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Devoted to Advocacy, Education & Action

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Health is Primary City Tour Chicago Style

Launched at the 2014 AAFP Annual Scientific Assembly, the Health Is Primary campaign is family medicine's message to America – primary care, family medicine and better health. The family of family medicine organizations are united under the common collaborative organization Family Medicine for America's Health. You can learn more about them and the member organizations at www.fmahealth.org. The Illinois Academy of Family Physicians has played a leading role in the development and advancement of the FMA Health work. IAFP executive director Vince Keenan, CAE is the AAFP Chapter Staff representative on the FMA Health board of directors. Jerry Kruse, MD of SIU School of Medicine and SIU Healthcare is the Society of Teachers of Family Medicine (STFM) member of the board of directors. With these two outstanding influencers on the board, the IAFP was quick to raise our hand and offer to host a City Tour stop for the Health is Primary Campaign.

Tracey Smith and IAFP President Janet Albers, MD. Photo by Peter Hoffman

The first city tour stops were Seattle, WA in March and Raleigh, NC in April. IAFP leaders and staff worked with the Family Medicine for America's Health team to assemble an all-star family medicine panel for the live press event at the MATTER Lab in the Merchandise Mart in downtown Chicago. Additionally, IAFP student board member Kristina Dakis worked with IAFP to plan an evening dinner event for resident and student members to showcase Health is Primary to family medicine's future.

Special thanks to the IAFP board members on this task force who served as advisors to the Health is Primary City Tour planning: James Valek, MD; Janet Albers, MD; Monica Fudala, MD; Donald Lurye, MD and Kristina Dakis (now an MD at UIC Family Medicine Residency).

The Health is Primary campaign will work to increase the collaboration between physicians, systems and patients and to communicate about important health issues. The goal is to transform the family medicine specialty to ensure that we can meet the nation's health care needs and, ultimately, improve the health of every American. This means:

- Furthering the evolution of the patient-centered medical home;
- Advancing the use of technology in a manner that is helpful to the provider and the patient;

Dorothy Dschida, MD and Santina Wheat, MD with daughter Evie. Photo by Peter Hoffman

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President's Message

Janet Albers, MD

I hope that you're all enjoying some summer vacation, staycation, or any activity that helps you to rest and recharge for the upcoming back to school physical season! While the children were enjoying summer break, many parents were anxiously awaiting the U.S. Supreme Court (SCOTUS) to finish their homework and announce their ruling in the landmark case which would either preserve or decimate the security of health care coverage for millions around the country. Likewise, health care providers, supporters in government and advocates maintained that the Affordable Care Act must be preserved as intended.

Finally on June 25, the High Court issued a 6-3 decision in favor of the U.S. Dept. of Health and Human Services (HHS), concluding that the law did intend to provide federal subsidies to all insurance consumers, whether they lived in a state that runs their own state-based exchange, or in a state that relies on the federal healthcare.gov exchange. When the ACA took effect in 2014, 16 states established their own marketplaces for health insurance. The other 34 states did not, partly because their leadership was opposed to the law. Residents of these states use the federal exchange on the national healthcare.gov website to buy insurance plans. Illinois has not been able to set up our own exchange, so we use a state-federal partnership model, in the hope of eventually establishing our own state exchange. Therefore, thousands of Illinois families faced the real possibility of losing needed financial assistance to afford their premiums.

Without question, the SCOTUS ruling was very important to preserve insurance coverage for many of our patients here in the Springfield area. In my clinic, we have seen many patients who didn't receive care before the ACA, and many who wouldn't have been able to afford insurance premiums without the subsidies.

In Sangamon County the number of uninsured has dropped by 66 percent! Our challenge is getting all of these new patients in for care and addressing their multiple issues which have gone untreated because they didn't have the coverage to pay for care. We are using a team approach with care coordination and behavioral integration. So many of the conditions we see are more than physical ailments, and are often made worse by their circumstances. In family medicine, we understand the social determinants of health and are working to address all the issues that will truly help our patients be well. This takes more than an EMR and e-prescribing. It takes people and resources and community collaboration. Family physicians are uniquely equipped to do this work and are taking the lead. The Health is Primary movement by Family Medicine for America's Health is showcasing family medicine models around the country that are leading with better care, and complete care. When we hosted a Health is Primary City Tour in May, I was proud to showcase my clinic's behavioral health integration model, and excited to learn about the amazing work of our members who shared their story. Read about them all in this issue.

Although we know addressing medical, behavioral and social determinants are all necessary, this work can be overwhelming too. Added paperwork, pre-certifications, packed schedules, while seeking community resources to meet an overwhelming need. Thus the importance of strengthening our QUADRUPLE aim. Better health, better healthcare, lower cost and provider satisfaction! This is where the movement to team-based care can really turn the tide away from physician burnout. I have hope for our youngest family physicians that they will practice in a model that ensures they are not trying to do it all. We have to be aware of possible burnout and ground ourselves in the 4-Cs that Dr. Starla Fitch, bestselling author and a medical school classmate of mine, describes in her book, *Remedy for Burnout: Clarity, Creativity, Compassion and Connectedness*!

1. Clarity: Know/define your purpose.
2. Creativity: Be creative in how you approach each day- even the mundane things.
3. Compassion: Care for the patient in front of you and those you work with. ("I see you. I am here.") Showing compassion releases serotonin which reduces stress and burnout.
4. Connectedness: Finally, realize that we are interconnected. Establish that connection with those around you. According to research, lack of connectedness affects your health as much as smoking, obesity and hypertension!

Allow me to suggest a place to help define those four C's for you. This year the IAFP annual meeting is combined with the regional Family Medicine Midwest Conference, October 9-11 in Rosemont (right by O'Hare airport). FM Midwest is the premiere event to attract Midwest medical school students to our residency programs and ultimately to our communities. Your clarity of purpose, not only to care for patients, but also to share that passion and purpose to the next generation of family physicians, will inspire these new family physicians and motivate you to continue your amazing work. You can help inspire these young family physicians at the conference, while also earning CME on some amazing topics. If you need to catch up on Maintenance of Certification Part IV Self-Assessment Modules (SAM), we have four of them on the schedule. I can tell you, doing these SAMs in a group environment definitely makes this mundane process much less painful! Because our theme is Celebrating Diversity, Our Patients, Our Communities and Ourselves, you'll find so many ways that family medicine is caring for patients from all walks of life and how our compassion ensures we are especially effective in moving the needle towards better care and lower total costs. And ultimately, the annual meeting and Family Medicine Midwest is the place for family physicians from across the career span and from all over the Midwest to build that "connectedness" and say "I am here, I see you and I want to help."

It's been a turbulent time for health care – trying to keep up with the demands and change, while still being the doctor you want to be. Join us in October and let's work together!

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IAFP News

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- Ensuring a strong primary care workforce; and,
- Shifting the payment system to improve the quality of care and the health of patients.
- Improving primary care physician satisfaction.

