spouse Luncheon
7pm-10pm Quiz Bowl & Dinner
9pm-12am Hospitality Suite

Nov. 16, 2013 - Saturday

7:00am-8:00am Registration/Continental Breakfast/Exhibits
8:00am-9:00am TBA
9:00am-11:30am HIV/AIDS Update -Sam Matheny, MD
10:00am-10:30am Break/Exhibits
11:30am-5:30pm KBML Approved Courses to Meet HB1 Objectives
11:30am-12:30pm KASPER — Speaker: *David Hopkins*
1:30pm-2:30pm Controlled Substance: Treatment for Chronic Pain, Speaker: *Molly Rutherford, MD*
2:30pm-3:30pm Controlled Substance: Drug Screening Procedures, Speaker: *Rick Miles, MD*
4:00pm-5:30pm New Opioid REMS — CAFP

Nov. 16, 2013 - Saturday

continued

12:30pm-1:30pm Lunch/Exhibits-KAFP-FND *Product Theater*
12:30pm-1:30pm Past President Luncheon
3:30pm-4:00pm Break/Exhibit
7:30pm Reception/Annual Banquet
10:00pm-12:00am Hospitality Suite

Nov. 17, 2013 - Sunday

9am-10am KAFP Foundation Breakfast, Adjourned

REGISTRATION BROCHURE COMING SOON!

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BILL CRUMP, M.D.

Tending the MEDICAL HOME: 2013

The process of providing health care in this country is broken. This is not news to anyone who has tried to be there for their patients while still paying the bills. A system "designed" to meet the needs of acute illnesses paid for out of pocket (or with a barter system using vegetables and fowl) by the patient worked fairly well in the 1910s. Doctors provided "charity care" because it was the right thing to do, and there was enough profit in the overall system to support this approach. Then insurance companies stepped in to lessen the short-term financial impact on the individual patient. For catastrophic costs, this system seemed to make sense. For day-to-day care, it obviously benefited the insurers, who made money, invested it, and made more money. Fee-for-service including insurance payments was still profitable for doctors and hospitals, despite an entire new layer of necessary billing and the wasted effort involved. Each patient had a personal family doctor, subspecialists were rare, and costs were reasonable.

There is no agreement on when this changed, but most cite the advent of Medicare in 1965, followed by Medicaid. For a while, it seemed to make sense. Medicare provided health insurance for those 65 years old and older and the disabled. Medicaid covered the poor who were also in a vulnerable situation, such as pregnant patients and children. Doctors and hospitals were paid a reasonable rate, elders could spend less time worrying about financial ruin caused by a prolonged illness, and Medicaid payment for charity care at least covered the overhead costs, if not compensating for the doctors' time. Medicaid coverage for obstetrical care provided more accessible prenatal care and delivery, and children of poor families could get preventive and illness care.

MEDICAL CARE BECAME A COMMODITY, AND A FASHIONABLE ONE AT THAT. AMERICANS SAW THE MEDICAL SYSTEM AS ANOTHER PLACE TO SHOP FOR THE BEST, AND THE SOLID AMERICAN CONCEPT OF "MORE MUST BE BEST" FLOURISHED.

Then something happened. Medical care became a commodity, and a fashionable one at that. Americans saw the medical system as another place to shop for the best, and the solid American concept of "more must be best" flourished. At the same time, subspecialties were born. Even at this point, most of a person's care was provided or closely managed by their personal physician. Family Medicine became a Board certified specialty in 1969. Then the next big thing happened. Medical technology exploded. The diagnostician's hands, eyes, and ears were largely replaced with elegant imaging capabilities. Fiber optic and then digital cameras were made so small and reliable that there was almost no internal structure that couldn't be accessed from some orifice. Subspecialists could focus on "their"

continued on page 12 >>

orifice or "oscopy" and became "ologists." A very large, expensive but still profitable industry was developed that grew more rapidly than automotive manufacturing, the previous leader, and made the U.S. the envy of the world. Especially in our cities, an individual's prestige was marked by how many subspecialists he had seen and how many orifices had been traversed.

Then we realized that we couldn't afford this monster that we had built. Patients were only paying 10-20% of the real cost of each ologist expedition, and the poor were paying nothing. Our government, knowing that Americans would never voluntarily give up such a good deal, tightened the screws on doctors and hospitals. Generous per diem rates to hospitals changed to a prospective payment system for DRGs. This meant that the hospital was paid a flat rate by severity of illness of their patient, no matter how long the patient stayed in the hospital. Overnight, the usual profit margin of 15-20% dropped dramatically. A good small business might have a profit margin of 10%. Hospitals now were functioning at the 1-3% level.

It was harder for the payers to cut doctors' payments. There is serious talk now about paying doctors by a fixed payment per ambulatory episode of care, but the real cost is still the fees for procedures, emergency department visits, and hospitalization. The government has just taken the "slow drain" approach. By failing to increase payments to doctors to keep up with inflation, they are effectively paying them less each year. With the advent of Accountable Care Organizations, the government is hoping that costs can be controlled by putting doctors and hospitals at risk in the same financial entity.

