ILLINOIS ACADEMY OF FAMILY PHYSICIANS
Devoted to Advocacy, Education & Action

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2015 IAFP Awards Honorees

Family Physician of the Year: Elba M. Villavicencio, MD – NorthShore University HealthSystem

Dr. Villavicencio was nominated by patient Vicky Soberano. She is relatively new to Illinois, but quickly established herself among her patients and colleagues with NorthShore University Health System. Her practice is located in Gurnee. She has also practiced in Columbia and Ecuador. Her story is one of change and determination and success. Since joining the NorthShore Medical Center, she quickly won the hearts and loyalty of her patients and the respect of her colleagues.

Vicky is an experienced patient, having seen many doctors throughout her life due to health problems in childhood. She met "Dr. V." by chance and after one visit, knew that she had found the doctor for herself and her family. She told IAFP how Dr. V. confidently and compassionately guided her through two health scares. But their relationship has built ever stronger over time. Vicky says she is the only doctor who was able to help her lose weight and quit a 35-year smoking habit. "What is not easy and what makes her so unique is how she uses the tools she was given. She recognizes what her patients need. I would love to say I'm her favorite, but I know she treats all her patients like she treats me."

Her physician career began as a rural service physician in Ecuador after graduating from medical school there in 1990. The one-year commitment to working in the Andean mountains or the rain forest is a requirement of all medical school graduates in Ecuador. From there, she spent several more years in Ecuador, including completing a residency program in anesthesiology before becoming a community medicine physician in Bogota, Columbia.

She came to the U.S. in 2000 and eight years later, started family medicine residency training in New York. Less than a year after completing residency training, she joined NorthShore University HealthSystem.

Dr. V. is also a preceptor for the University of Chicago NorthShore Family Medicine Residency Program. Her colleague, Deeba Masgood, MD at University of Chicago Pritzker School of Medicine reiterates Dr. Villavicencio's holistic approach to caring for patients, including lifestyle issues and support systems. "One patient was so motivated by her clinical style that he wants to pursue a medical career," she reports. That patient, Mark Sterling Carlson says, "Dr. Villavicencio is one of the very few doctors I have come across that will take her time and go to extreme lengths to make sure that everything is taken care of completely… to make sure you get the full attention and full treatment of every visit."

Colleague Lisa M. Wiederin sums it up: "I so like all the qualities that Dr. Villavicencio possesses, medically and personally, that I switched my entire family to her care. I have the opportunity to see her from three different perspectives, a patient, a parent and a co-worker. They all add up to one quality physician."

To make being active fun, Dr. V. encourages patients to incorporate dance, and as a professional salsa dancer herself, she's able to practice what she preaches!

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President's Message

Janet Albers, MD

Being the IAFP President has been an amazing experience for me. It truly feels like the year has flown by! I've travelled to many states, fielded phone calls from the media, advocated on the state and national level for family medicine, and represented our membership on advisory boards, task forces and even at the Health is Primary City Tour press conference. I appreciate your confidence in allowing me to serve you during these exciting times for family medicine!

As I wrap up my year as president, I've had time to reflect on all I've witnessed in this position. Before I pass the title and responsibilities of president to Alvia Siddiqi, MD, I will present my President's Awards to three amazing people who have brought much progress and meaning to the work we do as an Academy over the past year. This award is given at the discretion of the IAFP president to honor an individual or an organization that is making a difference in providing a healthier future for our state and our patients. I look forward to presenting each of the recipients with their awards while sharing their accomplishments at the IAFP's Annual Awards banquet on October 9. While the people in the room that night will hear all about these award honorees first hand, I would like to share my admiration for them with our entire membership. If you know any of these three, be sure to offer them your congratulations as well!

Kristina Dakis, MD of Chicago

Kristina graduated from University of Illinois at Chicago College of Medicine this year and is one of the most outstanding student leaders I've ever met. Kristina served as the student member of the IAFP board of directors from 2014 to June of this year and was always prepared and engaged at our IAFP board meetings. Her passion for family medicine and the underserved of Chicago shone through in everything she did. Her consistent advocacy for our Family Medicine Midwest conference provided a successful stream of Illinois medical students the opportunity to attend the conference. She's been involved in planning the conference for the past two years, as well. This year, Kristina stepped up in planning and leading the Health is Primary Student/Resident event at UIC on May 19 with Dr. James Valek. Dr. Kristina Dakis is the future of family medicine and represents everything that is right with our specialty. She continued to trumpet family medicine at every opportunity at UIC, sharing her story and her belief that family medicine is the solution to so many of our health care dilemmas. I know she will continue that exemplary leadership and advocacy in residency at the University of Illinois at Chicago Family Medicine Residency. I can't wait to see where her career takes her next.

Illinois Primary Health Care Association

The Illinois Primary Health Care Association has been a tremendous organizational advocate in building a better healthcare system for patients and community health centers, while advocating for policies that protect both stakeholders. Thirteen percent of our IAFP members work in Federally Qualified Health Centers (FQHCs), sharing in our mission of high-quality, community-based primary care. IPHCA's outstanding work in supporting enrollment of eligible patients in Medicaid and Get Covered Illinois has been key to the success of the Affordable Care Act in Illinois. IPHCA's educational resources and support to federally qualified health centers throughout the State have fostered growth and expansion of health care services for those most in need. IPHCA member clinics are delivering on the promise of expanded access to primary care for all patients under the ACA. IAFP and IPHCA have supported each other in our like-minded goals for many years. Rajesh Parikh, MD, Vice President of Clinical Services and Workforce Development, will accept this award.