The Chicago City tour followed a similar format to Raleigh and Seattle; but we had so many great speakers to offer, that our event was divided into two separate panel discussions. The event kicked off with a welcome from Vince Keenan, Dr. Kruse, Illinois Osteopathic Medical Society president Alicia Martin, DO and FMA Health Chair (and past president of AAFP) Glen Stream, MD.

Stream offered the big picture request, "Put the health back in healthcare so we can deliver on the promise of the Triple Aim." He cited research supporting that access to primary care equals longer and healthier lives. Even adding one family physician per 10,000 people decreases hospital admissions, surgeries and ER visits. Along with better health comes big savings in health care spending; US adults with a Primary Care Physicians have 33% less health care costs.

The opening included a showing of the essential Health is Primary video, which lives at http://healthisprimary.org/media if you would like to see it and even share it in your practice or professional circles.

Noted author and documentary filmmaker T.R. Reid served as the moderator for the City Tour events, including Chicago. He used his extensive history and experience from covering health care around the globe to effectively guide the conversation and transition among presenters.

The first panel included

- Thomas Cornwell, MD – founder of the Home Centered Care Institute, and a pioneer and national leader in home care practice
- Opella Ernest, MD – Vice President and Chief Medical Officer, BlueCross BlueShield of Illinois (BCBSIL), whose innovation in care management and payment is changing the health care delivery system to improve outcomes, reduce chronic illness burden and reduce duplication and waste
- Javette C. Orgain, MD, MPH – AAFP Vice Speaker, Chair of the Illinois State Board of Health and current physician at VITAS Health Care providing hospice and home care

Dr. Cornwell is a living success story of starting from scratch – able to grow and spread house call programs that he built up over nearly 20 years. Now this once-struggling model has evolved to a point that it works, it's successful, it saves money and provides immense satisfaction to patients and caregivers. Cornwell is now working in collaboration with programs throughout the region to start home care programs and training students and residents in home care medicine.

"The goal is to help the patients and their family caregivers," says Cornwell. "Meanwhile, the cost savings is huge among the most expensive patients." The top one percent of most expensive Medicare patients average $98,000 in spending per year. House calls tend to care for those patients, simply by removing the ambulance and emergency room costs, the savings begin. The population age 85+ is quadrupling by 2050. Home care can help keep them out of costly hospital and nursing home settings, while providing the security and comfort of staying at home. In fact, Cornwell's hospital, Northwestern Medicine Central DuPage, has not had a Medicare readmission penalty for 30- day readmissions following discharge, a tremendous accomplishment.

It's a very unique situation when the patient panel is entirely homebound, and overwhelmingly elderly. Cornwell say 25% of his patient panel passes away each year. Last year, 222 of those patient deaths (80%) were at home – 70% with hospice care. "You really have to have conversations with the patient and honor what they want. Most want to die at home, but often if they say they don't want to be at home, it's because they worry about their family."

Cornwell uses high tech to go with his high touch. He has an EKG and his Epic E.H.R. on his phone. "I need the technology, but the real value is talking and coordinating and managing and helping the patient and the caregiver."

Cornwell is the current president of the American Academy of Home Care Medicine. Since he started house calls the payment system has improved, allowing home care to survive and begin to thrive. The most common visit code payment is $130, which has doubled since the mid-1990s.

Dr. Cornwell was featured in an AAFP News Now article that week. Read it at http://www.aafp.org/news/practice-professional-issues/20150526hip-cornwell.html

One obstacle is the loss of revenue with travel time. Meanwhile each patient is a complex visit. So can you do both office and home care? Absolutely. Cornwell is working on developing a program with UIC. Physicians can start out maintaining office and add the house calls until the volume is there. House calls are required of family medicine residencies by accrediting body ACGME. So the training is there, now the model and system needs to be there to greet them upon residency completion.

Dr. Orgain addressed the benefits of the primary care delivered through hospice care and the value it brings to the end of life process. "We need a change in culture on death and dying in America," she said. Hospice care is very much a team-based model that can be used for virtually any patient in the final months of life. VITAS has an interdisciplinary team that meets weekly, with a physician, nurse home care, chaplain, social workers - -all talking about each patient's GOAL. "What we need is culture shift – don't keep sending them back to the hospital. That's not what they need at this point." She encourages families to have those conversations early on and make decisions around the care patients will want.

VITAS is one of the largest hospice providers in the nation. There are 10,000 hospice providers in the U.S. – and the movement is increasing as hospice becomes a necessary component. "We want patients in comfortable safe environment. The invasive procedures are not good. Sometimes more medicine is more harmful than helpful at end of life," says Orgain. Learn more about VITAS at www.vitas.com.

So where does today's family physician fit in this picture? Often it is the patient's family physician who collaborates with hospice and brings them into that service. We have geriatrics and palliative fellowships to train more physicians in this specific avenue of primary care – part of the total care. "We need to educate the specialists to consider hospice before going to treatments and potential harms. We are committed to a patient-centered system," concludes Orgain.

Family medicine can't do it alone and we need to engage others to build that patient-centered system. Family Medicine for America's Health wants to encourage those collaborative discussions to improve end-of-life care.

The over-arching question for the first panel: Why isn't the payment system better? "It's PAYMENT for work you do," says Orgain. "Pay for the work we do and quality of care. Payment for services that are invisible to most. Patients in hospice often live longer than hospitalized patients. Medicare is considering changes for hospice payments. We need your advocacy to change the system. We are working on this at national level." Cornwell added, "They (Centers for Medicare and Medicaid Services) are seeing the value. It is happening, we produce the value."

BlueCross BlueShield's New Payment Model

In terms of improving health outcomes across the lifespan, partnerships between providers and health plans in value based payment systems may be the future that makes everyone happier. Dr. Opella Ernest described the direction of health care delivery as a transfer from fee-for-service to value and how do we help docs do that? Her interest is creating and succeeding with models for smaller two-to-five physician practices so they can make that move. "Our goal is to move to value-based care entirely. Let's give incentives for providers to deliver care on totally comprehensive experience for patients."

Incentive models have been around for years, but the Affordable Care Act (ACA) urged America to make these pilots and experiments the base of a more permanent system. BCBSIL is using an Intensive Medical Home – putting their focus on highest risk (and costliest) patients. They will pay for resources needed in the office and then the physician decides how to use those resources based on the practice needs. Dr. Ernest summarized that progress "requires focus and scale to move the needle in healthcare transformation."

The BCBSIL ACO arrangement with Advocate Health Care is in the second phase of their second agreement, with nine ACOs providing coordinated care services for 450,000 members. They are a PPO (preferred provider organization) so patients are not required to be in a care coordination model, but the doctors work with the patients to give them a regular point of care, a medical home. Using BCBSIL analytics, they are able to decide which patients belong to whose practice. Dr. Ernest reports that all Blue Cross health plans in the nation are working on this approach. Will prices, as in insurance premiums, be lower? She can't say at this point in time. "The goal is improved quality. There will be a spike in health care costs with the new access but the long term goal is lower costs over time through reduced emergency and hospital care that results from the access to timely primary and outpatient care. Doctors love it." More information on Intensive Medical Homes in Illinois is available at http://www.bcbsil.com/company-info/news/news?lid=iacd4v4y.