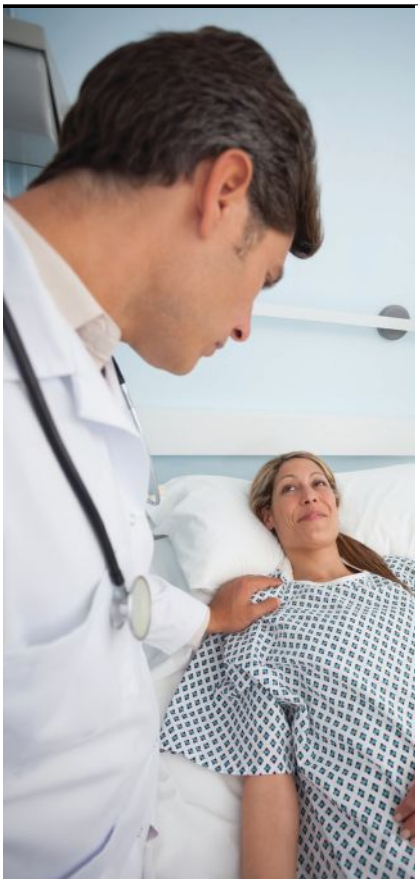
But where were our patients during all this upheaval? Most continued on their usual way, dining from the ologist menu as needed. In the late 1980s, led by an upstart group of academic family doctors, the negatives of this approach for patients became apparent. False positive tests led to more tests, sometimes biopsies, and

some patients were harmed. Medicines were not without side effects, and hospitals could be dangerous places. Seeing several different doctors at the same time led to hazardous overlaps in treatments and emergency departments often repeated unnecessary tests, with more false positives, and the cycle continued. The value of continuity of care was clear to our patients, we thought.

The failure of the health care reforms of the Clinton era can be blamed on many things, but many believe it was largely because the American public simply was not ready to be constrained by a "gatekeeper" standing between them and the ologist menu. Most saw this as just a way to keep them from spending "their money" that the insurance companies or the government owed them. Americans did not understand, or believe in, the concept that a personal physician coordinating their care would not only save money but was actually better for them as individuals.

So what's different now? We have 20 years more data from leaders like Dr. Barbara Starfield and others that make the case even more strongly. Many more specialty societies have publicly supported the concept of the Patient Centered Medical Home (PCMH). Fortune 500 companies are "all in" on the concept. Demonstration projects with federal funding are underway to pay primary care physicians for managing patients over time whether they are seen in the office or not. For the first time in almost 100 years, primary care physicians may be paid what they are truly worth again. But the determining factor on whether the current PCMH movement will succeed or go the way of the Clinton health plan will be the attention paid to the first two words of the new effort. What makes what we do PATIENT CENTERED?

In the editorial I wrote in this journal in 2007 on this issue[1], I summarized a 2006 piece[2] that still provides a nice framework for our current efforts. In the other articles in this issue of your journal, we will showcase some current efforts in our state. As you



read them, consider how each approaches the following 4 questions:

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?

We hope to provide summaries of how our membership is addressing these important questions along with updates on those leading the effort in future issues. We invite you to send us summaries of your efforts. Let's get this right this time. The stakes are just too high to let others mandate where and how we do this doctoring thing.

REFERENCES:

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"THE STAKES ARE JUST TOO HIGH TO LET OTHERS MANDATE WHERE AND HOW WE DO THIS DOCTORING THING"




One Residency's Experience with beginning the transition to a PATIENT CENTERED *Medical Home Model*

BACKGROUND

The family medicine residency in Madisonville Kentucky was the first in the commonwealth, a key part of the vision of Dr. Loman Trover to make this town of 20,000 a regional referral center and a leader in community-based education. Recently the Trover Health System has joined the Baptist Health system, with the residency now called Baptist Health Madisonville. It is a 6-6-6 unopposed program with a traditional rotation-based curriculum with a heavy emphasis on adult inpatient care. All Family Medicine faculty admit to the ICU and two of the faculty practice obstetrics. The program has a long tradition of valuing continuity, with each resident expected to admit and manage the patients from their assigned panel throughout their hospital stay regardless of their current rotation, under faculty supervision. Unassigned patients are admitted in a call rotation to the family medicine residency service, and these patients become part of the continuity panel of the admitting resident. The insurance mix of the residency and faculty practices mirror those of other primary care practices in town.

"THE PATH IS YET UNCLEAR, AND THE REMAINDER OF THE RESIDENTS, FACULTY, AND STAFF MUST BE BROUGHT ALONG AS THE PROCESS CONTINUES. THE FIRST STEP OF IMPLEMENTING PRE-SESSION HUDDLES WILL REVEAL MUCH ABOUT HOW THE REMAINDER OF THIS ADVENTURE PLAYS OUT."

The outpatient center for the residency is located on the first floor of a large multi-specialty clinic and is a traditional long hall of exam rooms and a nursing station near the centrally located waiting room. One end of the long hall is the residency practice, with the other for the four faculty to practice. Appointments may be made either through a central call center shared with the rest of the multi-specialty clinic or directly with the two front office staff located adjacent to the waiting room. New patients can usually be given an appointment within a day of their request. Two medical assistants (MA) work at the resident end and call and place patients in the exam room, completing vital signs and medication reconciliation in the electronic health record (EHR). The resident is then notified by the MA that a patient is ready, and there is no assignment of MA to resident, with the next available MA beginning the process with the next available patient.

