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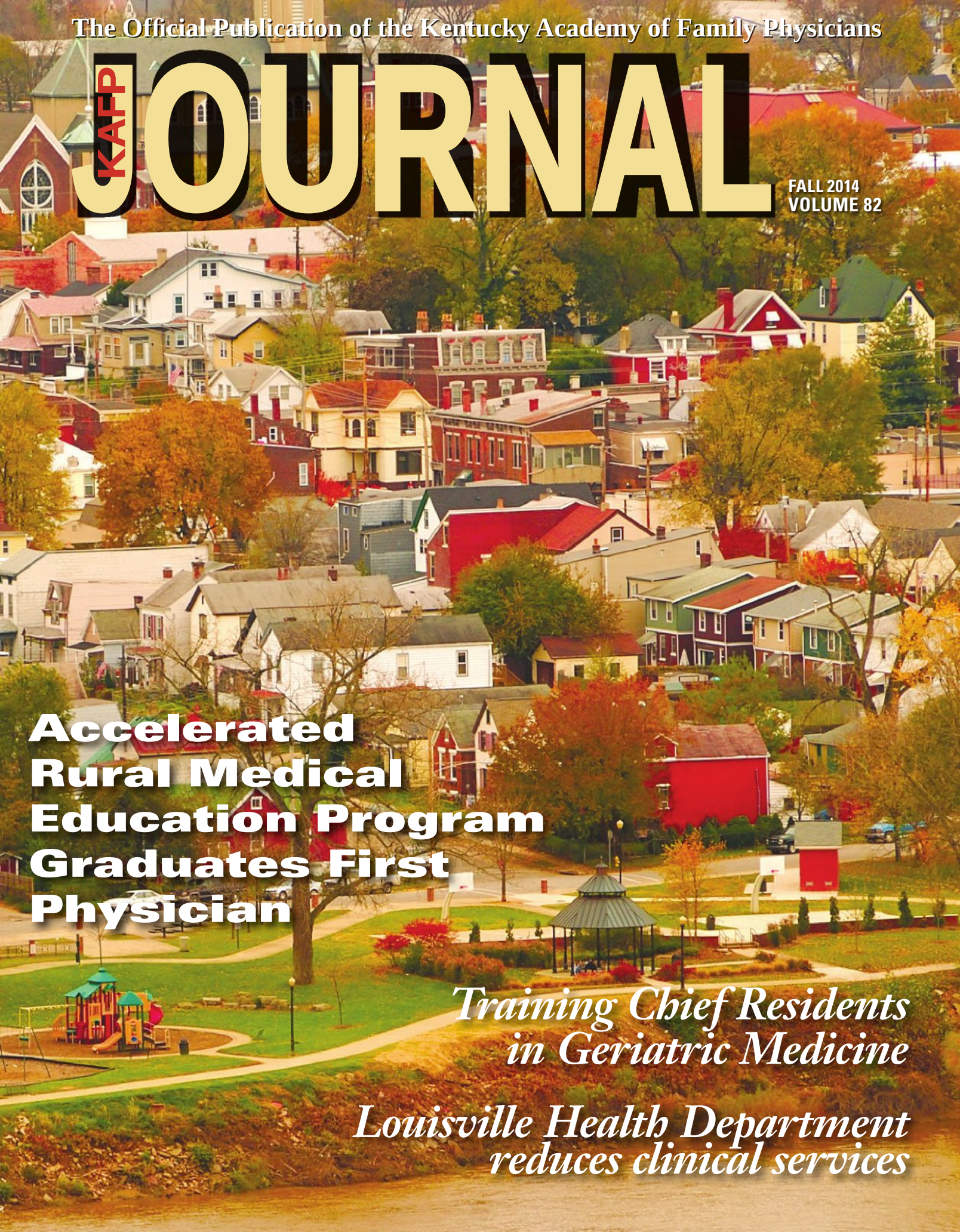

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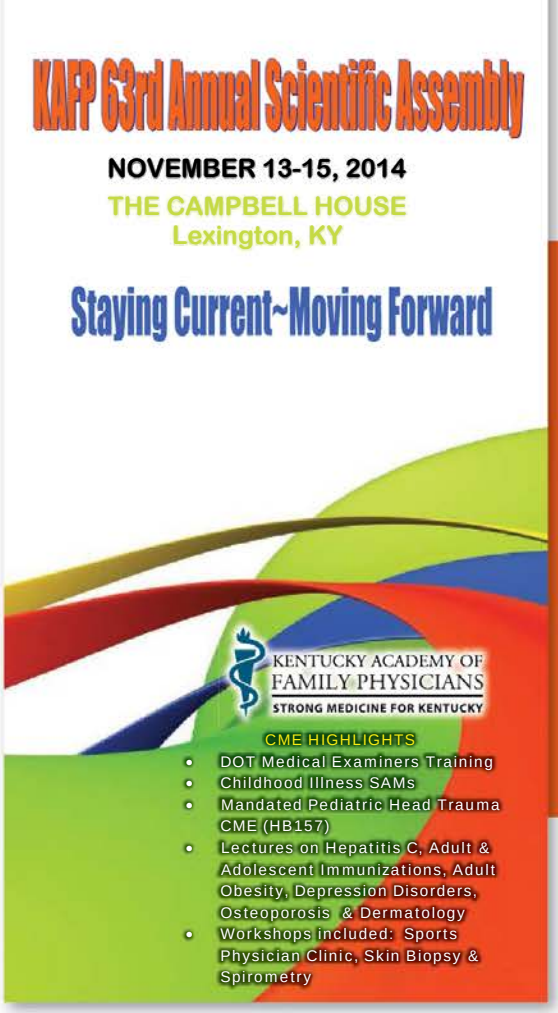

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message from Your PRESIDENT

One More Time…

It is hard to believe that this is my last article as president in the Journal. It has been quite a year! Mostly it has been a learning experience – I've had to learn to budget my time much more closely than I was before. And I've learned to pack more efficiently, but I don't think that will ever be my area of excellence! I've really enjoyed working with the staff of KAFP and meeting new Family Physicians from Kentucky and around the US. I have learned an amazing amount of information on boards and governance and how an organization really works. And it has been eye-opening to see what changes we can make for the good by working together with a plan, both at the state and national levels.