Tracey Smith, DNP, PHCNS-BC, MS
Director of Medical Education and Community Outreach, Department of Family and Community Medicine, Southern Illinois University School of Medicine

Oh, where do I begin in describing my longtime colleague and friend? For years, Tracey Smith has done excellent work as the staff liaison to the SIU Family Medicine Interest Group and with students in general. Dr. Smith has coordinated and shepherded "med student generations" of Tar Wars presenters, ensuring our local Springfield schools get this important tobacco prevention lesson every year. In fact, our SIU FMIG has won first place nationally from AAFP the past two years in a row for their coordinated Tar Wars efforts. Tracey isn't a family physician, but she certainly understands us and has taught many current family physicians as Director of Medical Student Education for the Department of Family and Community Medicine at SIU. Tracey Smith is a key member of our department and represents the importance of the interdisciplinary team that our students will work in for the rest of their careers. Also as Director of Outreach and Chair of the Community Health Policy Committee at SIU, Tracey has been instrumental in efforts to serve the homeless, advance population health and develop a hot-spotting program for those patients that are most vulnerable. Tracey is more than a valuable teammate, she's my hero!

Here is one of my favorite photos from this year, with Tracey Smith. I can't wait to present these awards and add new fun memories in honoring my President's Awards recipients. I wish all the best to Dr. Siddiqi, and I hope she enjoys her year as president as much as I did. Thanks again for allowing me to serve!

As policyholders, we appreciate ISMIE Mutual Insurance Company's dedicated work to keep our reputations and livelihoods intact. From its innovative programs to manage liability risk to providing us with solid coverage, ISMIE Mutual is our Physician-First Service Insurer®. Founded, owned and managed by physician policyholders, ISMIE remains committed to protecting physicians and our practices.

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IAFP News

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Teacher of the Year – Employed: Richard V.V. Stringham, MD, FAAFP – University of Illinois at Chicago, Department of Family Medicine

Dr. Stringham is a fan favorite among UIC medical student family medicine leaders. He was nominated for the award by then-students Mustafa Alavi and Kristina Dakis (who are both now family medicine residents), along with department head John Hickner, MD. He joined the UIC Department in 2008 and was named Associate Professor this year. He has won numerous Golden Apple and other teaching awards, both at UIC and his previous location of UCLA.

He was recently appointed Assistant Dean for M3 and M4 Curriculum at UIC, due to his excellent work in medical student education at UIC.

"The time has finally come when the country is seeing the vital importance of family medicine as being integral to improving our healthcare system. I feel family medicine is becoming more and more important in medical school education as well. A growing number of family physicians are in positions of leadership at our medical schools," says Stringham.

One of his biggest fans is Dr. Hickner, "You have to see Rik in action to know how he demonstrates his highly effective teaching style. He is dynamic, humorous and knows the content cold. He is compassionate with all students, yet pushes them hard to learn. In addition to his skill as a one-on-one and classroom teacher, he is a terrific educational administrator. Under his leadership, the Family Medicine Clerkship at UIC has been consistently the top rated required clerkship at UIC-COM."

For Stringham, education is more of a two-way street than simply educators and students. "I receive way more knowledge and inspiration from the medical students, family medicine residents, and fellow faculty that I work with than I could ever give back," he says. "I am where I am because many people have seen my potential - before I did - and have given me the opportunity to grow professional as a family medicine educator."

Former IAFP student board member Kristina Dakis is now a first year resident at UIC. In her support for Dr. Stringham, she outlined the many roles he played in her journey to family medicine, all the way through the process. "This past year Dr. Stringham served as an amazing mentor while I applied to residency. He was more than willing to sit down with me, review my personal statement, and discuss all of my options. At all times, it was clear how invested Dr. Stringham was in my success. I knew I could trust him to give me excellent advice and to help me make decisions that were best for me."

Dakis sums up the many facets of Dr. Stringham that make him the 2015 IAFP Teacher of the Year. "He is a phenomenal teacher who devotes himself to his students' education and growth, who is incredibly passionate about his patients, and who has inspired countless students to pursue a career in family medicine."

Distinguished Service Award – Thomas H. Miller, MD – Southern Illinois University Quincy Family Medicine Residency Program

The Distinguished Service Award is given at the discretion of the Public Relations Task Force, to honor an outstanding career. Dr. Miller is being honored for his 23 years of service to Illinois. He has been with the SIU- Quincy Family Medicine Residency since 1994 and was named the program director in 2003. He's active in the community serving on a variety of boards covering health and child advocacy issues. He was nominated by IAFP president Janet Albers, MD, Chair of the Family and Community Medicine Department at Southern Illinois School of Medicine.

Dr. Miller truly cares about the community he works and lives in. He has been involved in numerous local television and radio interviews to educate the public on the importance of preventative care, evidence-based medicine, and health care costs.

Dr. Albers praises the complete package of Dr. Miller, as the "epitome of a family physician." She relays all the many ways the he serves the residency and the community of Quincy. He delivers babies and cares for seniors. Under his leadership, the residency program recently received a grant from the Illinois Children's Health Foundation to integrate children's behavioral health into the medical home at Quincy Family Medicine.

Isidoros Vardaros, M.D., former resident and current faculty at SIU Quincy says Miller's constant support for his residents and

patients is the reason she chose to stay in the same town to practice medicine post residency. "My fondest memories of residency include Dr. Miller coaching me through deliveries in the latest and earliest of hours; him second assisting in surgical procedures when he didn't have to; and him being there for me as a teacher, colleague, and friend during my brightest and darkest moments. He is the first person I consider for medical and professional advice because of the wealth of knowledge and skill sets I have gained under his guidance."

Former resident Preet Joshi, MD credits Miller with helping him manage the culture change from Houston to Quincy, "Dr. Miller sees in all residents potential that I don't think we even knew we had. I saw how he carried himself day to day. I knew I had to be better, not only to impress him, but also for myself."