At the conclusion of each visit faculty supervision is completed and lab or imaging is ordered via the EHR and communicated verbally to the MA or the patient is directed and discharged by the resident. Timing for return visits is communicated via

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Table 1

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 pt, 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)

a paper temporary document to the front desk staff. Messages from existing patients are communicated through a work list in the EHR that is checked by the assigned resident at the end of each workday and assigned to an MA or managed by calling the patient. The latter is the strong tradition of the residency, with the philosophy that personal communication by the resident is the best way to learn these skills before this is later delegated to an MA in practice. Calls from existing patients for appointments can usually be accommodated on the same day with a covering resident or within 3-5 days with the assigned resident (PCP).

It was within the context of this traditional practice environment that residency leadership, with strong support from Baptist Health leadership, made the decision that transition to a Patient Centered Medical Home (PCMH) was needed to prepare the trainees for future practice. A contract was completed with TransforMED®, a company hosted by the American Academy of Family Physicians, which has a long tradition of assisting practices, and some residencies, to become a PCMH. This report summarizes resident perceptions of the first stage of this process, with the plan to report updates along the way of the continuing 2-3 year process.

Prior to the TransforMED® team arriving, two recent articles on facility design and innovative MA function [1, 2] for PCMH were provided to residency leadership. Scheduling prevented the presentation to the residents by residency faculty of an overview of the PCMH until after the first on-site consultation. This presentation reviewed the 2007 joint principles agreed to by AAFP, AAP, and ACP [3], see TABLE 1. At the conclusion of the first on-site consultation by TransforMED®, the two chief residents were asked to provide their impressions of the process as well as answers to the four key questions shown in Table 2, drawn from a 2006 reference[4].

The first day-long session with the consultants included two facilitators working with the program director, two chief residents, key clinic managers and representatives of the front desk and MA staff. Topics included metrics, access, and communications. There was a large group lunch session that included all employees and providers.

FEEDBACK FROM RESIDENTS

Understanding of the PCMH concept

Even after the large group lunch session, almost all of the residents stated that they did not understand what PCMH is. The most common perception was that it had something to do with "ObamaCare." The question asked spontaneously by most was why we were doing this now. The residents attending the small group sessions began the day confused as to the meaning of PCMH as well, and they were also concerned about the effect on their personal routines.

PCMH was seen as an amorphous idea without any set implementation plans. They had heard of the idea of "wiping the slate clean" with other practices before building a PCMH but assumed that was an exaggeration of this transformation. The expectation of the planning process was to get a better understanding of patient flow through a typical visit and what things could actually be changed in concrete terms. Previous concepts associated with PCMH included generalizations about "improved patient flow" and "better preventive management" and of the clinic as "a home for the patient's medical needs." To the residents, none of those nebulous descriptors sounded like the speakers understood their topic in the slightest.

At the end of the day, the perception was clear that PCMH is all about delivering high quality care to the patient. It actually revolves around the patient and their needs. Making

sure that they have their PCP available (rather than just a well-trained and well intentioned covering physician) almost all of the time seemed to be the key strategy. The most obvious reason for this is to avoid the patient going to an urgent care or emergency department where they would most likely see someone who is unaware of the nuances of their previous medical experiences. This could result in repeating unnecessary tests and potentially dangerous interventions resulting from false positive results. PCMH was perceived as a platform where primary care doctors and sub specialists will be able to communicate more efficiently about the care they are providing to their mutual patients. In the long run it could help reduce the cost of health care.

The day's process provided some surprises for the chief residents. The facilitators, instead of speaking with a patriarchal tone of command typical of an expert, tried to elicit the expectations and desires of the small groups to help shape the future of the residency program. As the day progressed, they realized that looking for concrete changes to the practice was the wrong way to go about beginning this effort. While changes will be needed, the point of the day-long meeting was to get this group of caring people who work in this environment to try to find different ways to alter the practice, slowly, from the current setup to the PCMH model. It was reassuring to see that the consultants came not to dictate change but rather to facilitate discussion amongst those who must actually make the changes needed.

From this first day of planning activities, the group decided to implement pre-clinic "team huddles" immediately. These are brief team-wide discussions about the patients on the schedule to plan what will be needed for each in advance.

FOUR KEY QUESTIONS:

How will PCMH facilitate access and continuity?

Coordinated care by the whole team and assigning clear responsibilities to each person in the team can help reduce waiting room times and also patient's exam room door-to-door time. This will help open up more appointment slots and increase physician availability for their patients' same day access. From a broader perspective, the provision of a "patient portal" was seen as a key strategy. This will allow patients to access lab results, medication lists, and customized patient education information. As collaborative care plans are established, the patient can see this at any time and suggest changes.

How will PCMH increase the patient's participation?

Providing patients with informational tools, online resources, and easy access to

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their physicians by electronic communication can keep them more aware of their progress. This will give them an opportunity to be more involved in their care as they know they have a provider who listens to them and they have easy access to them at all times. The key strategy here is the collaborative care plan (5). This brief document allows the patient to establish measurable goals like blood pressure or HgbA1c with the advice of their physician. This would include both short-term and long-term goals, and is clearly "owned" by the patient.

How will PCMH provide skills for patient self-care?

PCMH can provide onsite resources like dieticians, nutritionists, and care managers whom the patient can turn to for help. Physician teaching will also be a big part in this health care model as physicians will have more time to spend with and come to know their patients. This will encourage the patients to follow the recommendations of their physician more effectively and with a better understanding. Self-monitoring is a key strategy, and the care manager can sit with individual patients and allow them to learn finger stick blood sugar or blood pressure measurement, as well as more complex issues such as carbohydrate counting or sliding scale insulin regimens.

How will PCMH coordinate care among clinical settings?