The overall consensus, not enough people outside of primary care fully understand the value of a primary care physician. So how do we get people educated? Dr. Stream says "that's the goal – to get the stakeholders and the patients to understand the concept and use it."

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The second panel covered the evolution of patient-centered, comprehensive, community-based care and the future of family medicine – the workforce.

- Janet Albers, MD – IAFP President, Chair of Family and Community Medicine at Southern Illinois University School of Medicine.
- Deborah Edberg, MD – program director Northwestern McGaw Family Medicine residency program, a Teaching Health Center pilot program funded by the Affordable Care Act.
- Kohar Jones, MD – University of Chicago – Pritzker School of Medicine, who practices in underserved south side neighborhoods and dedicates her practice to including social justice and health determinants. She blogs at www.koharjones.com.
- Carolyn Lopez, MD – President of the Chicago Board of Health, past IAFP president and past Speaker of the AAFP Congress of Delegates.

L to R: Stream, Reid, Dietitian Mary D'Anza, Edberg, Jones, Lopez. Photo by Peter Hoffman

Given the family medicine mantra of right care, right place and right time, how do we factor in the retail health clinics and their growth in into the marketplace? These clinics are opening everywhere touting convenience without an appointment. Primary care physicians are hoping their E.H.R. can tie the two effectively. Can new patients get from an initial visit to a retail clinic to a medical home when they need it? But with the current and growing primary care physician shortage, most have busy practices. Retail clinics are good for the walking well who need a quick fix, and they cater to our society's sense of consumerism. Therefore it's important that physicians establish the relationship with their patients, so that if they need to use a retail clinic, that clinic will follow up with the primary physician. You can find AAFP's policy at http://www.aafp.org/news/practice-professional-issues/20150731retailclinics.html

IAFP board member and IAFP's task force chair James Valek, MD of Chicago surmised that it still is best handled at the patient-physician level, "We know how to discuss goals of care with our patients. We need to advocate for them. We are not a gatekeeper. We are all about the right place, right time and not volume. Providers across the system need to work together on what's best for the patient, and that actually varies by person."

Dr. Carolyn Lopez has been working on public health policy her entire career. As the president of the Chicago Board of Health, she's been facilitating health policy changes in the nation's third-largest city. "I love getting feedback from the Chicago community to set the direction for Chicago Department of Public Health actions. We made a difference to get city ordinances for regulating e-cigarettes and higher tobacco taxes," she says. "Meanwhile we passed a resolution against Medicaid cuts and the jobs that will be lost as a result. These cuts could have a big negative economic impact on our city when we cut health care access. Family medicine and primary care are at the junction of public and population health and I'm happy to be living at the junction and living the dream."

The city touts *Healthy Chicago*, a blueprint launched in 2011, where tobacco was one of the targeted priorities because of the root cause and contributor of most chronic disease. They've already seen significant reductions in youth smoking rates. http://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/PublicHlthAgenda2011.pdf

Team approach of primary care and behavioral health in same setting.
Dr. Janet Albers shared the SIU Family Health Center integrated model. They have the behavioral therapists on-site at the clinic so patients are not asked to go somewhere else to get desperately needed services. "Patients who are sent to another location may not show up or feel unwelcome in an unfamiliar setting," explained Albers. The primary care providers do the screening for kids up to 18. If they get a positive screen, the PCP can immediately grab a member of the behavioral health team and do the first intervention right then and go from there.

The practice is also proactive in the morning huddle and can plan the intervention before the patient arrives. "The providers then complete the 'warm handoff' to part of the health care team. Patients do better physically when we address the behavioral and mental health issues and their medical issues," Albers continued.

"We use EVERY opportunity to screen patients ages 11-18. Both child and their parent fill out the screen and sometimes they don't agree," said Albers. "Parents seem to welcome this process because it helps them."

In terms of payment, rural health clinics and FQHCs (SIU is an FQHC) get some payment. The screenings have payment codes. But there is still room for improvement and Dr. Albers expects that will happen as results are more available. Learn more about their efforts here: http://www.iafp.com/assets/docs/FMAHealth/hip-may19-casestudies.pdf

Training the model primary care physician workforce
Northwestern McGaw Family Medicine Residency program at Erie Family Health Center in Chicago's Humboldt Park neighborhood is a new program, but quickly established as a model for community-based family medicine and leadership in health care transformation. Program director Deborah Edberg, MD has shepherded two classes of eight residents through graduation; and nearly all of them are practicing in the Chicago underserved communities like those served by Erie. The Teaching Health Center model was created and funded by the Affordable Care Act for five years, and now these programs face an ongoing battle for the federal funding extensions to continue to fill the needs in underserved communities.

"We train in the community health centers, so these physicians are prepared and happy to practice in those settings. Our graduates are guaranteed to meet the need," says Edberg. Residents train in team-based care with behavioral health and social work. Erie even has access to lawyers to help patients navigate the obstacles in their daily lives which negatively impact their health, such as shelter, transportation and access to food and other services.

"We care for very vulnerable patients with lots of social stressors. Diagnosis and treatment alone are not enough," explained Edberg. "We have to address the other factors. Why aren't they taking their prescriptions? Go find out! Undocumented residents are often afraid to get services that are available to them."

Observing family members during a patient visit can also reveal a lot. Edberg says is takes only two minutes to dig deeper and help them. "They come in for medical issues – for example, the kids need shots. Women may come for checkup or follow up care after a hospitalization. They don't know that they can have a family physician option, even without the ability to pay. Financially it makes the most sense – our system pays for those who don't have care so the best way to save the system money is to keep them out of ER and hospital and at the same time improve their quality of life."

Erie Family Health has 13 sites which employ hundreds of people from the community. The return on the investment in physician training goes well beyond a resident's three years there. Erie Family Health is meeting access shortages, especially through the residency, with 13,000 additional visits and 3,000 more patients just at the residency sites in the short term. In the long term, recent data shows that residents that train in FQHCs are three times more likely to work in a community health center and continue providing care to those underserved patients.

Edberg also says her program will train happier, successful physicians, less likely to head toward burnout. In team-based models, it's not the doctor's sole responsibility to address all the issues. "The fascinating challenge of primary care is how much you have to know. So we teach them how to learn, they will always be learning and they can handle this," explains Edberg.

Good mentors in primary care will show students how to have a happy life in primary care. Even still, the lower payment to primary care physicians is a factor. "I think it's the [payment] differential that hurts the overall numbers for family medicine. Higher salaries equal respect in our society." Edberg agrees that medical school debt burden is a factor, but we demonstrate what we value with the dollars we spend in health care, and it's time to show that we value primary care today more than ever.

Dr. Kohar Jones truly emphasizes training physicians in the community setting to meet the needs of that community and preparing the physician to practice in a similar community after residency. She cites many of the community challenges that negatively impact health; such as street violence, alcohol and tobacco use, substance abuse, family violence, mental illness, lack of adequate nutrition and unsafe neighborhoods. Her mission is training the next generation of physicians to be aware of this and responsive to those needs. Currently the U.S. averages $2.9 trillion per year in healthcare spending, and 70 percent goes to lifestyle-based disease. How do we change behavior to change this preventable outcome?