This year he was elected to board of directors of the Association for Family Medicine Residency Directors (AFMRD). "Dr. Miller is taking his skills and insight for education beyond Quincy to the national level. He is the ultimate professional," concludes Dr. Albers.

The IAFP Public Relations Task Force, chaired by Kristin D. Drynan, MD of Geneva, evaluated the nominees for IAFP awards. The awards process is only possible because of the wonderful support of the colleagues and patients who took the time to nominate outstanding family physicians and describe the impact these members have in their communities. Each of these outstanding members will be honored at the IAFP Annual Meeting Awards Banquet on October 9, 2015.

Congratulations to AAFP Exemplary Teacher of the Year – Volunteer Faculty: Alisha T. Thomas, MD – PCC Family Health Center, Austin (Chicago)

Alisha Thomas, MD Joined PCC Wellness – Austin Family Health Center upon residency completion at West Suburban Family Medicine Residency Program in Oak Park. Today she serves as the organization's community liaison, representing PCC at local events and health fairs. She leads the pilot program called Education-Centered Medical Home for Northwestern University Feinberg School of Medicine, providing longitudinal experience in the medical home philosophy. Her students nominated her for the Teacher of the Year award. Dr. Wanda Filer, AAFP President, will present the award at the IAFP awards dinner.

AAFP Congress of Delegates Report

Family physicians from across the country and the US Territories gathered in Denver for AAFP Congress of Delegates September 28-30. Family medicine celebrated the demise of the SGR, cautiously anticipated the arrival of MACRA and bemoaned the continuous beast called meaningful use. Meanwhile the Congress continued the time honored tradition of resolution, discussion, debate, amendment and finally adoption of policy to guide the Academy and its 120,000+ members.

Issues that generated significant discussion included Affordable Care Act Coverage for U.S. citizens in the territories of Guam, the U.S. Virgin Islands and Puerto Rico. Resolutions on reclassifying medical marijuana and even decriminalizing recreational use of marijuana brought passionate discussion from both sides. Reference committees and the Congress even tackled climate change, nuclear disarmament, zero tolerance in schools, poverty and mandatory drug test reporting for pregnant women. Be sure to view the full report on the AAFP web site at http://www.aafp.org/about/governance/congress-delegates/2015.html. Your AAFP ID is required for login.

IAFP was well-represented by delegates Kathleen J. Miller, MD of Decatur and David J. Hagan, MD of Gibson City, who were charged with casting the Illinois votes on Resolutions and in the elections for the AAFP officers and board members. Asim Jaffer, MD of Peoria and Sachin Dixit, MD of Orland Park served as alternate delegates and provided reference committee testimony. IAFP officers met throughout the weekend on AAFP and IAFP business. Thank you to board chair Edward A. Blumen, MD; president Janet Albers, MD; president-elect Alvia Siddiqi, MD; first vice president Donald Lurye, MD; second vice president Asim Jaffer, MD; and past president Carolyn Lopez for all their hard work and counsel.

The Illinois chapter introduced two resolutions:
Resolution 208 – Age Discrimination Employment Act Exemption The Commission on Organization and Finance recommended this resolution be referred to the board of directors.
RESOLVED, That the American Academy of Family Physicians work with the appropriate federal policymaking authority to allow credentialing organizations to enact dementia screening programs, thereby creating an exemption to the Age Discrimination Employment Act.

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Resolution 409 – Electronic Cigarettes – Our resolution was only slightly amended, and then adopted by the Congress of Delegates.
RESOLVED, That the American Academy of Family Physicians communicate its concerns about the ill effects of tobacco products, e-cigarettes and their component products and accoutrements to companies with retail clinics and urge them to cease the sale of these products.

The Illinois chapter also submitted three Resolutions of Condolence for three of our members who passed away since the 2014 Congress of Delegates. You can view all of them at http://www.aafp.org/about/governance/congress-delegates/2015/resolutions-condolence.html.
-Robert Heerens, MD, FAAFP
-Boyd McCracken, MD
-Paul Sunderland, MD

Illinois celebrates the election of Javette C. Orgain, MD as Speaker of the Congress of Delegates
After four years as Vice Speaker, Dr. Orgain has been elected by acclamation as Speaker of the AAFP Congress of Delegates. Orgain has been a leader, presider and mentor, not only at the AAFP Congress, but also for the students and resident congresses at the AAFP National Conference, and the young leaders at the National Conference of Constituency Leaders. In her acceptance speech, Dr. Orgain remarked: As your speaker, I welcome continued activism. This Congress of Delegates is transitioning from Dr. John Meigs, southern gentleman to me - Dr. Javette Orgain, urban guerilla. I expect, as do our members, that the actions of this Congress of Delegates will be the armor, a protective vest while we navigate towards solutions to the health consequences of such issues as food insecurity, homelessness, violence, human trafficking as well as workforce shortages, our lack of time to fully address the public health challenges we face in a broken system, and physician burnout. Our future lies in having a cohesive voice and strengthening partnerships especially with the public health community.

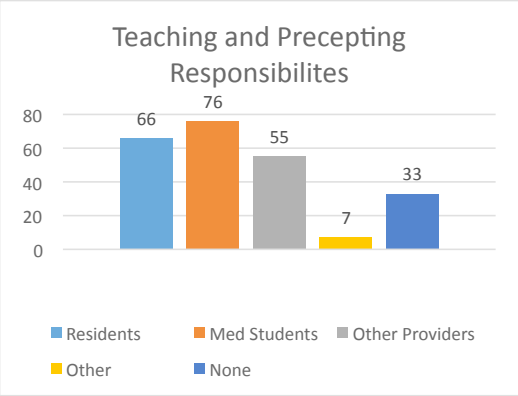
Congratulations to Deborah Edberg, MD who has been named chair of the AAFP Commission on Education!
The mission of the Commission on Education is to provide a venue for the development of recommended policy and the dissemination of expertise and new information related to the education and professional development of family physicians until completion of the residency training period. Its priority areas include: workforce, curriculum, National Conference, work hours, educational awards, student interest, and international family medicine.