The Baptist Health (BH) system in Madisonville already has a lot of coordination, with hospital, ED, urgent care, and outpatient sites all having access to the other's electronic records. For consultants or primary care physicians outside of BH, this will be a challenge. The care manager can facilitate movement of records between systems, ideally in advance of each scheduled visit. Currently several different EHR systems are used in town, and a key strategy will be making them more interoperable. Evidence-based reminders and collaborative care plans cannot be provided with the current residency EHR. Changes here will require a new generation of the current EHR, or perhaps a complete EHR change. A key strategy is the ability to share the collaborative care plan with all sites that the patient may access on a 24/7 basis.

Table Two

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?

At the conclusion of this first phase of transition to a PCMH, the chief residents were cautiously optimistic that success is possible. The path is yet unclear, and the remainder of the residents, faculty, and staff must be brought along as the process continues. The first step of implementing pre-session huddles will reveal much about how the remainder of this adventure plays out.

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WILLIAM C THORNBURY. M.D.

How mobility within the MEDICAL HOME CAN POSITIVELY DISRUPT HEALTHCARE

The culture that shops online, banks online, buys books – movies – music online, will conduct a portion of their healthcare online. The question is, "With whom will they conduct it?"

Introduction

Has it ever occurred to you that patients today receive medical care in the same manner that our grandparents did? We, as patients, go to the doctor to wait (and, wait) in the lobby of a chronically congested office for care.

One would assume that the proliferation of technology would improve our healthcare system. But, in a time when information is exchanged at the speed of light, certain aspects of our health system have never been more dysfunctional. Some have estimated that our country will have a shortfall of 45,000 primary care physicians by the end of the decade. Baby Boomers are retiring at 10,000 a day. And we notice the "slow down" of our most senior physicians – working only enough to reach retirement because they feel that they no longer "fit" into our current evolution of healthcare. Ironically, despite our nation's wholesale adoption of technology, we have a growing health access problem.

In my practice of family medicine, we began to ask ourselves how we could not only address this, but also improve our care and service to our patients. And, it was that decision – that we were no longer going to kick-the-can down the road – which led us into a new delivery model of healthcare.

A Lean Solution

Our clinic is located in a small town in south central Kentucky. Like many, we shared the problems of being unable to attend to our patients in a timely manner. A staff, hardworking all, felt overwhelmed with providing daily acute care needs, superimposed on the demands of chronic disease and health maintenance. We could rarely accept new patients due to this burden. However, about three years ago, on the strong advice of my brother who is a hospital administrator, I accepted an invitation to train under the supervision of Toyota in the study of Lean Systems engineering. Thereafter, I not only visualize my clinical care differently, I see the health system differently.

Shortly after World War II, Toyota developed a new system of management and production to become competitive in the automotive industry. This system, referred to as True Lean, uses principles to relentlessly improve value to their customer by removing waste and improving service. It champions a culture of continual improvement at every organizational level. It relies on a concept of team where each role is important, recognized, and has responsibility. It uses an 8-step problem-solving method as its mechanism for improvement. The root-cause of a problem is embraced, rather than hidden. (When was the last time you heard someone admit a patient care mistake openly?) "Find a problem, fix a problem, see that it never comes back," is a common maxim. Refined over 60 years, this is the scientific principle translated into action.

Ultimately, our team asked, "If the same True Lean problem-solving process were applied to improve our delivery of outpatient medical care, what might be its outcome?" This led to a rather surprising conclusion. The root cause of our clinic's congestion was that about 40% of patients simply didn't need to be there. We felt that those patients could be cared for equally well, and safely, outside the confines of our brick and mortar clinic.

We reviewed the literature for online care safety[1], and the known experience of online care within the model of the Medical Home model[2] and felt comfortable applying it to our practice.

Online care (e-Visits) worked well for about a week before our first problem: care after hours. There was simply no efficient way to contact the physician, login from an outside computer, open a program, go to another computer, open a file, and meet our efficiency needs. So, we then engineered the encounter through a smartphone to allow the care request to follow the physician. Then our second problem became apparent: how do you attach relevant medical history (MH) to the history of present illness (HPI) in the communication to the physician and deliver a clear care plan along with patient education materials back to the patient in less than 4 minutes?

Our Solution

Ultimately, we came to engineer, develop, and test (with the association of a University-based partnership) a technology to provide online care via mobile platforms (smartphone/tablet). For lack of a better phrase, it was a "house call by smartphone." However, after studying this for the last few years, we have come to believe that it is much more than a catchy phrase. We believe that it represents a new model of healthcare delivery and qualifies as a disruptive technology as defined by Christianson[3].

A patient desiring this option of care must register with the service, choose a credentialed provider, and securely provide their basic health history (MH). Once approved by the practice, they can request care at any time. For a care request, the patient logs into the secure website, reviews their MH, and conducts e-commerce to compensate the provider for care. An interrogation engine asks a series of questions which completes a thorough medical history. The HPI and MH are forwarded to the physician along with any photos a patient may wish to attach. Because most care is conducted by the physician on a smartphone, the provider has the option of either calling the patient or conducting a video visit. Our experience was that less than 30 percent of encounters warrant a phone call, and rarely was a video visit necessary. An assessment is made, prescriptions communicated to the pharmacy, and a full instruction/disease-specific information sheet returned to the patient. The encounter takes about 15 minutes for the patient and averaged about 3 minutes for the physician. After two years, 95% of care requests from patients were deemed appropriate to be addressed by this method by the physician.