Many of the leaders of the KAFP have been working for a very long time to impact the future of Family Medicine and the healthcare environment. They have been very involved in advocating for our specialty and for us as the primary providers for our patients. Once upon a time, they too took that very first step to be involved in the Kentucky Academy. This year I have tried to focus my attention on increasing our membership and on making the KAFP more accessible or "friendly" as we need some fresh ideas to better align ourselves with the changing landscapes. Quite frankly, no one is showing up for the business meetings – rarely district directors and certainly not delegates. We need YOUR involvement to continue what was started. And that's why the KAFP needs to make a few changes in how things are done.

WHY PUSH TO CHANGE TO AN ALL-MEMBER OPEN BUSINESS MEETING, AND THUS DISSOLVE THE CONGRESS? BECAUSE BY LIMITING WHO CAN BE INVOLVED, WE EFFECTIVELY CLOSE THE KAFP TO NEW FAMILY PHYSICIANS.

By no means does anyone want to discount where we've been or those who established our current organization. But we need to think outside of the box so that the KAFP will be here in the future to continue advocating for us and being of value to our members. We need to be of use to younger members. Depending on which decade you became a family physician, you might even say the KAFP needs to "get some groove back" or inject some "cool factor" into the way we do things. Maybe we just need to be a little more "hip." (I hope my kids read this – it's a mom's job to embarrass them!) That's why you received a survey this summer about changing our current Congress of Delegates annual meeting to an All-Member Open Business Meeting concept. Thank you for responding and for your comments. The concerns that were expressed are being addressed in the reorganization of this new system. It was overwhelmingly in favor of changing to

the All-Member concept and this is what will be proposed at the Annual Meeting in November. The Congress of Delegates will still meet, and the Delegates that attend representing their Districts will vote on the proposed changes to the Bylaws.

Why do this? Why push to change to an All-Member Open Business Meeting, and thus dissolve the Congress? Because by limiting who can be involved, we effectively close the KAFP to new Family Physicians. If we want to further Family Medicine we have to do it together with fresh and innovative members and with new perceptions of who we are. The KAFP leaders want to be open to new possibilities. The dictum that "Once you've seen one Family Practice you've seen them all," is no longer true. We practice Direct Care, Concierge Medicine, Urgent Care, Emergency Medicine, Patient Centered Medical Home, Sports Medicine, and Hospital Medicine. The one-size-fits-all standard no longer applies, and we need input from those in the trenches. And to get that input we need to make it easier for you to be involved and have a say in the direction of your Academy.

How will it work? Anyone who is an Active, Life, Student, or Resident Member attending the Annual Assembly, or who comes to the Business Meeting only, will be able to vote on resolutions, express their views and affect where and how Family Medicine goes into the future. Every KAFP member will have a voice. And hopefully, increased participation will make the KAFP a more active, more visible, and stronger organization. Plus, your participation helps us find the future leaders of the Academy. *We need your skills and talents to take ownership of Family Medicine and give value to being a member of KAFP.*

We really want to see you at the Annual Meeting in November. Your President-Elect has worked very hard to make those three days a valuable experience and to keep us up to date and current. And as we learned at the AAFP's Annual Leadership Forum, we've got to make it fun! It can be a time for *YOU* – a time to connect with colleagues, acquaint yourself with new colleagues, and take a break from your routine. This isn't your momma's KAFP anymore! There will be workshops on skin biopsies and spirometry, and I am very excited about our social media set up. We've got Hepatitis C updates and a workshop on how to be mindful during our day. Does anyone else need to get some mandated CME? We've got you covered! Do you ever wonder what all those name badge ribbons mean and how some people seem to have enough ribbons to hang down to their waists? Come get your own set of ribbons and see what others' REALLY say! And this may be your last chance to be a Delegate. Come serve as a Delegate for your District and have the opportunity to jumpstart your involvement and begin making changes.

It truly is an exciting time of change at KAFP and a great time to be a Family Physician. America may finally realize just how much they need us!

There are so many Led Zeppelin lyrics I could leave with you this last time, and because it's too hard to choose, I will leave you with a few. Thanks for giving me the opportunity to be your President. It's been a hectic year, but it's been a blast. See you in November.

So if you wake up with the sunrise, and all your dreams are still as new,
And happiness is what you need so bad, the answer lies with you.

-What Is and What Should Never Be

Why don't you take a good look at yourself and describe what you see,
And….do you like it?
There you sit, sitting spare like a book on a shelf rustin'
….I know that it's all a state of mind.

-Misty Mountain Hop

Leaves are falling all around, it's time I was on my way
Thanks to you, I'm much obliged for such a pleasant stay
But now it's time for me to go. The autumn moon lights my way
….but I know I've got one thing I've got to do…
Ramble on, And now's the time, the time is now.

-Ramble On

COMMITTEE CHAIRS AND FOUNDATION

ADVOCACY COMMITTEE
Nancy Swikert, M.D.
e-mail: Ddwarrow@aol.com

Brent Wright, M.D.
e-mail: rbwright@tjsamson.org

BYLAWS COMMITTEE
Jerry Martin, M.D.
email: martinj@twc.com

Mont Wood, M.D.
e-mail: robert.wood@bhsi.com

COMMUNICATION COMMITTEE
William Crump, M.D.
e-mail: bill.crump@bhsi.com

A. Stevens Wrightson, M.D.
e-mail: alan.wrightson@eku.edu

M. Eli Pendleton, M.D.
email: eli.pendleton@louisville.edu

EDUCATION COMMITTEE
Melissa Zook, M.D.
email: mzook@londonwomenscare.com

FINANCE COMMITTEE
John Darnell, Jr., M.D.
email: john.darnell54@gmail.com

Gay Fulkerson, M.D.
e-mail: drgfulk@kynet.net

LEADERSHIP COMMITTEE
Mark Boyd, M.D.
email: mboyd@stelizabeth.com
Ron Waldrige, II, M.D.
email: r.waldridge@att.net