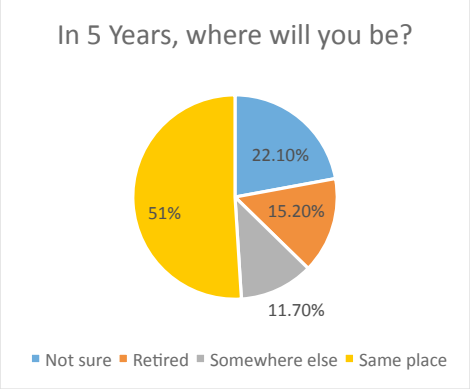
IAFP bi-annual member survey – a snapshot of the membership

Every two years the IAFP surveys active members to get a pulse on who they are, what they need and how they feel the Academy is serving them in key areas. Full results will be shared with the IAFP board of directors at their October 11 meeting. All active members who have a valid email address in the IAFP member database received the link to the online survey via three separate emails. Active members who do not have a valid email address on file received a printed version via US mail. A total of 149 surveys were completed.

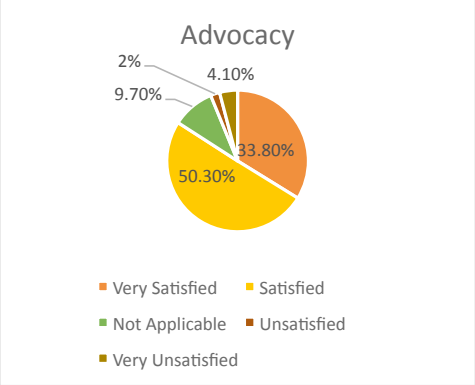
Where they practice

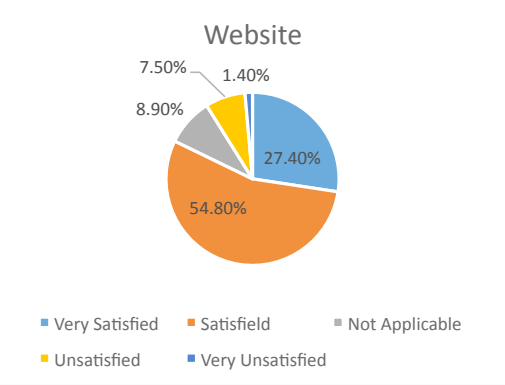
Practice Setting	# of Responses
Private practice owner	30
Private practice employed	17
FQHC or Rural Health Clinic	19
Residency Program	19
Hospital Employed	37
Not seeing patients	6
University employed	8
Urgent Care	3
Home Visits	2
Other	5

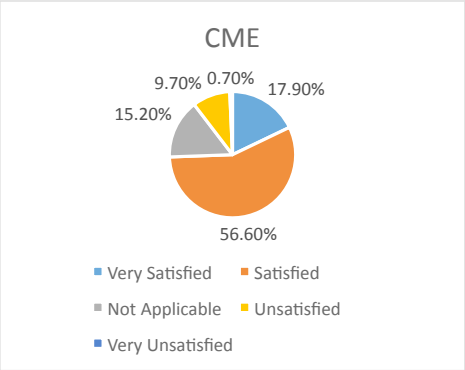


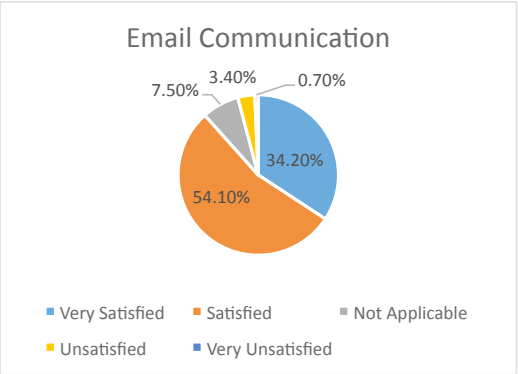


Satisfaction with the Academy Services

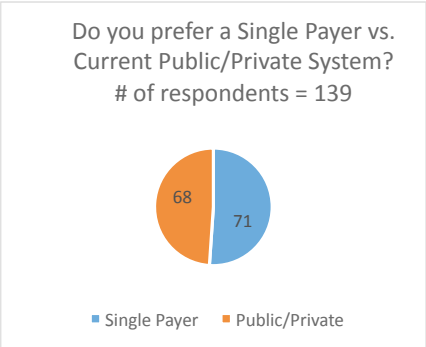


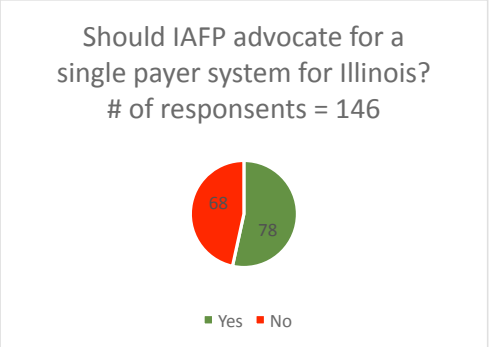






Single Payer issue. A resolution passed at the 2014 IAFP All Member Assembly that directed the Academy to survey active members about the idea of a single payer health care system. The results from those two questions are below.





Teaching Health Centers Update

Submitted by Deborah L. Edberg, MD – Program Director, Northwestern McGaw Family Medicine Residency Program at Erie Family Health Center, with resources from the American Association of Teaching Health Centers

The United States faces a triple challenge -- an aging population, 30 million newly insured citizens in 2014, and the chronic shortage of primary care providers in poor, rural and inner city communities. By 2025, the United States will require an additional 52,000 primary care physicians. The shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 60 million people living in these areas experience disparities in health care access. Traditional, hospital-based residency programs have not been able to sufficiently respond to these challenges. In fact, their graduates are trending toward subspecialty careers which continues to produce an inordinate proportion of specialists at the expense of primary care.