What could this process become?

Once you begin to conduct care this way, it becomes immediately apparent that you've opened a new generation of telemedicine – one that's cheaper and more efficient than other previous forms. It is telemedicine for the common man. We see it as a complement to current academic

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models that provide subspecialty care to disparate populations. More importantly it was efficient, efficient enough to engage our physicians. This means that for the first time, online care and telemedicine could be conducted within the Medical Home by the patient's personal physician. Potentially this process addresses the access issue that is part of the patient centered medical home that every study shows lowers costs and improves outcomes.

When we learned that we could extend this new service from acute care to management of chronic conditions, the magnitude of the innovation became clear. By some estimates, 75% of our health dollars are spent on stable chronic care. In our experience, using this technology increased our capacity by 15% in the traditional fee for service portion of our practice while taking very little of our time. In effect, it added an extra hour each day to our traditional practice by keeping patients out who didn't need to be there to get what they needed. Surveyed patients using the new technology were uniformly positive, with 97% saying they would use it again. Further, the per-capita cost of care decreased 15% - critical for health systems struggling on a 1-2% margin. Most importantly, surveyed patients, frankly, loved it. To restate: We provide care in less time, using fewer resources and, patients actually preferred it 97% of the time.

Our model estimates that in outpatient care alone, the United States can save $30 billion per year. It wouldn't be difficult for a medical economist to extrapolate that using this tool for hospital discharge follow-up might exceed this number. Some report that a simple phone follow-up from a non-physician can reduce re-admits 25%. This process could move some current emergency department (ED) care into primary care clinics, which would now have the capacity to accommodate them. This provides for both short term savings from addressing uncompensated care and long term savings from better chronic disease management. Other access points, such as palliative care, home health, and long-term care are also opportunities for cost savings. Most importantly, the cost to industry for lost time, talent, and productivity could be estimated. Indeed, this new delivery model has the potential to bend the health care cost curve for the first time, changing from the model of Blockbuster® to Netflix®.

Implications

Mobility in online care is one of the rare examples in which disruption can improve each aspect of the health system. Patients can receive care from their own provider anytime, anywhere. Medical providers increase access, lower liability contrasted to undocumented phone calls, and retain compensation for their intellectual work. Health systems can improve revenue from clinics, reduce readmissions, and reduce ED misuse. And, they can now stake a claim on the most valuable real estate in healthcare: the peripheral device. In essence, they have a communication tool directly to their patients. Employers can see less absenteeism and presenteeism (coming to work ill), and ultimately stabilize insurance costs. Third party insurers can see less acuity and lower costs, allowing them to assess risk (the same can be said of ACOs). Lastly, governments can increase access, lower cost of care, and make their medical workforce more efficient.

Market displacement may occur for retail clinics, be they onsite or virtual. Also, traditional first-generation telemedicine models may have to change to account for the involvement of a patient's primary care physician as well as medical specialties, dentists, and allied health professions.

The power of true mobility in health delivery might be condensed into a phrase borrowed from Christiansen[3]. Discussing how a disruption within the least profitable part of an industry ultimately trickles up to affect the entire system, he used the example of rebar in the steel industry. In healthcare, this translates to, "We can make a profit on Medicaid/Medicare." And with this, our entire health economy changes.

Now what?

The culture that has computer access and embraces e-commerce will champion online healthcare. They want the same thing that we all do, less disruption in our daily life. HMOs in the 1980's taught us that patients will leave their physician if necessary to get what they want. The market's response has been online care via the Internet, retail clinics (increasingly becoming virtual), Urgent Care, and ED misuse. However, as physicians, we understand that what patients really want is convenience and the care of their private physician. True mobility for patients and physicians offers both. In our clinic, we've found true value for our patients in mobile online care. They not only appreciate the fact that we demonstrate respect for their needs but it has, ironically, brought us closer together.

Four Key Questions

1. How will this make it easier for patients to get access to care and obtain continuity?

This new process is designed specifically to accomplish this goal. The key strategy is that it provides access not just to a well-trained associate of the patient's personal physician, but to their personal physician him- or herself. Because the time required for each e-visit is so short, most physicians will choose to answer the patient's request in the evening even if not on traditional "call." This brings access to all the nuances that make this patient's situation unique, and most of these nuances are not in the traditional medical record, and reside only in the memory of the personal physician. The physician can choose to "sign off" at some time at night for personal time and sleep, and we found that very few e- visit requests come overnight.

2. How will it provide ways to increase the patient's participation in their care?

The high rate of patient satisfaction and ability to get their needs met on their own schedule should translate to patients' feeling of ownership of their health, something we will continue to monitor. By providing digital access to patient education materials chosen for them at the time of our response we expect their participation to increase, reaching them at their most "teachable moment." We also found that because the follow-up of stable chronic disease can be accomplished for many patients online, they take even further ownership and appreciate the deference of not having to disrupt their schedule to return to the clinic unnecessarily.

3. How will it provide the skills necessary for patient self-care?

The process we use begins with asking the patient to answer three questions: 1. Do you think that the problem could be handled by phone with the doctor? 2. Could in-person care wait a day if it had to? 3. Would you be willing to wait a few hours for a response (if necessary) rather than be seen in the office later? With these criteria our 2-year study found that about 97% of care requests by patients could be handled by online care. We believe that this process will begin the patient's "self-triage" thinking that is the gateway to self-management. The actual skills of, for example, self blood glucose monitoring or measuring blood pressure can be assisted with providing digital learning resources, but will still require face-to-face teaching time.