University of Chicago provides space and opportunities to teach students about these issues. One goal is how to shift community behavior from destructive to healthy. Jones described their Summer Service Partnership (SSP) program. Since 2009, medical students are linked with south side high school and social work students. They learn together through lectures and field trips and partnerships with community organizations. These groups investigate what shapes health and what promotes good health. They choose the topic and work together to develop and implement a project in eight weeks. Examples include advocating for kitchens at charter schools and attending Chicago Board of Education meetings and asking them to shift food choices to improve nutrition for Chicago children who eat two meals a day at school. Popular topics are obesity and violence, two pervasive issues in these neighborhoods. "There is up a 17-year life span differences in different zip codes of Chicago. Violence breeds hopelessness. Building relationships on teams through projects with small but meaningful changes can combat the hopelessness," says Jones.

One example of the SSP, they created a mural in Grand Crossing –with the message "What you choose today changes all of your tomorrows." The mural is located across from Gary Coleman youth center. It is still untouched by graffiti. Photos provided by Kohar Jones

The SSP teaches these young people how to advocate – op-ed writing, voicing a commitment to change and the related skills training in advocacy. Participants work and learn as a team combining leadership and partnerships addressing social determinants of health.

Reid asked Edberg if these Teaching Health Center Family Medicine Residencies help residents economically in their next steps. Many are National Health Service Corps scholars and some benefit from state-based loan repayment programs. Most importantly these training programs fuel the fire for those physicians that want to answer a calling to serve. "You have to follow your passion and feel fulfilled by what you do. How can we have doctors who want to work in an FQHC and see Medicaid patients, if they are not happy in their careers?"

Kristina Dakis, MD graduated from University of Illinois at Chicago College of Medicine, the state's largest medical school. "About ten percent of UIC students go into family medicine, but that's not enough," she said. "Some schools don't have family medicine clerkships. How can we get them more excited about family medicine if they don't have direct positive experiences?"

Health is Primary evening event

Dr. Dakis' question provided the perfect transition to the Health is Primary's evening event for students and residents later that evening at UIC. Maybe the best answer came from UIC student Jordan Hoerr. The evening began with attendees being asked for one word or phrase that describes family medicine. His answer: "Kinetic Dynamics" – which sounds pretty awesome. Dakis and Valek moderated a discussion which included the morning panelists Drs. Orgain, Albers and Edberg, who was joined by current resident Neha Sachdev, MD and UIC Global Health expert Andrew Dykens, MD rounded out the panel to share all that is amazing, impactful and challenging about family medicine.

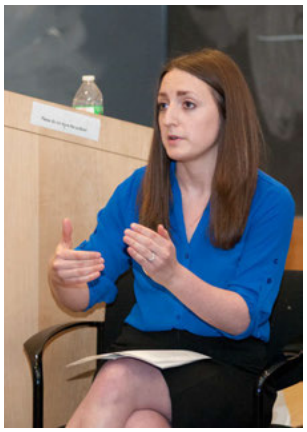
Students, residents and faculty alike shared a common frustration that family medicine and primary care are not core missions at medical schools. UIC Dept. of Family Medicine Head John Hickner, MD lamented the lack of transparency when schools celebrate primary care on Match Day, knowing that most of their internal medicine graduates will not be career primary care physicians, but subspecialists.

Meanwhile discussion turned to the attendees from Chicago College of Osteopathic Medicine and how they are able to graduate a higher rate of family medicine physicians. Students felt that primary care was the answer to many of our nation's health problems - but there was concern that most medical schools still aren't encouraging enough students to pursue primary care fields, and family medicine in particular. The osteopathic students reported that family medicine was encouraged by medical school faculty starting in the M1 year. They also have a 12-week Family Medicine clerkship during their 3rd year, while most allopathic schools had a six-week family medicine clerkship... or no clerkship at all.

Kinetic Dynamics came from Jordan Hoerr. Photo by Joshua Clark

Evening Panel: Orgain, Albers, Dykens, Edberg and Sachdev. Photo by Joshua Clark

Dr. Cornwell shares his story. Photo by Peter Hoffman



Kristina Dakis, MD moderates the evening event. Photo by Joshua Clark.

Dr. Orgain at the morning event. Photo by Peter Hoffman.

The overall tone was curiosity, optimism and excitement. Most of the students there had either decided on family medicine or were eager to learn more about the field. An encouraging element of the discussion centered on the importance of advocating for your specialty and patients. Students were also able to get a bigger picture of the wide variety of career opportunities in family medicine, and the importance of a stronger primary care workforce to address and correct health care disparities. The event was an excellent opportunity for student and resident leaders from across the state to connect and share ideas about the future of family medicine. Family Medicine for America's Health representatives Vince Keenan and Mal O'Connor, PhD provided a framework for attendees to volunteer as "field reporters" to document and share the innovations they experience during their educational rotations.

Here is a link: http://cfarsurveys.polldaddy.com/s/fmahealth-chicago-city-tour that students and residents can use to describe innovations they discover ways in which the future that Family Medicine for America's Health is trying to spread across the country is already alive and well in Illinois.

"Innovative physicians and teams transforming their clinical practices, working with patients and families in creative ways, using technology to improve relationships with patients and enhancing the way their practice runs. Some are experimenting with alternative payment models like direct primary care," says O'Connor. We know there are innovative faculty members who are adept at attracting medical students to family medicine – and some are doing fascinating work training inter–professional teams. We hope to collect and share those successes."

Dakis sums up the event positively, "I believe the take home message was that family medicine has a bright future. The nation is starting to realize the tremendous value of primary care, and there is a large amount of innovation taking place in family medicine," she said. "Personally, I was humbled to learn how many passionate, dedicated student and resident leaders there are in family medicine. I hope we continue working together to spread the message of family medicine and to improve the lives of our patients."

About Erie Family Health Center and the Teaching Health Center Residency Program

Provided by Erie Family Health Center

The Need – Building the Primary Care Workforce in Underserved Communities

- To maintain the status quo, Illinois will require an additional 1,063 primary care physicians by 2030, a 12% increase of the state's current (as of 2010) 8,832 practicing PCPs.
- Components of Illinois's increased need for PCPs include 45% from increased utilization due to aging, 33% due to population growth, and 21% due to a greater insured population following the Affordable Care Act (ACA).

Meeting the Need – The Northwestern McGaw Family Medicine Residency Program

- Erie has partnered with Northwestern and Norwegian American Hospital to establish the Teaching Health Center Graduate Medical Education Program formally known as the Northwestern McGaw Family Medicine Residency Program.
- The Teaching Health Center Program is a unique and innovative collaboration that combines the resources of a successful and sustainable community health center with the support of a nationally recognized academic health center and medical school, in conjunction with a safety net hospital.
- Residents train in a state-of-the-art community based health center, utilizing the latest technology to improve patient health outcomes over time.
- The Teaching Health Center Program changes the paradigm of traditional medical education, focusing on developing the residency program within community based ambulatory primary care settings, which will ultimately produce primary care physicians ready to deliver health care in a reformed system to the underserved.