The Teaching Health Center Graduate Medical Education Program (THCGME) is a five-year initiative that began in 2011 as a provision of the Affordable Care Act (ACA) administered through the Health Resources and Services Administration (HRSA). The program provides funding directly to community-based clinical organizations to recruit and train primary care physicians and dentists. By moving primary care training into the community, Teaching Health Centers (THCs) are on the leading edge of innovative educational programming dedicated to ensuring a prepared and sufficient supply of health professionals for the US population and the rapidly evolving healthcare system.

The first TCHGME-funded cohort graduated earlier this year, and are going on to practice in the areas where they are most needed*:

Graduating Residents practicing in:	THCGME	Traditional GME
Primary Care	91%	23%
Underserved Areas	76%	26%
Rural Settings	21%	8%
Community Health Centers	40%	4%

*Data collected in July 2014 from first THCGME cohort.

As of July 2015, there are more than 690 primary care residents in sixty funded THCs in 27 states and the District of Columbia. It is expected that by July 2016 the program will support over 810 residency slots per year. The McGaw Northwestern Family Medicine Residency Program at Erie Family Health Center is one of the original 11 Teaching Health Centers and is currently the only one in Illinois. With ongoing and secure funding, this program could expand to other community health centers throughout the state and the nation.

Congressional Briefings in January

On January 20, the AATHC (American Association of Teaching Health Centers) Executive Committee and a handful of THCs presented congressional briefings on the THCGME program. The briefings and associated meetings were focused on key congressional staff for Members from committees with oversight of the THCGME program: the House Committees on Energy and Commerce, Ways and Means; and Senate Committees on Finance, and Health, Education, Labor, and Pensions (HELP). Our discussions were important in educating new Members and staff, and setting the stage for a busy February and March.

In April 2015, the Senate passed the Medicare Access and CHIP Reauthorization Act of 2015 (HR 2), which repealed the sustainable growth rate (SGR) formula and extended several key programs of importance to family medicine. Due in part to ongoing advocacy by the AATHC among other organizations including the AAFP, STFM and NACHC, an extension of the Teaching Health Center funding was included in this act. The language of the legislation approved a two-year extension of the funding for the existing Teaching Health Centers without allowing for expansion. Unfortunately the funding allotted was for a little over half of the amount the health centers needed to continue to run the programs. The AATHC advocated to HRSA to release the full amount needed to keep the programs whole for the first year with less remaining for the second year, allowing for more time for long-term solutions advocacy. Instead HRSA decided to keep the released amount the same for two years threatening the ability for the programs to remain open until the end of the two years. They came to this decision in consultation with some of larger family medicine organizations, including the AAFP, in discord with the Teaching Health Centers.

AATHC has continued ongoing advocacy to try to persuade HRSA to change its decision regarding the immediate funding shortfall alongside ongoing advocacy on Capitol Hill to find a better long term solution. In July of 2015 the Teaching Health Centers residents introduced a resolution at the National Conference requesting that the AAFP reverse its prior recommendation to HRSA and align any future recommendations regarding Teaching Health Centers with those of the American Association of Teaching Health Centers. This resolution passed out of reference committee and has been sent to the Commission on Governmental Advocacy.

Last month, the American Association of Teaching Health Centers held its annual conference in Washington, DC, attended by over half of all Teaching Health Centers. Highlights included a videotaped welcome message to AATHC from U.S. Sen. Patty Murray of Washington state who is the most senior senator in the minority on both the Health, Education, Labor and Pensions (HELP) Committee and the Labor, Health, Education Appropriations Subcommittee. The Senator expressed her strong support for AATHC and its work and committed to working with the membership to find funding solutions for THCs.

We also arranged for Congresswoman Cathy McMorris-Rodgers (R-WA-5th), who serves on the House Energy and Commerce Committee and Health Subcommittee to personally speak to the Association and take questions. Her remarks focused on the dire need for primary health care in rural areas, and applauded the AATHC for its efforts and successes in addressing this need. A lively discussion was held with representatives of HRSA regarding the release of the funding. HRSA offered a compromise to move the 9th quarter of the funding up front, but cautioned that if that quarter of funding was released now, leaving no funding for the final quarter, the program would end abruptly in June of 2017 and would have to re-start that September with a new application process likely lasting another year, thus leaving the entire year unfunded.

The program leaders were well received on Capitol Hill with meetings with aides from Senators and Congressmen from both sides of the aisle and all across the country. The current plan to address the immediate funding shortfall is to attach additional funding onto legislation on mental health. In terms of legislation, both the House Energy & Commerce Committee and Senate Health, Education, Labor, and Pensions (HELP) Committee have introduced mental health legislation and indicated that the THCGME program could be germane to these bills. Representative Tim Murphy (R-PA-18) has introduced H.R. 2646: the Helping Families in Mental Health Crisis Act of 2015. In the Senate, Senator Chris Murphy (D-CT) and Senator Bill Cassidy (R-LA) are co-sponsors of S. 1945: the Mental Health Reform Act of 2015. Additionally, Senator Patty Murray (D-WA) and Senator Lamar Alexander (R-TN) have re-introduced S. 1983: the Mental Health Awareness and Improvement Act of 2015. Notably, S. 1983 is scheduled to be marked-up on September 30. We have drafted legislative language to provide additional funding to close the gap in the funding shortfall for the THCGME program. Several other aides have agreed to work with HRSA on releasing the final quarter early without creating the threat of ending the program abruptly and threatening funding for the entire year.