KAFP FOUNDATION-RESEARCH COMMITTEE
TBA

PRACTICE ENHANCEMENT COMMITTEE
Michael King, M.D.
e-mail: mrking02@uky.edu

KAFP FOUNDATION
President
Nancy Swikert, M.D.
email: Ddwarrow@aol.com

Secretary/Treasurer
Baretta Casey, M.D.
email: bcase2@uky.edu

Member-at-Large
John Darnell, Jr., M.D.
email: john.darnell54@gmail.com

Member-at-Large
Patty Swiney, M.D.
email: PSwine@aol.com

Member-at-Large
Lisa Corum, M.D.
email: lisacorum@att.net

2013-2014 OFFICERS, DIRECTORS AND DELEGATES

KAFP OFFICERS

Immediate Past-President, *Ron Waldridge, II, M.D.*
60 Mack Walters Rd.
Shelbyville, KY 40065
OFFICE: 502-633-4622
Fax: 502-633-6925
e-mail: r.waldridge@att.net

President, *Patty Swiney, M.D.*
266 Bourbon Acres Rd.
Paris, KY 40361
OFFICE: 859-987-3230
Fax: 859-987-1113
e-mail: PSwine@aol.com

President-Elect, *Melissa Zook, M.D.*
Bluegrass PCP
803 Meyers Baker Rd., Ste. 150
London, KY 40741
Office: 606-657-0903
Fax: None
Email: mzook@londonwomenscare.com

Vice President, *Lisa Corum, M.D.*
11501 Redwood Way
Louisville, KY 40223
OFFICE: 502-244-1651
Fax: 502-240-0398
e-mail: lisacorum@att.net

Treasurer, *John H. Darnell, Jr., M.D.*
1504 Ruddy Rd.
Lawrenceburg, KY 40342
OFFICE: 606-833-6201
Fax: 606-833-4269
e-mail: john.darnell54@gmail.com

Secretary, *William "Chuck" Thornbury, M.D.,*
211 Professional Park Dr.,
Glasgow, KY 42141
OFFICE: 270-659-9696, 270-659-9797
e-mail: wctmd@glasgow-ky.com

AAFP DELEGATES AND ALTERNATES

Delegate, *Nancy Swikert, M.D.*
10003 Country Hills Ct.
Union, KY 41091
OFFICE: 859-384-2660
Fax: 859-384-5232
e-mail: ddwarrow@aol.com

Delegate, *Mont Wood, M.D.*
200 Clinic Dr.
Madisonville, KY 42431
OFFICE: 270-825-6690
Fax: 270-825-6696
e-mail: robert.wood@bhsi.com

Alternate, *Pat Williams, M.D.*
110 So. Ninth St.
Mayfield, KY 42066
OFFICE: 270-247-7795
Fax: 270-247-9013
e-mail: dr.pat@bellsouth.net

Alternate, *Richard Miles, M.D.*
124 Dowell Rd.
Russell Springs, KY 42642
OFFICE: 270-866-2440
Fax: 270-866-2442
e-mail: rsmfp80@duo-county.com

KAFP CONGRESS OF DELEGATES

Speaker, *Sam Matheny, M.D.*
474 West Third St.
Lexington, KY 40508
OFFICE: 859-323-5512
Fax: 859-323-6661
e-mail: matheny@uky.edu

Vice Speaker, *John Patterson, M.D., MSPH*
119 McDowell Rd. #2.
Lexington, KY 40502
OFFICE: 859-373-0033
Fax: None
e-mail: japatt@windstream.net

KAFP RESIDENT/STUDENT MEMBER

Primary Resident: *Melissa Haddix, D.O.*,
PGY-3, East Kentucky (St. Claire14, UK15, UofL16, Glasgow17, Baptist HLT18, St. Elizabeth19)
Alternate Resident - *OPEN*
Primary Student: *Sonia Ford, UK-MS3*
Alternate Student-*OPEN UofL*

REGIONAL DIRECTORS

Region I-(Districts 1, 2, 3 & 6)
Alben Shockley, M.D.
Convenient Care
2211 Mayfair Dr., Ste. 101
Owensboro, KY 42301
Office: 270-688-1352
Fax: 270-683-4313
e-mail: abshock@aol.com

Region II (Districts 5)
Renee Girdler, M.D.
5501 Meadow Stream Way
Crestwood, KY 40014
OFFICE: 502-852-2822
Fax: 502-852-2819
e-mail: rvgird01@louisville.edu

Region III (Districts 4, 7, 8, 9 & 10)
Kevin Pearce, M.D.
KY Clinic 302
740 S Limestone
Lexington, KY 40536
OFFICE: 859-323-5938
Fax: 859-323-6661
e-mail: kpearce@email.uky.edu

Region IV (Districts 11, 12, 13, 14 & 15)
Lisa Fugate, D.O.
1101 St. Christopher Dr. #4105
Ashland, KY 41105
OFFICE: 606-836-3196
Fax: 606-836-2564
e-mail: lisafugate@alltel.net

ALL BUSINESS MEETING RESOLUTION

Sponsored by: Patricia "Patty" A. Swiney, MD; Ron Waldridge, MD, II; Melissa Zook, MD; John Darnell, Jr., MD; Lisa Corum, MD; William "Chuck" Thornbury, MD

Submitted: October 1, 2014

WHEREAS, the Kentucky Academy of Family Physicians desires to increase membership participation in the business activities of the chapter; and

WHEREAS, the Kentucky Academy of Family Physicians has used a Congress of Delegates with elected representatives from geographic areas to serve as the body that administers the control of the chapter; and

WHEREAS, the concept of electing delegates is laborious and carries with it negative perceptions among members resulting in fewer members electing to be delegates and participating in the Kentucky Academy of Family Physician's Congress of Delegates; and

WHEREAS, the majority of state chapters have moved from a Congress of Delegates to an All Member Business Meeting to accommodate an open administrative and business process to all members; and

WHEREAS, the All Members Business Meeting is open to all paid members of the chapter to vote and participate in the administrative process of the meeting similar to the activates and duties once performed by elected geographic delegates; and

WHEREAS, these chapters that have an All Member Business Meeting find that it increases participation among all members; and

RESOLVED, that the Kentucky Academy of Family Physician replace the Congress of Delegates with an All Members Business Meeting; and

RESOLVED, that the Kentucky Academy of Family Physicians direct its Board of Directors to revise the existing bylaws to accommodate the change to an All Members Business Meeting.[1]

[1] NOTE: THIS RESOLUTION WILL BE VOTED ON AT THE KENTUCKY ACADEMY OF FAMILY PHYSICIANS' ANNUAL MEETING AT THE CAMPBELL HOUSE IN LEXINGTON ON FRIDAY NOVEMBER 14, 2014 AT 11:30AM

ACCELERATED RURAL MEDICAL EDUCATION PROGRAM

Graduates First Physician

Ashley Flanary Jessup, 24, intends to return to practice in hometown Benton, Ky.