4. How will it coordinate care among different clinical settings?

With 97% of patients able to conduct care online, the few exceptions were directed to in-office follow-up with us, requiring only coordination among our providers. However, we anticipate that it will become necessary on occasion to forward a summary (HPI/PHM/photos) of a request for care to a third party (colleague, Urgent Clinic, ED) to maximize continuity. In a rural area with fewer providers, the need to avoid multiple re-testing that can come from seeing several different physicians concurrently is much less of an issue than in urban areas.

Conclusion

Certainly, this new e-visit tool will require some refinement with experience. Nonetheless, medical care delivery will move forward into the virtual space. The question is at what point will family medicine recognize and embrace this inevitability? The delivery model that the public values is the same model that expands the Medical Home, increases access, lowers global costs, and potentially provides an immediate partial solution to the healthcare manpower shortage. E-visits could be adapted to implement care to Medicaid patients affordably, but this will require additional innovation. Currently what is required is physician leadership, support from policy makers and payers, and education of the public.

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Sejal Duggal, M.D. is staying with Baptist Health Madisonville Associates as an out-patient Family Medicine Physician.

Faryaal Ihsan, M.D. is staying with Baptist Health Madisonville Associates as an out-patient Family Medicine Physician.

Alisa Marzec, M.D. is staying with Baptist Health Medical Associates as a Family Medicine Physician in Hopkinsville.

Diana Nims, M.D. is staying with Baptist Health Madisonville Family Medicine Residency Program as an Associate Director.

Marissa Stewart-Jaynes, M.D. will be moving to Paducah, KY and joining Lourdes as an out-patient Family Medicine Physician.

Amit Duggal, M.D. is a December Graduate. He plans to stay with Baptist Health Madisonville in the Emergency Department as a Family Medicine Physician.

CONGRATULATIONS TO OUR 2013 GRADUATES!!

It is with a heavy heart that we bid goodbye to our 2013 graduates. Being a rural training track and small residency program, we develop close relationships with the residents and feel like we are losing part of our family when they graduate and move on. We wish them the very best!

ROY ABRAHAM, M.D.
Dr. Abraham will be joining St. Vincent's in Elwood, Indiana, as an emergency medicine physician.

SHILPAN PATEL, M.D.
Dr. Patel will be close by as he is joining the Appalachian Regional Healthcare group in West Liberty, Kentucky as a family medicine physician.

For More Information Contact:
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Private Practice in Cold Springs KY

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UNIVERSITY OF KENTUCKY EAST KENTUCKY FAMILY MEDICINE RESIDENCY PROGRAM

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The University of Kentucky East Kentucky Family Medicine Residency Program is located in Hazard, KY. The program is dual accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) for four positions each program year. The program currently has a component of 13 residents.

The program's mission is to prepare family practitioners who are dedicated to meeting the health care needs of the people of rural Appalachia. The residents' training is designed to prepare them for meeting the unique demands of a rural practice and for providing quality care in rural settings. Since the program's beginning in 1991, 66 residents have completed their family medicine training. Dr. Bowman will be joining King's Daughters Medical Center, Stone Street Clinic, Morehead, KY. Dr. Osborne-Lewis will be joining St. Elizabeth Physicians in Butler, KY. Drs. Muralidhar and Ravi will be joining Lake Cumberland Regional Hospital in Somerset, KY. Dr. Douglas will be joining ARH Middlesboro Family Medicine Clinic.

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UNIVERSITY OF KENTUCKY (LEXINGTON) FAMILY AND COMMUNITY MEDICINE RESIDENCY PROGRAM

Over the last 39 years, our residency program has trained 251 graduates, the majority of which practice in Kentucky. Our mission statement demonstrates our three-fold purpose to recruit excellent students, to provide training that is second to none, individualized to the resident's needs, and to graduate family physicians who will become well-respected clinicians in their community. Our training encompasses experiences at the University of Kentucky Hospital as well as providing continuity hospital care in a smaller more patient-centered environment, UK Good Samaritan Hospital within UK Healthcare. We also utilize community sites both in Lexington and in surrounding rural communities, allowing our program to have the best of both worlds and prepare our residents well for a wide variety of patient care needs. We are very proud of our 2013 Graduates.

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Jessica Rapp, DO
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Shannon Voogt, MD
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University of Kentucky Department of Family and Community Medicine, Lexington, KY

DEPARTMENT OF FAMILY AND GERIATRIC MEDICINE AT THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

The University of Louisville Family Medicine Centers are divisions of the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine. The faculty and residents are committed to providing quality patient care that requires the joint efforts of our patients, their families, and our staff. Our graduating residents for 2013 include: Cristy Abreu, M.D. is joining a practice in Hopkinsville, KY. Ismat Asad, M.D. is joining a practice in Louisville, KY and Anton Grankin, M.D. is joining a practice in Southern Indiana. April Halleron, M.D., Neetu Jose, M.D., Shawna Kauffman, M.D. are joining practices in Louisville, KY. Arthi Kaundar, M.D. is joining The Family Health Centers in Louisville, KY and Jena Ruxer, M.D. is joining a practice in Louisville, KY.

Cristy Abreu, M.D.

Ismat Asad, M.D.

Anton Grankin, M.D.

April Halleron, M.D.

Neetu Jose, M.D.

Shawna Kauffman, M.D.