IAFP will continue to update members when there is actionable opportunities to contact the Illinois Congressional delegation on the Teaching Health Centers.

More information is available on the American Association of Teaching Health Centers website at http://www.aathc.org/.

Dr. Edberg testifies on Capitol Hill in 2014 in support of the Teaching Health Center Program. Photo courtesy of the U.S. Senate

Chicago *Essential* Evidence Update

The faculty will provide an engaging, rapid-fire review of the most important research publications of the past two years. They will present and critically appraise new research evidence and meta-analyses that will either change your practice or confirm that your current approaches are supported by solid evidence from randomized trials and other high quality studies.

Returns to Chicago
March 17-18, 2016

UIC Department of Family Medicine
UNIVERSITY OF ILLINOIS AT CHICAGO
COLLEGE OF MEDICINE

ILLINOIS ACADEMY OF FAMILY PHYSICIANS
Devoted to Advocacy, Education & Action

Fees:

$295 Conference Registration—includes materials, breakfast both days and lunch on Thursday

$50 Discount for New Physician members
NO FEE for residents!

Online registration will be available in December

Location Information

University of Illinois at Chicago
Molecular Biology Research Building
900 S. Ashland Ave. Chicago, IL 60607
UIC is accessible by the CTA Blue Line trains.

Conference Faculty

John Hickner, MD, MSc. Department Head and Professor of Family Medicine
University of Illinois at Chicago
Mark Ebell, MD, MSc Professor, College of Public Health
University of Georgia

Feedback from previous attendees

***Going to definitely return and will try and bring my whole residency next year.**
Unbiased evidence that is important and practical, done with some *personality.
A fresh look at our *entrenched practices
***The rapid pace was streamlined, efficient, yet thorough and kept my attention.**
***With this knowledge, I can have really great discussions with my patients and reach real goals!**

Learning Objectives

Using an engaging, up-to-date format of presentations & discussions, attendees will be able to do the following:

- Interpret the most recently published data from research and clinical trial articles that have clinical implications for family medicine;
- Discuss the evidence on new, revised, and standard treatment approaches for diabetes, pediatrics, women's health, sports medicine, cardiovascular and GI and pain management, as they relate to primary care practitioners;
- Describe updates in clinical decision tools for screening and differential diagnosis of those diseases;
- Compare and contrast the efficacy and safety of new pharmaceutical treatments and those with newly expanded indications;
- Review evidence-based clinical practice guidelines with implications for family medicine.

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Alvia Siddiqi, MD, FAAFP
Medical Director, Advocate Physician Partners
IAFP President as of October 10, 2015

Why did you decide to pursue the IAFP presidency this early in your career?

I had been involved with IAFP since I was a medical student and during residency, I was selected as the AAFP Resident Scholar to the FMCC in Washington DC. This was where I was able to lobby on Capitol Hill alongside IAFP mentors like Ellen Brull, Javette Orgain, and Carolyn Lopez and experience firsthand the advocacy power of IAFP and AAFP. Years later, Mike Temporal was IAFP Board Chair during the time in which I was ending my three year term as Board of Director. He asked me to strongly consider pursuing the position of Vice President and continue down the path of presidency.

I believe that our organization has been successful in advocacy, education, leadership training, and mentorship. I am honored by the opportunities IAFP and AAFP have afforded me; appointments to the AAFP Commission on Quality and Practice and its Executive Committee, Subcommittee on Health and Equity (SHE), NQF Medicaid Task Forces for Adult and Pediatric Core Measure sets, and most recently, an opportunity to serve on the CMS Advisory Panel on Outreach and Education (APOE).

How do you think family medicine has changed in the last five years?

The healthcare landscape has placed increased demands on our profession in order to meet the goals of the triple aim: improved quality of care, better patient experience and outcomes, and lower costs. Although the individual physician-patient relationship is still sacred, family physicians are now increasingly expected to understand how to engage and practice within Accountable Care Organizations (ACOs), team-based care models, and patient-centered medical homes and neighborhoods where effective population management and quality-based performance are key measures of provider success.

How are you managing changing to a new job along with transitioning to the IAFP presidency?

I recently joined Advocate Healthcare, which is an organizational leader in ACO and population health management and committed to caring for the nearly 100,000 Medicaid members enrolled in the Advocate Accountable Care Entity (ACE). My position is the Medical Director for the Advocate ACE strategy, which is an exciting opportunity for me to make a difference in the lives of this underserved population. My new job complements my IAFP tenure well and on stressful days, my husband reminds me that I thrive in challenging environments!

How do you balance your career with a young family?

I have three young daughters under age five and although that does make my life a bit more challenging, they truly bring forth a balance in my life that I really enjoy. My husband is incredibly supportive. I also don't watch TV – unless you count Sprout and Disney Junior. I strive to be a good role model to my young daughters and help them recognize that being a mother does not mean you have to choose between your family and pursuit of a successful professional career.

What are you most looking forward to as President of IAFP?

I am truly excited to lead our organization. I recognize the value we must place on the young student and resident membership. Their retention rates and those of young New Physicians are critical to the future success of our organization. I have visited residency programs and medical schools in order to increase interest in IAFP and family Medicine. Recognizing that women now comprise roughly 55% of the family medicine residency programs, I firmly believe that we need to locally support female mentorship. I have benefitted from many female mentors throughout my career, many of whom I met through IAFP. I would like to facilitate mentorship between seasoned and newer IAFP female members and provide an open forum to discuss issues relevant to female family medicine physicians, including contract negotiations, balancing career and family lives, and career development.

Anything that you are willing to share that would surprise the membership?

Two of my unique interests are in Medical Ethics and foreign languages. I competed in Ethics bowl competitions when I was at Loyola as both an undergrad and later as a medical student. I also have a love of languages. I speak Urdu/Hindi fluently which is my native language, but also speak Spanish and French.