Dr. Ashley Jessup, first RMAT graduate, receiving her diploma from Dr. Toni Ganzel, Dean, ULSOM

Ashley Flanary Jessup always wanted to be a doctor when she grew up. She just never imagined that along the way she would blaze a new trail for medical education in Kentucky. Growing up in the small rural town of Benton, Ky., Jessup didn't fit the typical demographic for a medical school candidate. But she held on to her dream and now, at age 24, that determination has paid off.

When Jessup received her medical degree in June, the University of Louisville celebrated not only her success, but a historic first when Jessup became the first person to graduate the School of Medicine's Rural Medical Accelerated Track program, or RMAT. This new program enables students to finish medical school in three years, reducing cost and time commitments for rural students who plan to open practices in small towns in Kentucky.

Rural doctors are desperately needed in the United States. Nationwide, 20 percent of the U.S. population is living in small towns or far away from big cities, but only 9 percent of physicians practice in those rural areas. Family doctors are distributed more evenly, with 22 percent practicing outside large cities, but the need is still greater. Proponents of the RMAT model hope that more successes like Jessup's will pave the way for more doctors to go where they are needed.

William Crump, M.D., associate dean of the Trover Campus of the University of Louisville School of Medicine, says that outcome is likely, considering Kentucky's numbers. He stressed that "most of the counties in Kentucky that are underserved are only underserved by an average of 1.5 full-time equivalent positions. This means that placing one or two more physicians permanently in a county may move it from being an underserved to an adequately served county. It's hard enough to recruit a doctor to a small town. The key is to find one who fits the community and will stay long-term."

The idea for an accelerated medical track gained national attention in 2006 with an essay by the editor of Academic Medicine, an internationally renowned medical journal. The essay made the case that financial barriers may keep many students coming from families with more modest incomes—the ones most likely to choose a rural medical path—from considering medical school. At the same time, a strategic planning process by Kentucky Academy of Family Physicians supported a proposal for a three-year track to rural practice. The University of Louisville began the planning process in 2009.

Crump says the RMAT program will definitely help Kentucky's shortage of doctors and healthcare providers in rural areas. In his opinion, "The best way to get a doctor to a rural area is to get a medical student from a rural area." The program channels students from small towns that truly want to study family medicine, and then keeps them in that channel. And it is the first in our region.

Students in the RMAT have the same required curriculum as traditional four-year medical students, but it is condensed into three years with an emphasis on rural practice. The program begins with a four-week experience in a rural community practice near the student's home done just after the first year of medical school. It also includes a six-week Family Medicine Acting Internship on a busy hospital teaching service in Madisonville during the middle of the third (and final) year. They take step 2 CK and CS in the spring of their third year.

Jessup says the program was fast-paced, but manageable. "At first glance, it sounds overwhelming, but if you take things one step at a time, it isn't." In fact, Jessup was able to find the time to get married during her time in the RMAT program. She says the biggest advantage of the program was the financial aspect. "One less year of school means one less

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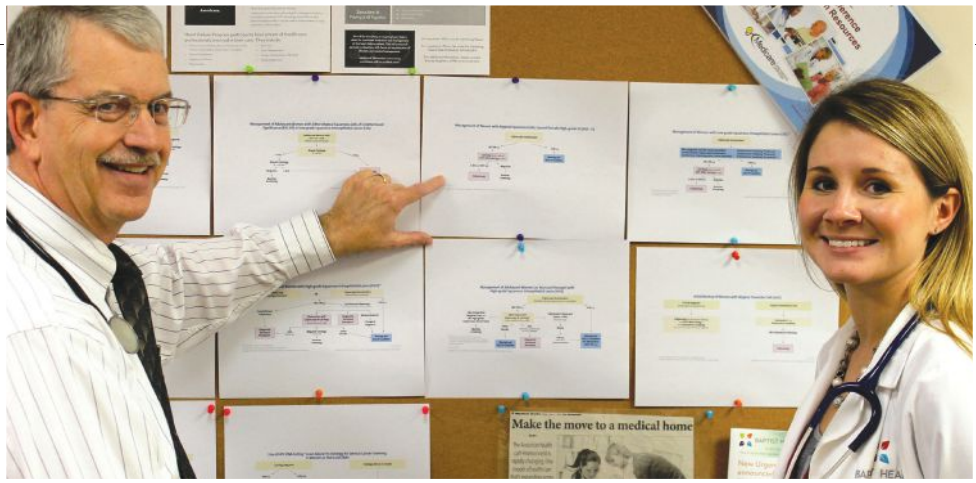
year of tuition, and I was finished one year sooner," she said.

Denying the label of a trailblazer, Jessup gives the credit to others. "I would consider all of the faculty and staff who envisioned the program as the trailblazers," she said. "They laid the plans for me and made it all possible." She simply says she worked hard and did what every other medical student does—just in a smaller amount of time. She views herself as just another kid who dreamed of becoming a doctor, and hopes that more will follow in her footsteps at UofL.



Dr. Ashley Jessup, first RMAT graduate, discussing the implementation of the Patient Centered Medical Home concept in her residency at Baptist Health Madisonville with Dr. Bill Crump.