Impact

- Expanded Erie's capacity to provide services to more than 2,850 patients, through 13,000 patients per year.
  - o These services are provided at Erie's health center in Humboldt Park whose income level, poverty rate and other key indicators make it one of the most high-need communities in the City.
- Increased Erie Faculty productivity by close to 40%.
  - o This will continue to be particularly critical as Erie projects a 35% growth rate in patients over the next five years.
- Nearly all graduates have chosen to remain in safety-net primary care, addressing critical provider shortages in these communities.
  - o Health Center trained physicians are three times more likely to work in a Health Center and almost 3 times more likely to work in underserved setting.
  - o Trains young doctors to be future community health center leaders, advocates, and researchers.

Innovation in Family Medicine Be Well-Lake County

Community Cooperation for Medically Underserved Diabetes Patients

Provided by NorthShore University HealthSystem

More than seven percent of Lake County's 700,000 residents are battling diabetes. Each year, hundreds of diabetes patients in Lake County are hospitalized due to complications with their disease. NorthShore University HealthSystem and the Lake County Health Department and Community Health Center recognized that many of these complications can – and should – be prevented. The two joined forces to develop what has grown to a fully comprehensive diabetes management program for more than 1,000 medically underserved patients.

Health Care Challenge:

Proper diabetes management is critical, since complications can lead to heart disease, stroke, blindness and kidney disease. NorthShore University HealthSystem and the Lake County Health Department and Community Health Center have collaborated to develop "Be Well-Lake County." This program for medically underserved diabetes patients provides disease management, subspecialty care, assistance with medication and testing supplies, on-site Hemoglobin A1C testing, an exercise training component and a community garden. Be Well provides integrated diabetes treatment, education, and support resources to more than 1,000 medically underserved patients.

Be Well patient Petra Narvaez was introduced to the program when she was hospitalized for one week because her blood sugar levels were too high. It was at that point that she learned her cataracts was related to complications with her diabetes. "I couldn't believe it – I felt overwhelmed, especially with the amounts of medication I had to start taking," recalls the 64-year-old North Chicago resident. "I didn't know if I was going to be able to see again."

Family Medicine's Solution:

Be Well-Lake County has grown to become a comprehensive, fully integrated program. Since its inception, Be Well has always been patient focused. But the physicians who are part of this program think beyond their "normal" focus. For example,

staff recognized that patients' access to fresh, healthier food options were limited due to the food desert in which they were living. Physicians, program staff and NorthShore donors worked together to start a now fully-functioning community garden. Patients maintain and water the garden throughout the summer months, and each year patients harvest hundreds of pounds of produce to enjoy with their families. In another example of community cooperation, Be Well physicians noticed that patients were facing major gum disease and oral health issues due to complications with their diabetes. Be Well launched a dental program that continues to see patients – some of whom have not visited a dentist in 10+ years.

The lines of responsibility in this partnership are clear. The Health Department provides the primary care physicians, medical assistants, nurses, nurse practitioners, a dietitian, a program coordinator, a case manager and a translator. NorthShore University HealthSystem provides subspecialty care, marketing and public relations support, a grant writer and fundraising assistance.

This nationally recognized program offers a coordinated network of services, including:

- Assistance with medication and testing supplies
- Subspecialty care access for cardiology, ophthalmology, endocrinology, podiatry, and nephrology
- On-site Hemoglobin A1C testing
- Diabetes self-management education classes and support group
- Fitness program
- Paid membership to a fitness center for those who qualify
- Nutrition education offered by a registered dietitian

Patient Benefits:

Be Well staff worked with Petra to better manage her blood sugar levels. She met with the Be Well dietitian for medical nutrition therapy. She lost weight and was finally given a second chance to see again. Petra underwent eye surgery at NorthShore with a Be Well ophthalmologist, and she regained her eyesight. "It has changed my life for the best. It was extremely difficult for me to accept the fact that I had lost my eyesight due to cataracts and other complications. I received the care I needed and for this I am most grateful."

Petra regularly keeps her doctor appointments. She takes full advantage of additional support offered through the Be Well program, such as meeting with her dietitian to improve her eating and dietary choices, and continuing her retinal screenings to monitor her vision. Petra has attended healthy cooking demonstrations, where she learns how to cook with healthier options to better manage her diabetes. She has also found a support system and respite among fellow patients and physicians of the Be Well-Lake County diabetes management program. Many Be Well patients find that simply knowing they are not alone in their struggle with diabetes provides inspiration and support.

Petra's life-changing experiences have – quite literally – impacted her outlook and approach to her health. Her advice to other patients is clear: "For people struggling with diabetes out there - seek treatment right away. And follow the doctor's advice and recommendations!" she advises.

IAFP Annual Meeting links with Family Medicine Midwest

Members have a unique opportunity to combine IAFP leadership with the regional networking and collaboration of the Family Medicine Midwest Conference, with the theme "Celebrating Diversity, Our Patients, Our Communities and Ourselves." Both meetings will run simultaneously at the Loews Chicago O'Hare Hotel in Rosemont. The full schedule of IAFP Annual Meeting events is published in this issue and online registration is open at www.iafp.com.

Highlights of the IAFP meeting include:
-Four Self-Assessment Module (SAM) Workshops – Separate Registration Required
-Plenary addresses from AAFP president-elect Wanda Filer, MD, MBA, FAAFP and Chicago's Fred Richardson, MD, FAAFP.
-CME programs across seven tracks over a day and a half – earn up to 12 CME credits!
-Committee meetings
-All Member Assembly, including AAFP Fellow Convocation, the inauguration of a new president and installation of the newly-elected board members. The All-Member Assembly also debates and votes on resolutions submitted by members.

Resolutions to the 2015 IAFP All-Member Assembly
Currently we have three resolutions submitted. The deadline for resolutions in advance is August 26. Members may submit their resolutions via email to Vincent D. Keenan, IAFP Executive Vice President at vkeenan@iafp.com. Any resolution submitted after that date will be brought before the Assembly as a Late Resolution, where 3/4 of the present members will need to vote in favor of considering the resolution. All IAFP Active and Life members in good standing are eligible to vote on resolutions at the All-Member Assembly. IAFP Resident and Student constituencies may have a delegation of five voters at the All-Member Assembly.