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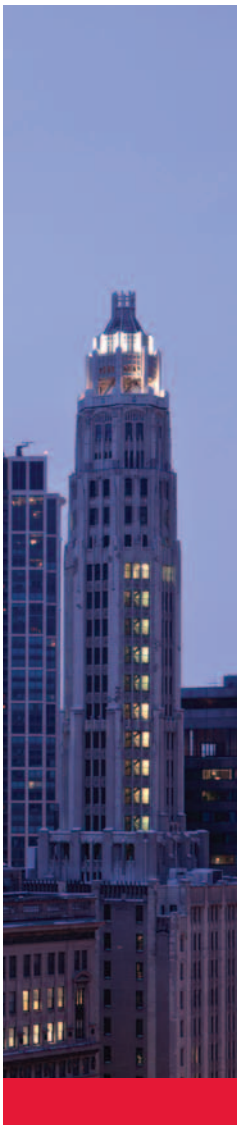

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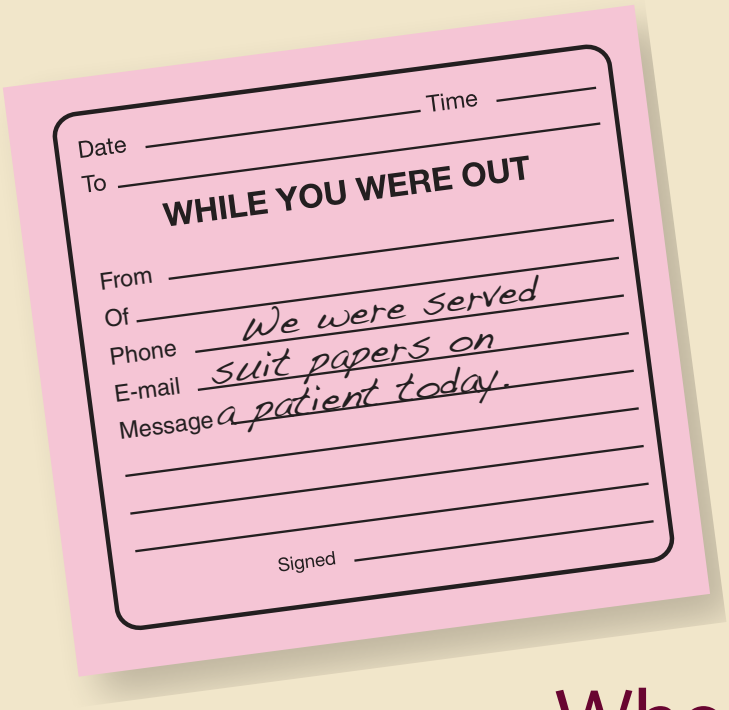

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News You Can Use

Ineffectual transitions of care can contribute to death

Stasia Kahn, MD of Wheaton. *Reprinted with permission of the author.*

A few months ago my family and I buried my mother. She was 85, and she died from an acute treatable infectious disease. The circumstances leading to her death spanned several weeks from when she was ill at home to the time she was in the hospital. Her death was untimely, as she did not have cancer or an end-stage chronic disease. There was a delay in treatment from when my mother presented to the ER and was sent home, to when she was started on intravenous antibiotics during her subsequent hospitalization. The delay in treatment most likely contributed to her death. In the end when it became clear that the situation was futile, life support measures were withdrawn and she died peacefully in a hospice facility. My family eulogized our mother in a very moving ceremony. Being a physician, I was not allowed down time for grieving or exhaustion. I returned to work the Monday after the Friday funeral and immediately tried to catch up on patient care activities and running the business of my medical practice. All the while, I was sorely missing my mother, and I was fooling myself into believing that I was at peace with my mom's death. Finally it came to me in a reflective moment on Easter Sunday that there was more that I needed to share about my mother's death that I hadn't said at her memorial service.

Tech savvy consumer

My mother believed in the power of the electronic medical record and was hoping to live to see the day when healthcare providers shared information electronically as a matter of routine. She died before this vision became a reality. My mother was very well educated on the topic of electronic medical records and health information exchange because like most mothers she was interested in my career and wanted to support me. Twelve years ago when my previous practice went live on our first EMR, my mom came to visit and watched the children so that I could stay late at the office each night during that first week and not have to worry about getting home. Ever since that day, most of our phone conversations included her query about how the medical records business was going. She didn't use the terms EMR or Health Information Exchange, but she would cut out articles and send them to me in the mail about both of these topics, as she knew that I was an early adopter of EMR and pioneer in the field of health information exchange.

I have been sharing summary of care records electronically with other providers since 2005. I also had an early interest in personal health records and I created a Consumer Empowerment National Demonstration (CEND) personal health record for my mother seven years ago and she kept it up for a bit but over time her medications and health conditions changed, and since it was an untethered PHR, it was difficult for her to maintain.

She was very happy when her primary care doctor, whom she was very fond of, started using an EMR. When he referred my mom to a new specialist she would ask the specialist if he or she was able to look up her information in the computer system and it perplexed her that sometimes they had access to her electronic medical record and sometimes not. She was very frustrated that her specialists didn't routinely share information about her with her primary care provider. Sometimes when her medical conditions were not responding to her treatment plan her primary care doctor would call her other physicians to discuss her case. She was very appreciative of these telephone communications.

Failed transition of care

A contributing factor to my mother's death was that she had an ineffectual transition of care. Her death could just as easily been the untimely death of one of my own patients. My hope is that by sharing this story that other deaths might be prevented.

My mom and I lived in different states but the failures that contributed to her untimely death are the same issues that could lead to adverse events when my own patients experience a transition of care from their home to an acute care facility.