MOST OF THOSE PROGRAMS REQUIRE GRADS TO MOVE RIGHT INTO THE FAMILY MEDICINE RESIDENCY AT THE SITE OF THE MEDICAL SCHOOL CAMPUS, WITH NO ABILITY TO INTERVIEW OTHER PLACES AND GO THROUGH THE MATCH. WE MADE A DECISION EARLY ON THAT WE WOULD NOT LIMIT RMAT GRADS TO SPECIALTY OR SITE.

Crump says students who have chosen to take the accelerated path have done very well with the course load despite initial fears to the contrary. "Even though the program is stressful and does not leave much wiggle room, students who are focused and efficient will succeed," he says. Two second-year medical students have finished eight weeks of clinical rotations and Crump says several first-year students have expressed an interest in the program.

In Crump's view, the RMAT program has had an amazing start. "I tend to think of it as my 'baby'," he says. "When we started in 2006, we had a vision, and we have seen that vision come true. We have overcome the doubters and the skeptics. The former and current Deans were both vocal advocates for the approval of our program. When we were approved for accreditation in 2011, we were the second program in the country to be approved. There are now 14 other medical schools that have such accelerated programs, but Trover is the only one with a rural focus."

"Most of those programs require grads to move right into the Family Medicine residency at the site of the medical school campus, with no ability to interview other places and go through the match. We made a decision early on that we would not limit RMAT grads to specialty or site. RMAT students interview and go through the match like anyone else, just during their third year. This means that program directors have to decide whether to rank RMAT students before Step 2 scores are available. In these students' Dean's letters, we highlight that they have had eight weeks of clinical rotations before the beginning of the third year as well as eight weeks each of internal medicine and surgery during the third year. The grades and shelf exam scores from these rotations should be good predictors of the likelihood of passing step 2."

"Our program also allows the RMAT student to move back to the 4-year curriculum any time prior to entering the match during the third year. If an RMAT student has a significant illness, academic difficulty, or decides along the way that rural Family Medicine is not for them, they can transition back to the four-year path. Another unique aspect of our program is when the decision to enter RMAT must be made. Most accelerated programs admit the student to the program as they begin medical school. This naturally leads the admissions staff to choose students with higher grades and MCATs to 'hedge their bet' that the student will be able to succeed with an accelerated schedule. However, this approach may exclude the 'late bloomers' who have all the predictors of successful small town practice, but maybe not the best grades. Students apply for RMAT during the spring of their second year of medical school, and the selection committee then has three semesters of basic science performance and evaluations from eight weeks of rural clinical rotations to serve as a basis for the decision."

Jessup says she is proof of the RMAT program's success. With her successful graduation from UofL's program, Jessup hopes to return to her hometown of Benton to begin her practice after her residency in Madisonville. She says she is very excited to have the chance to make a difference in her community, and is optimistic about the program's future. "We wanted to make the RMAT successful, and we all worked together to make it happen."

Sarah Bode at ULSOM Office of Communications and Marketing wrote the first version of this story.

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BY R. BRENT WRIGHT, MD, MMM, MALLIKARJUN SAMALA, MD, MPH, PH.D.

DISRUPTING THE TELEMEDICINE PARADIGM:
Google Glass in healthcare

Background

For decades we have been challenged to design a new healthcare system that will deliver care that is both high quality and low cost. The Affordable Care Act has given legislative direction to the healthcare system of the future. Technology designed to enable fluidity of information exchange across the healthcare continuum currently exists, but we find ourselves within a quagmire of patchworked software solutions that does not deliver its promise of seamlessly connected information exchange.

Like rest of the world, the United States has a growing elderly population. By 2050, the United States population is expected to grow to 400 million, from the 317 million of today.[1] The population above 65 years of age is expected to increase from 43 million in 2012 to 92 million by 2060. The population above 85 years of age, who require the most healthcare, is expected to increase to 18.2 million by 2060 from the 5.9 million of today.[2] The aging population will have an impact on shifting healthcare towards chronic disease management through long-term services such as nursing home, home health, personal care, and adult day care.

Estimates from the National Health Interview Survey in 2012 showed that half of U.S. adults have at least one chronic condition and one in four adults have multiple chronic conditions.[3] According to Centers for Medicare and Medicaid Services, the healthcare cost in the U.S. is expected to increase from 3 trillion dollars in 2013 to 5 trillion dollars by 2022.[4] The Association of American Medical Colleges in 2008 projected that there will be a shortage of 124,000 physicians by 2025, 46,000 of whom will be primary care physicians.[5]

Telemedicine has for years shown promise in connecting patients and providers from different locations through video connectivity, and is considered to be a viable option for enhanced healthcare delivery,[6] but the universality of telemedicine has not been realized throughout all of medicine. Statistics from the American Telemedicine Association show that there are more than 200 telemedicine networks connecting 2000 healthcare institutions across the United States and the approximate total cost of a telemedicine encounter is $35, which is equal to the co-pay of a major health visit.[7] By utilizing telemedicine, medical personnel can deliver patient care in a volume that far exceeds face to face care,[8] but numerous barriers have existed such as cost and administrative buy-in. Even though the U.S. government is spending $240 million per year on telemedicine[9] and telemedicine promises greater access, adoption and execution of telemedicine practices into the current healthcare system has been suboptimal with varied distribution.[10,11] Use of telemedicine in healthcare is time consuming and more cumbersome as it requires additional effort and technical expertise. The equipment is massive, requires more space to use in the office, and appears chaotic with added connections.[11] Unfortunately, traditional telemedicine design prevents a seamless workflow and there has not been a solution that is low cost, mobile, and wearable until now.

Introduction

Glass, made by Google, is a wearable technology in the form of eyeglasses that offers media collection, photo and video, as well as internet connectivity. It is this connectivity that offers great promise. The University of Louisville/Glasgow Family Medicine Residency in January of 2014 obtained this wearable technology to assess for potential benefits in patient care. Faculty, Residents, and Staff were given opportunity to wear and comment regarding the functionality of Glass and discuss the possibility for patient care. The following were found to be possibilities and challenges for utilizing Glass within healthcare.