Arthi Kaundar, M.D.

Jena Ruxer, M.D.

The University of Kentucky Department of Family and Community Medicine

BY DR. KEVIN PEARCE

The University of Kentucky Department of Family and Community Medicine (UK DFCM) strives to improve the health of the people of Kentucky and society at large through excellence in healthcare delivery, education of physicians and other healthcare professionals and the advancement of knowledge through research and scholarship. Our education of medical students and our residency training programs are designed to produce well-rounded physicians, with special emphasis on addressing primary care physician shortages in Kentucky. Our faculty and residents provide care to patients in central and eastern Kentucky via family medicine centers located in Lexington, Hazard, Morehead, Georgetown, and Hindman. Research and scholarship activities in the UK DFCM cluster into three broad areas: health services research, health behaviors research and educational innovations.

The 2012-2013 academic year has been productive and exciting for the UK DFCM. Each of our residency programs (Lexington, Hazard, Morehead) has a full complement of excellent young physicians in training. Our Sports Medicine Fellowship Program continues to thrive as well and we are still accepting two new fellows each year from a large pool of applicants. These residents and fellows have been quite productive this past academic year in terms of scholarly work, presenting 12 papers at either statewide or national conferences. Among the residents in our Lexington and Morehead programs, six participated in our Global Health Track for residents, and five participated in our Sports Medicine Track. Those in the Sports Medicine Track developed scholarly work leading to presentations at two national Sports Medicine conferences (in San Diego and Indianapolis). They also published an article in the KAFP Journal on risk-assessment for sudden cardiac arrest as a component of the sport pre-participation exam. Residents in the Global Health track traveled to Quito, Ecuador to learn and assist in meeting the medical needs underserved communities there. Others presented a poster on using global health training tracks to teach community medicine at a national conference in Washington, DC.

The UK DFCM faculty and residents continue to teach and mentor medical students on a daily basis. During the past academic year, 105 UK medical students completed the required third-year Family Medicine clerkship, with 69 of these in a rural AHEC setting. This essential course greatly depends on the participation of our community-based faculty and would be impossible without their interest and involvement. The DFCM faculty also continues to offer a broad array of electives for medical students at all levels of instruction. Examples include include the Healer's Art, Mindfulness in Medicine, Leadership in Rural and Underserved Health, Medical Spanish and Sports Medicine.

One of our newest offerings is a Global Health Track for medical students. The DFCM has been responsible for the development of this innovative set of electives, open to all UK medical students. These experiences maintain and strengthen student interest in serving people who are most in need. There is good evidence that students who work in resource-limited settings via global health experiences are more likely to practice in underserved settings after residency. To date, over 70 UK medical students have enrolled in the Global Health Track, which includes activities spanning all four years of medical school. So far, students have had primary care experiences in Costa Rica, India, Ecuador, South Africa, Israel, and Zambia. Students who successfully complete the Global Health Track receive recognition at graduation.

Faculty and residents at all three residency programs remain productive with their research in areas pertinent to our mission, including practice-based quality improvement, chronic care, cancer prevention, sports medicine, complimentary-alternative medicine, community health, and uses of health information technology. The NIH Clinical and Translational Science Award to UK, the Kentucky Ambulatory Network and the UK Centers for Rural Health provide critical infrastructure and support for university-community partnerships in clinical and health services research.

With input from the KAFP and the AAFP, we are making steady progress toward NCQA Patient Centered Medical Home (PCMH) recognition, even as our Lexington, Hazard and Hindman offices await rollout of UK's electronic health record, which will occur during the coming academic year. Our progress toward PCMH recognition has been fueled by the excellent leadership of our site-based medical directors and residency program directors, and is partially supported by two grants from the U.S. Health Resources and Services Administration (HRSA).

In response to the focus for this issue of the KAFP Journal established by Dr. William Crump, we report herein some of the specific challenges of the PCMH model. While each of our sites has specific opportunities and challenges, we are generally making progress. We have decided to move ahead with PCMH principles rather than wait for the fundamental changes in reimbursement that are prerequisite for true population-based primary care and maximum wellness for all patients. Thus we are taking deliberate steps that will prepare us for value-based reimbursement while operating within the realities of the current fee-for-service environment. These steps include improved billing and coding procedures coupled with attention to systems-based practices that are designed to enhance practice efficiency, communication, access to care, patient activation, evidence-based practice and patient satisfaction.

Examples of specific steps toward the PCMH include:

- To enhance patient access and continuity of care, the Lexington unit has adopted a clinical microteam design that designates each resident, faculty physician, nurse practitioner, and nurse/CMA to one of six clinical teams that manage their assigned panel of patients. The patient panels originated from the continuity patients already assigned to each provider on a given microteam, and the panel grows as new patients enter the practice. Every effort is made to provide same-day appointments within the

patient's microteam. These teams meet every week to review their patient appointments for the coming week. They discuss the schedule and share specific patient issues and/or goals for their care.