Resolutions Submitted in Advance – Posted on the IAFP web site at www.iafp.com/2015-resolutions
1. Resolution of Condolence: Robert McCracken, MD – online only
2. Resolution of Condolence: Paul Sunderland MD – online only
3. Resolution to study change in IAFP Annual Meeting

Resolution to the IAFP All Member Assembly
Task Force to Study Change to Annual Business Meeting
Submitted by the IAFP Board of Directors

WHEREAS, IAFP started in 1947 and soon after formed a Congress of Delegates, which provided geographical representation for members in a House of Representatives style of governance. Around 1990, the number of geographical chapters was reduced from more than 50 to about 30. In 2004, the Congress of Delegates was dissolved and the current All Member Assembly was established in its place; and

WHEREAS, discussions during the change to the All Member Assembly included a possible change to an annual business meeting. The sentiment was that an annual business meeting may be the most efficient way to run the Academy's policy-making. However, a move to an annual business meeting might send a message that members' direct input into the Academy was not wanted. There was a sense that the All Member Assembly may be an interim step, and

WHEREAS, the 2015 All Member Assembly is the 11th All Member Assembly; and

WHEREAS, the All Member Assembly is described in Chapter 7 and 8 of the Illinois Academy of Family Physicians bylaws, and

WHEREAS, attendance at the last six All Member Assemblies has been as follows:

Actual number of members followed by number minus estimated 18 board members in attendance at each Assembly
2014 53 (35) Gurnee
2013 62 (44) Naperville
2012 37 (19) Itasca
2011 51 (32) Oak Brook
2010 32 (14) St. Louis
2009 40 (22) Oak Brook

WHEREAS, the linked report provides a preliminary list of the pros and cons of moving from an All Member Assembly to an annual business meeting, and

WHEREAS, the 2015 All Member Assembly provides a forum to gather advice, suggestions, opinions and information therefore be it

RESOLVED, that IAFP form a Task Force to investigate the possible change from the All Member Assembly format to an annual business meeting, including the following

1. The 2016 Bylaws Task Force supervises a survey of members about move to annual business meeting. Staff will gather information from other AAFP chapters that have moved to annual business meeting format and from association management community about formats for annual business meeting.
2. Discussions at February/March and May 2016 board meetings about findings
3. Report back to 2016 All Member Assembly with possible resolution to change to annual business meeting.

IAFP Annual Meeting Events with Family Medicine Midwest
October 9-11, 2015
Loews Chicago O'Hare
5300 N River Road, Rosemont, IL

Friday October 9, 2015

9:00 am	Registration opens
9:00 – 1:00	SAMs workshop 1 – topic: Hypertension
9:00 – 11:00 am	Finance Committee
	Public Health Committee
11:30 am – 1:30 pm	Clinically Integrated Networks Committee
	Government Relations Committee
2:00 – 3:30 pm	IAFP Foundation Meeting
2:00 – 4:00 pm	Family Medicine Educators Committee
	Family Physicians in FQHCs Committee
	Membership and Member Services Task Force
3:30 – 4:00 pm	Break
5:30 – 7:30 pm	Welcome Reception
7:00 – 9:00 pm	Product Theater - topic TBA

Saturday October 10, 2015

7:00 - 8:45 am	Breakfast & Opening Plenary –Wanda Filer, MD
9:00am - 12:00 pm	Educational Sessions (7 concurrent 50 min sessions)
8:00 – 12:30 pm	SAMs workshop 2 – topic: Asthma
12:00 - 1:30 pm	Speed Date Your Specialty Lunch
1:30 - 5:00 pm	SAMs workshop 3 – topic: Cerebrovascular Disease
2:00 – 4:00 pm	All Member Assembly
4:00-5:00 pm	New Physicians Committee Meeting
4:00 – 5:00 pm	Educational Sessions (4 concurrent 50 min sessions)

Sunday October 11, 2015

7:30 – 8:45 am	Breakfast & Closing Plenary –Fred Richardson, MD of Chicago
8:00 am – 12:00 pm	SAMs Workshop 4 – topic: TBA
9:00 – 12:00pm	IAFP Board meeting
9:30 - 10:20 am	Educational Sessions
10:30-11:45 am	Research Presentations

SAMs workshops open to all (separate fee applies)
Topics are subject to change. Education session topics will be posted on the IAFP website.

Candidates for the 2015-16 IAFP Board of Directors

All Active and Life members in good standing may vote for the IAFP board of directors via electronic ballot. Qualified members will receive an email with a link to voting. Members who do not receive or open IAFP email will need to go to this web site link to vote: https://www.surveymonkey.com/r/2015_Bd_Elections

All members may view the candidates, their CVs and their letter of interest on the IAFP web site at https://iafp.memberclicks.net/2015-board-candidates

This year's election has one candidate for all positions except for the Board of Directors, Class of 2018, where four candidates are running for three open positions. Therefore on the electronic ballot, members have the option to vote yes on the candidates vetted and approved by the IAFP Leadership Development Committee and then will also need to vote for up to three of the four candidates for the Board of Directors Class of 2018.

The 2015-16 IAFP board of directors will be installed at the IAFP annual meeting on Saturday, October 10th during the All-Member Assembly at 2:00 p.m. Wanda Filer, MD, MBA, FAAFP will be AAFP president at that time and will perform the installation of officers and also the convocation of Illinois Fellows of the American Academy of Family Physicians.

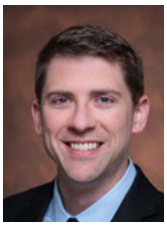
Alvia Siddiqi, MD of Inverness is the current President-elect and will move up to President.

President-elect: Donald Lurye, MD of Elmhurst

First Vice President: Asim Jaffer, MD of Peoria

Second Vice President: Sachin Dixit, MD of Orland Park

Class of 2018 (three slots open)



Michael Hanak, MD Chicago

Kohar Jones, MD Chicago

Lauren Oshman, MD Glenview

Tim Ott, DO Quincy

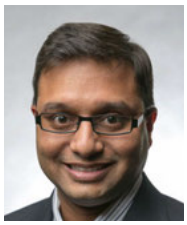
New Physician, Class of 2017:

Emma Daisy, MD Chicago

AAFP Delegate, 2015-2017

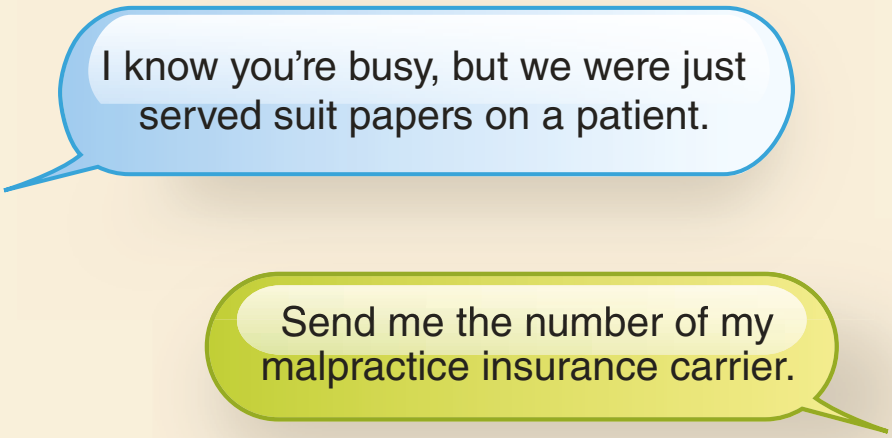
David J. Hagan, MD Gibson City

AAFP Alternate Delegate, 2015-2017



Sachin Dixit, MD (see second vice president above)

The IAFP Leadership Development Committee:
Carrie E. Nelson, MD –Chair
Glenn Skow, MD, MPH
Kelvin Wynn, MD
Michael Hanak, MD (recused himself from qualifying candidates for the IAFP Board Class of 2018)
Tabatha Wells, MD



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Illinois Action at AAFP National Conference of Family Medicine Residents and Medical Students

18 Illinois Family Medicine Residency programs joined together in the exhibit hall in Kansas City for the AAFP National Conference of Family Medicine Residents and Medical Students. Student delegate Emily Graber from UIC and Resident Delegate Jessica Reader, MD from Northwestern McGaw at Humboldt Park were very busy in their respective congresses and each authored or co-authored resolutions that were adopted or placed on the Calendar of Reaffirmation. UIC Student Lauren Segelhorst was elected as National FMIG Coordinator for the coming year. UIC alumni Mustafa Alavi, MD and Lauren Kendall, MD have also held this position recently. SIU-Springfield students Rachel Segal and Alejandro Montoya were honored for their first place award for FMIG programs teaching Tar Wars in the community. This is the second straight year that SIU Springfield School of Medicine has achieved this honor.