Possibilities

Telemedicine

Telemedicine appears to be the biggest opportunity for use of Glass in healthcare with its hands free, video recording and transmitting capabilities in a form that is more part of rather than an adjunct to the provider. Telemedicine with Glass promises to provide a higher quality, lower cost, virtual medicine for the future. In utilizing an existing product, eyeglasses, Glass incorporates itself into the workflow by being easily worn by the caregiver. Current telemedicine equipment is an expensive commodity that has been seen as a tool to deliver specialty care. The potential ubiquity

of Glass allows us to expand our view of telemedicine to one of telepresence.

Telepresence

Telepresence uses technology to create a sense of presence over distance. Glass can be used to perform surgeries by telepresence.[12] A general surgeon in a remote area can be assisted by a more specialized surgeon in an urban center with the help of Glass. Telepresence has been successfully conducted within United States and globally. Glass has successfully been used to train medical students and residents.[13] Telepresence moves beyond connectivity mediated by specialized equipment to accessibility for procedural and educational intervention. Glass is a tool to decrease waiting time, which is the waste of our most precious commodity.

Telehealth

What Glass allows us to do is to think more broadly on how we connect within healthcare. Telehealth needs to be viewed as healthcare communication that is immediate and robust, existing to connect medical homes and form medical neighborhoods. Glass needs to be viewed as a tool, much like a blood pressure cuff or otoscope to deliver healthcare. Health Departments can record and send video and pictures for comment and consultation from experts in neighboring communities or institutions across the nation. Glass gives us new possibilities to reexamine multiple processes in healthcare.

Proposed use cases

In evaluating the use of Glass in the care environment, the members of the residency community within Glasgow offered the following ideas:

- *Long-term Care:* Physician can interact with a nursing home patient without interrupting their clinic schedule with the help of someone at the facility using Glass. Providers of various skills can utilize Glass from the Long Term Care setting to present patient information to experienced clinicians. Nursing home personnel would have the ability to connect with emergency or other personnel with ease.
- *Home Care:* Home Health agencies could connect or record elements of exam to review later with their consulting physician. Attendants with questions regarding wound care or other procedural service could have real time, virtual guidance by experts thereby reducing the need for inconvenience to family and patient.
- *Emergency Medical Services (EMS):* EMS technician can videotape or scan the incident and interact with ER physician so that the ER can prepare and categorize their incoming patients. Glass has the potential to bring the Emergency Physician or Trauma Surgeon to the disaster scene for guidance of on the scene personnel.
- *Wound Care:* Wounds need to be monitored on a continued basis for improvement and treatment changes. Family, aides, or others could connect via Glass to Wound Care centers for monitoring and guidance, reducing the travel and cost associated with direct encounters.
- *Telemedicine:* There exists the capability of connecting team members who are practicing across different systems. If two individuals are in different care settings, they can consult via Glass, promoting efficiency.
- *eVisits:* The cost of Glass is such that caretakers could use the device to connect with physicians or other providers, reducing the necessity for travel and unnecessary face to face visits.

Challenges

Adoption

Any new technology will face adoption challenges. The use of the test unit

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showed that while there is great promise, the quality of video and photo capture will have to be improved for wider acceptance. This does not mean that we should discount this technology; as we have all experienced, technology will advance and improve. Our challenge in healthcare is to identify and formulate improvement before others within the industry make assumptions regarding our current needs.

Security/Confidentiality

As with any technology used for patient care, there are concerns regarding security and confidentiality. There is clear opportunity for companies to create applications that are secure for the delivery of telemedicine solutions using Glass. Secure applications will need to be piloted as they are developed for the market.

Efficiency

Use of Glass in healthcare has shown promise for efficiency and safety in areas like wound care, anesthesiology, surgery, intensive care, cardiology, pediatric surgery and emergency care.[14-17] Healthcare has to learn to be efficient and Glass holds promise, but there is a need for further development in areas such as privacy, video quality and streaming. Additionally application development will aid its ultimate best use and adoption.

EMR/EHR integration

Glass prepares for market at a time when many physicians are frustrated with the current roll out of Electronic Medical Records and meaningful use. If applications for Glass are developed to promote better use of electronic records, there may be a way to increase its use within the office environment.

Cost

Currently America is spending 3 trillion dollars per year on healthcare and is expected to increase in the future[4]. According to a recent report, implementation of Glass in fall injuries management in older population will reduce healthcare costs to the government by 30 billion dollars per year.[18] Even though it is relatively expensive to buy Glass currently ($1500), the advantages will make Glass a cost-effective technology for future healthcare delivery. Remember that Glass is much less expensive than early telemedicine technology which cost well above $50,000 for one unit.

Summary & Conclusion

The development of wearable technology is changing the promise of telemedicine in a way that makes remote delivery of healthcare fluid, efficient, and practical. Some of the hospitals in the U.S. have already brought Glass into their practice. Some hospitals like Rhode Island, Beth Israel Deaconess Medical Center, and UC-Irvine Medical center have started pilot projects on the use of Google Glass in the Emergency Room and Indiana University Medical Center is using it in the Surgery Department.[19, 20] More pilot projects should be conducted to explore the further benefits of Glass in healthcare.

The consensus conclusion of the Glasgow Residency was that Glass and other augmented reality devices need further evaluation for use in healthcare and have particular promise to Rural Health for the connection of patients with providers. Thought leaders in health information technology have called for this area to be exercised further.[21]

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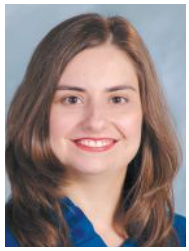
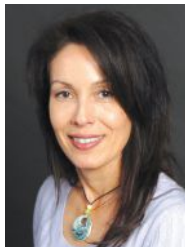
Dr. Brent Wright:
R. Brent Wright, MD, MMM is Associate Dean for Rural Health Innovation at the University of Louisville School of Medicine and Vice-Chair for Rural Health in the Department of Family & Geriatric Medicine.

Dr. Mallik Samala:
Mallik Samala, MD, MPH, PhD is a Postdoctoral Epidemiologist. He is currently working with the UofL/Glasgow Family Medicine Residency.