- The Morehead unit has established expanded hours on weeknights and Saturday mornings that accommodate walk-in patients, and thus decrease the number patients getting primary care outside of their "home' practice.
- The Hazard unit has improved primary provider availability through improved patient scheduling routines.
- To increase opportunities for our patients to participate in their care, the Lexington unit has implemented a new patient history self-reporting process, included a PHQ-2 screen for depression, and established a new PharmD consultation service to help patients manage multiple medications. In preparation for EMR adoption later this summer, they are also developing new patient education materials (in English and Spanish) for the most common health conditions and recommended preventive services, based upon the Health Beliefs Model. Patient Advisory boards are also being established.
- The Morehead unit recently trained the residents to use a program designed to activate diabetic patients for better self-care, resulting in improved diabetes management and patient satisfaction.
- In Hazard, the faculty and residents improved cervical cancer screening rates among their patients through patient education, patient reminders and provider reminders.
- Taking advantage of new CPT codes that support enhanced reimbursement for cost-effective primary care, the Lexington unit is piloting standardized operating procedures to improve care transitions for our patients who become hospitalized. A similar set of standard operating procedures will be developed for chronic care management. Both of these initiatives are designed to coordinate care among specialties and across care environments. Once these routines are established, the Hazard, Hindman and Georgetown units will adopt and adapt them for their use.

Our department continues to grow and develop. We plan to add two faculty physicians in Hazard this year, three in Lexington and one in Georgetown. Overall, the UK Department of Family and Community Medicine will continue its exciting work aimed at improving healthcare and the workforce that delivers it, and we look forward to another year of close collaboration with the KAFP.

University of Louisville Department of Family & Geriatric Medicine

BY DR. JIM O'BRIEN

2013 is a year of transition for us. Dr. O'Brien steps down as chair on June 30 after ten years as chair to become the Director of a newly formed Center on Optimal Aging. The Center will link closely with the department and be inclusive of other colleges across campus with an interest in aging.

The residency program has received accreditation by the RRC for five years, which is the most one can receive. So, kudos to the residency director, Dr. Ostapchuk, and the residency faculty: Drs. Wheeler, Wetherton, Pendleton and Becker.

Dr. Christian Furman, Vice Chair of Geriatrics, received a CMS innovation grant, one of 70 nationally and the only one in Kentucky. The purpose of the grant is to study end of life care in nursing homes. In addition, she was also awarded a Chief Resident Immersion Training grant (CRIT) to educate chief residents regarding aspects of geriatric care.

The implementation of the electronic health record has been a challenge and we are learning to cope.

Under the leadership of Dr. Renee Girdler we are applying for National Committee for Quality Assurance (NCQA) recognition as a level 3 Patient Centered Medical Home and expect this to be accomplished by fall of 2013. Elements of this process include:

- At the present time we have open access appointments for faculty and residents that allows for same day appointments.
- Patient participation in their care is achieved through group visits with an interdisciplinary team tailored for different disease states such as diabetes or asthma.
- We have also implemented self-management workshops called "Living Well Workshops" modeled on the Stanford program.
- A full time chronic care coordinator works to address gaps in care.

The Glasgow residency under the capable direction of Dr. Brent Wright continues to grow and flourish. The Master's program on Medical Ethics under the leadership of Dr. Doukas continues to excel. The new partnership with Kentucky One Health gives us the opportunity to be part of an expanded large primary care base.

On a personal note, the search for my position is concluding and should be completed in the next two months. I have enjoyed my time working with the Academy and at a time when Family Medicine is on the crest with health care reform, I see our department prospering under new leadership.

U OF L RURAL MEDICINE PROGRAM AMONG NATION'S BEST

LOUISVILLE, Ky. – The University of Louisville School of Medicine Trover Rural Campus recently was rated third best in the nation for identifying, nurturing and educating medical students who have an identified interest in future rural practice.

The study, conducted by researchers at the University of Colorado, ranked the percentage of graduates in rural practice for 35 programs throughout the United States. Sixty-two percent of the graduates of the UofL School of Medicine Trover Campus in Madisonville chose rural locations for their practice sites after graduation. The program trailed only East Tennessee State University and Louisiana State University. A report will be published in the premier medical education journal Academic Medicine in August.

"This national recognition is the fulfillment of Dr. Loman Trover's vision outlined almost 60 years ago of providing first class medical education in a small town with the goal of producing more physicians for rural Kentucky, and is a testament to the strong support we've had from the Louisville Campus over the past 15 years," said Bill Crump, M.D., associate dean for the Trover campus. "From the President and the deans to the individual faculty and staff, our team has proven the value of a collaboration of a rural campus and an urban university. The beneficiaries are our students and the rural Kentucky communities who receive these new doctors who are well prepared to care for them."

Nationally, only 3 percent of medical students report an interest in rural practice, while 20 percent of Americans live in rural areas, causing a severe physician maldistribution problem. This problem is especially large in Kentucky, with 59 of the 120 counties classified as rural, and almost 60 percent considered to be health professional shortage areas.

"One of our missions is to educate and train physicians to care for the people of Kentucky no matter where they live," said Toni Ganzel, M.D., M.B.A., dean of the UofL School of Medicine. "Our Trover campus is vital to fulfilling this mission and especially critical now because our state faces such a significant shortage of physicians, especially in rural areas. Dr. Crump's leadership of the program is one of the reasons for its success. We view the program as a model that has the potential to be implemented in other areas of Kentucky."

THE KENTUCKY ACADEMY OF FAMILY PHYSICIANS OUTSTANDING SENIOR MEDICAL STUDENT AWARD

William D. & Peggy Pratt Memorial Scholarship Award was presented to JARED SHANNON, University of Kentucky senior medical student, for his outstanding interest and application to family medicine.

Walter & Helene Zukof Memorial Scholarship Award was presented to ANDREW LUCKETT, University of Louisville graduating medical student, for his outstanding interest and application to family medicine.

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