Opportunities for Family Medicine Physicians

Wheaton Franciscan Medical Group is growing and looking for Family Medicine Physicians to join them in Southeast Wisconsin.

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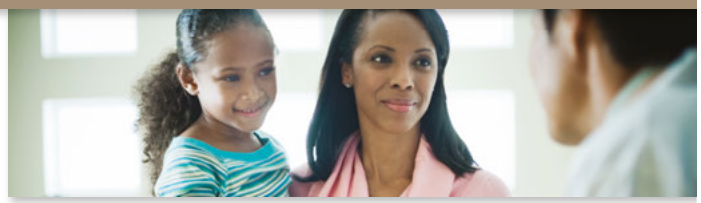

Learn More

For position information contact:

- **Brandon Wilson** for Milwaukee opportunities at *brandon.wilson@wfhc.org*, (414) 465-3118.
- **Carol Kamenar** for Racine opportunities at *carol.kamenar@wfhc.org*, (262) 687-6420.

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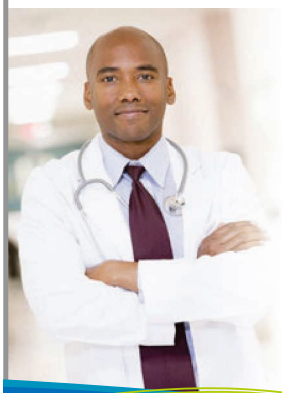

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Government Relations

"Continuous Session" waxes into the Dog Days of Summer

The Illinois General Assembly was scheduled to adjourn on Sunday, May 31st. In an unprecedented move, both the House Speaker and the Senate President called members into "continuous session." In years past, it would normally be the Governor calling the chambers into special session. A special session would limit the Legislature's action to a particular bill or subject matter. Continuous session has no such limit other than the priorities of leadership. This turn of events was brought on by the impasse on the FY2016 budget. Gov. Rauner vetoed the unbalanced budget that was sent to him by lawmakers. Negotiations continue as lawmakers shuttle between their home districts and Springfield for session days.

Even as elected officials have yet to pass a budget, a federal court has ordered the Illinois Department of Health Care and Family Services (DHFS) to pay health care providers for services rendered to Medicaid beneficiaries in Cook County pending resolution of the state budget. More details can be found here

Once a bill has passed both chambers, it is sent to the Governor in 30 days. Once on his desk, the Governor has 60 days to act on it. Any bill that passes both houses after May 31 through December 31, 2015 and contains an effective date prior to June 1, 2016 will require a 3/5ths vote in both chambers. This number is 71 in the House and 36 in the Senate.

Despite the fiscal impasse, there were several issues deliberated by lawmakers during the regular session where IAFP's voice was heard - here are the highlights:

Mandated Hep C Screening sent to the Governor SB661 (Sen. Mulroe D-10) passed both the Senate and House and awaits the Governor's action. Providers presented data that screenings ARE offered and a mandate was not needed. In fact, the number of reported cases of Hepatitis C increased from 6855 in 2013 to a total of 8863 in 2014 (a 29%). This could not have happened without an increase in screening/testing by physicians and other health professionals. IAFP sent the attached letter to the Governor urging him to veto the bill. Find all the IAFP letters on the www.iafp.com Government Relations page.

HEAL Act (sugary beverage tax) still in play for FY2016 Budget - The Healthy Eating and Active Living (HEAL) Act is still being considered by budgeteers as a viable addition to the state budget. IAFP partnered with the IL Chapter of the American Academy of Pediatrics (ICAAP) in a letter urging legislators to support the tax.

Comprehensive Opioid Legislation sent to the Governor HB 1 (Rep. Lang D-16) passed both the House and the Senate and awaits the Governor's action. As the most comprehensive legislation on opioids to date, the bill was negotiated throughout the legislative session to reflect collaboration and agreement among a wide array of parties.

Nurse Collaboration - HB421 (Rep. Feigenholtz D-12) was signed into law on July 29th and is now Public Act 99-0173. This legislation updated the APN practice act among other provisions agreed upon with physicians and APNs. Nothing in this Act will prevent a physician from including any restrictions on practice or requirements for communication within the collaborative agreement.

SB1498 amends the Good Samaritan Act to provide **liability protection for Volunteer Medical Reserve Corps** members assisting certified local health departments during emergencies that are not declared disasters. IAFP was listed as a supporting organization on the fact sheet. The bill was signed into law on July 14th and is now Public Act 99-0042

Health Care Right of Conscience Act (HCRCA) – SB 1564 (Sen. Biss D-9) provides that health care providers can assert religious objections to providing care and information if they have in place protocols designed to ensure that a patient gets the information needed to make an informed medical decision and to obtain needed care. The bill passed the Senate and remains on 3rd Reading in the House. The Springfield State Journal-Register printed an editorial July 18 with support for Health Care Right of Conscience Act, and specifically references IAFP's support for the measure which has passed the House and awaits action from the House and the Governor.

Certificate of Religious Exemption - SB1410 (Sen. Mulroe D-10) makes changes in the existing process by detailing the grounds for objection by the parent or guardian and the specific immunizations and/or examinations to which they object. Requires parents or legal guardians to submit the certificate to their local school authority, prior to the dates of entering kindergarten, sixth grade, and ninth grade (instead of annually), for each child for which they are requesting an exemption. The bill passed both chambers and IAFP has signed onto a letter to the Governor – who signed the bill on August 3.

What to expect this fall: Legislative leaders and the Governor will face ever-increasing pressure to pass a FY2016 budget as rank and file members have personal obligations and in some instances, hardships, that may prevent them from being present all at once to vote on the budget, which now requires 71 votes in the House and 36 in the Senate. Another consequence of continuous session is that a veto session calendar has not been issued. While this may not in itself be problematic, any vetoed bills being considered during veto session usually have proponents and opponents that use the late summer and early fall to reach out to legislators and prepare their strategies for under the dome. However, partisan politics and the impending state government shutdown have all but stilled this activity.

For more information on any of these issues or IAFP's advocacy, please contact Gordana Krkic, CAE, Deputy Executive Vice President of External Affairs at gkrkic@iafp.com or 630-427-8007.