BY NEIL PATIL, MD; RANGARAJ GOPALRAJ, MD, PHD; LAURA MORTON, MD, CMD; DANIELA NEAMTU, MD; DEMETRA ANTIMISIARIS, PHARM D; MONICA ANN SHAW, MD, FACP; CHRISTIAN DAVIS FURMAN, MD, MSPH, AGSF







TRAINING CHIEF RESIDENTS IN GERIATRIC MEDICINE

University of Louisville Geriatrics, part of the Department of Family and Geriatric Medicine, received a grant to train Chief Residents in the care of older adults. This grant was supported by the Donald W. Reynolds Foundation, Hearst Foundations, and The John A. Hartford Foundation. The Chief Resident Immersion Training Program (CRIT) was co-sponsored by the Association of Directors of Geriatric Academic Programs and Boston Medical Center. CRIT participants included chief residents, residency program directors responsible for training in surgical and medical specialties, and Geriatric and Internal Medicine faculty to facilitate the course. The program brought these individuals together for an intensive two-day program focused on:

1. incorporating geriatrics principles into chief resident teaching and administrative roles;
2. developing teaching and leadership skills with a focus on the care of complex older patients;
3. enhancing leadership and teaching skills that are necessary for a successful term as chief resident;
4. enhancing abilities to collaborate with other disciplines in the management of complex older patients;
5. and developing an achievable action project focused on a geriatrics care issue to be carried out during the chief residency year.

IT WAS FELT BY ALL THAT CRIT HAS HAD A POSITIVE IMPACT. COMMUNICATION BETWEEN THE GERIATRIC MEDICINE FACULTY AND FACULTY AND RESIDENTS IN OTHER DEPARTMENTS HAS INCREASED.

CRIT consisted of a retreat held at French Lick Resort in French Lick, Indiana on June 7-8, 2014. About an hour away from Louisville, it was felt to be far enough away from clinical duties to focus on learning geriatric medicine and leadership skills, but close enough for ease in logistical planning and costs. The atmosphere allowed for the participants to associate geriatric medicine with a pleasant experience and allowed families a chance to

enjoy the free time and social events. Geriatric medicine faculty presented the geriatric medicine content and Internal Medicine faculty presented the teaching and leadership skills content.

The program was well attended. Thirteen chiefs and ten program directors attended the conference. Nine University of Louisville faculty members were present to teach the material. The specialties represented included: Emergency Medicine, Family Medicine (both the Louisville and Glasgow sites), Internal Medicine, Otolaryngology, General Surgery, Dermatology, Medicine/Pediatrics, Podiatry, Radiation Oncology, Urology, and Psychiatry. The material presented was standardized (from a set curriculum), and consisted of core geriatrics principles and leadership and teaching skills. Through breakout sessions, and during time to work on action projects, the participants had the opportunity to learn from each other and share diverse perspectives on caring for older adults. They also had the opportunity to discuss and reflect on the special challenges that all providers face in caring for this population.

Impact of the program

It was felt by all that CRIT has had a positive impact. Communication between the geriatric medicine faculty and faculty and residents in other departments has increased. There are approximately 215 residents throughout all departments at the UofL School of Medicine, and all have a teaching role with medical students. Educating the chief residents extends the reach of this program to the residents at large, thereby greatly influencing the number of medical students who are educated about geriatrics.

As mentioned above, the Glasgow Residency program participated in CRIT as well. This further disseminates information about geriatric medicine throughout the Commonwealth of Kentucky. In the future, the goal is to include the other Family Medicine residencies throughout the state.

Action Projects

Each chief resident designed a preliminary action project during the retreat weekend and was paired with a Geriatric Medicine faculty or other designated faculty advisor to ensure completion of their action project over a six-month period. The project ideas covered educational intervention, diagnosis or systems-based issues. Specific projects such as advance care planning, cancer, cognitive disorder, delirium, gait disorder, polypharmacy and pressure ulcers were designed to address various patient care settings. The ongoing role of the faculty will be to advocate with the Chair or Program Director for each department to ensure the sustainability of the project.

Existing forums will be used to disseminate the knowledge garnered through the chief resident action projects. Each department at the university has didactic sessions, grand rounds, and journal clubs. UofL Geriatrics will ask each participating department/division to select at least one of these forums for the CRIT project presentation. The chiefs will

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also present their CRIT projects at the UofL Geriatrics Annual Symposium – a one day regional geriatric medicine meeting.

Sustainability

The CRIT retreat will occur again in 2015 due in a large part to grant funding. The plan is to sustain CRIT in 2016 and beyond with funding from UofL's Graduate Medical Education office, the Undergraduate Medical Education office, and the UofL Geriatric Medicine Advisory Board.

Given the aging population and limited numbers of geriatricians, training all physicians about caring for frail elders is an imperative task. CRIT allows the dissemination of geriatric principles to physicians in various specialties and at various levels of training – chief residents and program directors directly, and residents and medical students indirectly. In this way, geriatric medicine principles will be propagated to current and future physicians. In addition, the hope is that early exposure to best practices for caring for frail elders will spark interest in geriatric medicine as a specialty for developing physicians. Beyond geriatric medicine, CRIT also imparts practical leadership and educational, thereby training young physicians to be leaders in their respective fields. These educational endeavors have great potential to profoundly influence the practice of all areas of medicine through cultural change regarding patient-centered care of frail elders.

Personal reflection by Dr. Neil Patil, chief resident, UofL Family Medicine Residency

Merriam-Webster defines the act of immersing as "instruction based on extensive exposure to surroundings or conditions that are native or pertinent to the object of study." The CRIT retreat was a perfect opportunity to immerse a wide variety of residents from different specialties in the importance and complexities of care for Geriatric patients.

As one of the chief residents in attendance, I was able to see firsthand the impact this program had not only on me but also on my colleagues from UofL. From the lectures, to the small groups work shops, to the action plans, I was consistently impressed by the reception from the group and the relevance to our work in the hospitals and clinics. Most valuable was the vast knowledge the faculty provided as well as the perspectives shared by physicians from the represented specialties. I learned many valuable lessons that I have already begun to share with the residents in my program. I also continue to work with chief residents from other departments to make the university as a whole collectively more aware of the current guidelines when dealing with the aging population.