STEPS TO HELP YOU TRANSITION

The ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing.

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- Train Your Staff—Find options and resources to help your staff get ready for the transition
- Update Your Processes—Review your policies, procedures, forms, and templates
- Talk to Your Vendors and Payers—Talk to your software vendors, clearinghouses, and billing services
- Test Your Systems and Processes—Test within your practice and with your vendors and payers

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Continuing Medical Education

Annual Meeting Education at Family Medicine Midwest

The 2015 IAFP Annual Meeting will be held in conjunction with the 4th Annual Family Medicine Midwest Conference at the Loews Chicago O'Hare in Rosemont on October 9-11, 2015. Earn up to 12.00 CME credits while networking with colleagues from Illinois and around the Midwest!

Go to www.iafp.com and click on the link from the home page for easy online registration for all the education activities offered at this blockbuster regional meeting.

Pre-Conference Workshops

Family Medicine Midwest is pleased to offer five preconference workshops on Friday afternoon, providing a unique opportunity to collaborate and share information with colleagues across the Midwest that share your interests! For only $25 (in addition to the Family Medicine Midwest/Annual Meeting registration fee), you can attend any of the following preconference sessions:

Community and Population Health – Join your colleagues to discuss presentations and plan how to address population and community health in the work place.
Maternity Care Collaborative (Two 90-minute sessions) – This conference mainstay will cover the wide ranging issues facing mothers-to-be and their babies.
Integrative Medicine: Practical Implications of a "Whole Health Approach" – Highlighted by an integrative approach to chronic pain and mental health, this session is designed to educate the primary care provider with practical tools to approach difficult clinical problems with a patient-focused, "whole health" approach.
Osteopathic Manipulative Treatment (OMT) Tricks and Tips for the Non-D.O. Provider – This session will cover the vital information non-DO providers need to understand osteopathic treatment.
Global Health – This preconference workshop is dedicated to furthering global health education that advocates for family medicine and primary health solutions in low- and middle-income countries.

Plenary Sessions

There are two exciting plenary presentations at this year's conference. Wanda Filer, MD, MBA, FAAFP, AAFP President-Elect, Family Physician, York, PA, will present "The Renaissance of Family Medicine" to open the conference. Fred Richardson, MD, FAAFP, Founder and Medical director of Dr. Richardson's Neighborhood Family Practice, Oak Park, IL, is the closing plenary and will present "Back to the Future: Why the Old-Fashioned House Call is the Future for Family Medicine." Don't miss out on these incredible presentations!

Conference Sessions

IAFP members will have the opportunity to choose from 50 conference sessions at Family Medicine Midwest! The sessions will appeal to faculty, residents, and students alike, allowing for a variety of learning and networking opportunities throughout the event. Hands-on workshops will be offered at the beginner and intermediate levels. In addition, Family Medicine Midwest will include two poster sessions and a time block dedicated to research and paper presentations.
For a full list of detailed education session information, visit www.iafp.com/family-medicine-midwest.

SAMs Workshops

IAFP offers SAMs workshops as a part of the annual meeting. For an additional fee, attendees may attend SAMs on Hypertension (Friday afternoon), Asthma (Saturday morning), Cerebrovascular Disease (Saturday afternoon), and a topic TBD (Sunday morning). Don't miss out on this convenient opportunity to complete the knowledge assessment portion of the SAMs modules with a group of your peers! AAFP members can register for $275 per SAM and residents can register for the discounted fee of only $75.

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Leslie Mendoza Temple, MD
NorthShore University HealthSystem
Chair, IDPH Medical Cannabis Advisory Board

Why did you choose family medicine?
I liked so many specialties that it was natural to choose Family Medicine rather than limit my skill set to a certain age group ... or body part. I studied medicine abroad at the University of Santo Tomas in the Philippines and had an excellent exposure to family and community medicine. I've had a natural curiosity and desire to know as much about health and disease in people of all ages.

How do you think medicine has changed in the last five years?
I 'sub-specialized' in Integrative Medicine following my fellowship at the Arizona Center for Integrative Medicine (University of Arizona). Since 2003, I have noted greater acceptance and referrals for Integrative Medicine at my institution. Services like acupuncture, massage therapy, stress reduction, nutrition, and herbal/supplement counseling have seen a steady rise over the past 15 years of our clinic's existence. Our patients desire a more natural, holistic approach to healing and disease management, while combining their care with conventional medicine when it is necessary. I have witnessed more physicians in my system committed to training in this field, most of whom come from Family Medicine. I've also noticed an early shift at my institution towards prioritizing wellness and resilience for patients, providers and our management staff.

How did you get involved with the IDPH advisory task force on medical cannabis?
As an Integrative Family Medicine physician, I took one look at the list of eligible conditions for medical cannabis, and I thought to myself, "that list looks like my patient population!" I educated myself on endocannabinoid physiology and the potential for marijuana to help or harm my patients. I wanted to prepare for the wave of calls and requests for this medicine before it becomes available in the dispensaries. An open invitation to join the Medical Cannabis Advisory Board was published on the Illinois Department of Health website, so I applied. At our first meeting, I was elected Chairperson by the board members.

What issues are you confronting in this role?
This role is fascinating. In one day at the petition hearing, the committee evaluates medical evidence, listens to emotionally-charged patient and expert testimonies, debates pros and cons, and then votes on whether to accept or reject newly proposed conditions for medical cannabis. The main issue in this role currently is the learning curve that the board has faced in evaluating the conditions. There are no precedents for this kind of board in Illinois, and we are doing our best to serve the people of this state. Another issue regards the controversial and political nature of the Compassionate Use of Medical Cannabis Pilot Program, which has led to numerous delays in its implementation. There is a learning curve for physicians and other healthcare providers with allowing medical cannabis use for their patients. Only physicians in good standing can write the certification letters to allow patients to receive a registry card. My perception is that only a few physicians are willing to consider this. I hope to increase physician awareness and education on this medicine like any new therapy we've ever had to learn in training.

What are the most prevalent conditions you're seeing in your practice?
A majority of the conditions we take care of are cancer-related. Next in line are chronic pain, GI conditions, depression, anxiety, migraines, and autoimmune conditions. I see a fair share of persons with fibromyalgia, multiple sclerosis and neuropathic pain as well. These conditions are challenging to treat with conventional therapies alone, and I think our patients have benefited greatly from the integrative approach.

How do you balance the demands of the career with your personal well-being?
I say "no" to many evening work-related events or weekend lecture invitations. At this point in my life with three young children, I have prioritized evenings and weekends as family time. I also devote early mornings to exercise and have hired a personal trainer twice a week to make sure that I make it into the gym.

If you weren't a physician, what do you think you would be?
I would love to be a home school teacher for my children. But alas, the schedule does not allow.

Anything about you that would surprise us?
I have a side business. I co-own Mingle Juice Bar in Glenview, now one year old. After a year of struggling with the woes of opening a new business, it is doing well. I give much credit to my business partner Kim and my husband Brigham for its success. Planning, financing and running a retail food business has been one of the toughest things I've ever done, aside from completing residency and raising a family.

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