From my perspective, CRIT has shown great potential to have a lasting educational impact. It provides residents with knowledge and clinical skills to adequately care for our geriatric patients and will be a great opportunity to establish a strong foundation for residents in the years to come. I was honored to participate, and I recommend the future chief residents and faculty to take advantage as well.

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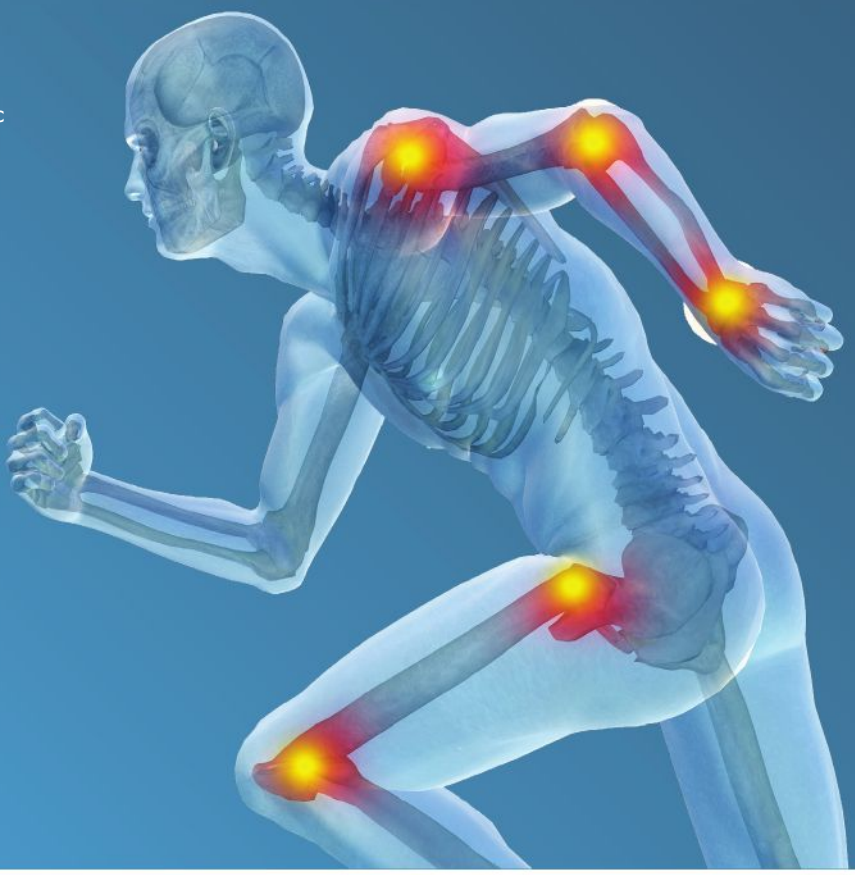

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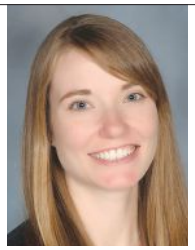

LOUISVILLE HEALTH DEPARTMENT REDUCES CLINICAL SERVICES – **rationale and impact**

The Louisville Metro Department of Public Health and Wellness (LMPHW) recently announced that it will no longer offer certain clinical services including family planning and STD clinics, and will reduce immunization clinics to one day per week. This reduction in clinical services coincides with the recent advancement and implementation of the Patient Protection and Affordable Care Act (PPACA) through which almost 80% of previous uninsured Kentuckians have access to affordable health insurance. By gaining access to affordable health insurance, patients now have access to a wide network of primary care providers in Louisville and comprehensive care through expanding Patient Centered Medical Homes (PCMH). Additionally, this reduction frees up funding for other, larger-scale, public health projects. Current efforts such as school nurses, smoking cessation programs, and maternal-child health initiatives will continue and are sure to benefit from an increase in money and focus.

Louisville has enjoyed a local health department, in some form or fashion, since 1866. Over that time the services provided have continually changed to meet new and expanding threats to public health. For many years, the LMPHW continued to offer services including an STD clinic to care for those who might not otherwise have access to care prior to the implementation of the PPACA. Services offered by the health department have, at one time or another, included immunization clinics, a tuberculosis clinic, family planning, and primary care services among others. These services have traditionally provided a "safety-net" for those individuals in the community without insurance or access to care.

Since the PPACA, over three quarters of all previously uninsured Kentuckians now have insurance. The Office of the Kentucky Health Benefit Exchange has employed and specially trained individuals called "kynectors" to help previously uninsured individuals navigate the state's health exchange, kynect.gov. Kynectors have traveled throughout the state and Louisville Metro holding seminars at local libraries, churches, and community functions to help individuals enroll with kynect. In addition, LMPHW formed a committee to design a curriculum to help individuals within Louisville Metro understand how to enroll, and fully realize the benefits of health insurance.

Dr LaQuandra Nesbitt, Director

of LMPHW, believes that the decision as to whether or not to offer clinical services should remain up to each local health department. Kentucky is a largely rural state and in many counties the local health department does serve as a true safety-net as there are few other sources of primary care services. However, in Louisville Metro, with a population around one and a quarter million, there are numerous primary care options. By eliminating certain services that can be managed by a patient's primary care physician, Dr. Nesbitt is helping to reduce fragmentation of care and improve continuity by encouraging individuals who are now insured to establish and seek care from a primary care PCMH.

By reducing clinical services and improving the health consciousness of individuals through community education programs, Dr. Nesbitt is increasing the connection between public health and clinical medicine. The concept of PCMH has long been championed by both Dr. Nesbitt and others within the national healthcare community as way to reduce overall healthcare costs while simultaneously improving patient outcomes. By reduced offering of competing clinical services, Louisville Metro will see improved health outcomes as it realizes benefits of increased utilization of the PCMH, and frees up their own services to focus on larger scale public health issues.

Benjamin Risner M.D., M.S., M.P.H. is a PGY-3 Family Medicine resident at the University of Louisville.

Sarah Moyer, M.D., M.P.H is an Assistant Professor in the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine. Dr. Moyer completed her MPH at Dartmouth and her residency training at Wake Forest before moving to Kentucky in 2013.

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