Failure to deliver tests results to primary care office

An initial communication error was the ineffectual data sharing of test results between the emergency room and my mother's primary care physician. Let's face it, one of the negative consequence of hospitals moving from paper records to an electronic medical record is that emergency room test results are no longer faxed or mailed to the primary care physician. For my mother this meant that the negative stool culture and the lack of testing for clostridium difficile by the emergency room, both critical pieces of information, were not delivered to her primary care physician. If he had been alerted to these test results he would most likely have ordered further testing and ultimately lifesaving antibiotics could have been started sooner. I encounter this same issue of crucial lab tests on my own patients treated in the ER not being delivered. The majority of my patients go to a

hospital that is on a different EMR than my practice. My office staff must log into the hospital EMR several times each day to print out labs on our patients seen in the emergency room. My staff is not allowed to route test results electronically for two of the three hospitals I am on staff at, and for this reason emergency room labs are printed and not routed.

Failure to exchange office notes with hospitalist
A second communication lapse occurred when my mother's condition deteriorated and she returned a second time to the hospital emergency room and was admitted to the hospital. She was admitted on a Sunday and her primary care provider's office was not open. It is possible that if she had been admitted during the week that a transition of care record could have been created by her primary care provider and shared with the hospitalist who was caring for my mother. My mother's mental status and her physical exam findings were very different on admission than at the time of her last encounter with her primary care provider. If the hospitalist had been aware of these critical changes in her status perhaps the impending sepsis could have been identified and treated sooner.

Inaccurate medication reconciliation
The third error was inaccurate medication reconciliation at the time of my mother's hospitalization. My mother had an up-to-date list of her medications that she brought with her to the hospital ER on her first encounter with the emergency room but at the time of the second encounter her condition had declined and she was less clear on her medications. In the days leading up to her hospitalization her primary care physician had made some changes to her medications. The lack of a concise listing of medications was unfortunate as her mental status changes were initially attributed to drug interactions rather than impending sepsis. If an up-to-date medication list had been requested from her primary care office it is possible that the correct diagnosis would have been made sooner. It is very important that ambulatory and acute care facilities share information during transitions of care. Increasingly across the United States, hospitalists are caring for patients on behalf of primary care providers. I use the services of hospitalists, as does my mother's primary care physician. I have implemented the following practices to ensure that my patients receive the best possible transition of care.

Best Practices for Optimal Transitions of Care
When a patient contacts the office by telephone or my cell phone after hours and it is deemed that going to the emergency room is the best plan of action, I complete the following steps:

- Create a telephone encounter in the EMR, explaining the present illness
- Create a transition of care referral
- EMR generates a summary of care record
- Fax all of the files to the hospital emergency room
- Call the emergency room and speak to the staff to alert them to expect a fax on my patient and to call me back if they do not receive the fax
- This last step is very important because frequently the fax will fail and the files will have to be resent to a different fax number.

There are times when my patients will present to the hospital without my knowledge. I have requested that the hospitalist service contact me when my patients are admitted but sometimes this does not happen.

When a patient is seen in the office and it is deemed that the patient needs to go to the emergency room the same steps are followed and in addition I will also request to be transferred to the clinical staff in the ER to give my impression of the situation.

When a patient is seen in the office and it is clear that the patient needs to be admitted to the hospital I complete the following steps:

- Complete the office encounter, print it out and hand it to the patient to bring to the hospital and give it to the nurse on admission
- Contact the hospitalist service by phone and determine which provider will be responsible for admitting my patient
- Discuss the case on the phone with the hospitalist.

The potential for health information exchange to improve transitions of care
A more optimal situation to deal with transitions of care between ambulatory and acute care facilities includes implementation of Health Information Exchange Service Provider (HISP) to HISP exchanges between ambulatory EMRs and hospital information systems. Unfortunately HISP to HISP exchanges are in limited use across the country. Widespread participation in health

information exchanges that allow for the sharing of ambulatory EMR generated files with emergency rooms or hospitalist services and emergency room test results with the patient's primary care physician's would be an additional way to improve transitions of care. Currently in my medical practice, we will continue to utilize multiple mediums to capture the necessary data to ensure that our patient's transitions of care are as effective as possible.

In closing, I have learned much in life and now in death from my mother. I will continue to be ever vigilant for my patients who have a change in their medical condition that requires them to seek care in a hospital. I will make sure that I review information in a timely fashion and communicate effectively with the emergency room physicians and hospitalists who care for my patients. I will continue to advocate for the advancement of health information exchange in the United States to insure that the most up to date information is available at transitions of care and hopefully prevent other untimely deaths.

In loving memory of Betty Volm.

Telemedicine Benefits and Risks

By Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor

ProAssurance. Treated Fairly

The healthcare landscape has changed radically in recent years. Implementation of the Affordable Care Act, expanding roles for nurse practitioners and physician assistants, meaningful use, and ICD-10 preparation are just the highlights. But one change that often gets overlooked is the rapid expansion of telemedicine.

Forty years ago hospitals used a form of telemedicine to reach patients in remote areas. Triaging a patient over the phone is, after all, just another form of telemedicine. Modern technology has opened up many new avenues for patients and physicians to communicate. Today telemedicine encompasses a vast array of services offered by virtually all medical specialties. Telemedicine is defined as "the ability to provide interactive healthcare utilizing modern technology and telecommunications." It includes interactive video, home monitoring devices, scanning and emailing photos, and myriad other ways physicians and patients can communicate without a face-to-face interaction.

Telemedicine is expanding not only by volume, but also by services offered. In 2013, a consulting firm estimated worldwide telemedicine use would grow by 18.5% per year through 2018. Another source opines that the United States telemedicine market "will grow from $240 million in revenue in 2013 to $1.9 billion in 2018"—an annual growth rate of more than 50%.

Telemedicine not only could increase revenue, but also decrease spending. One study revealed a health insurer saved approximately $10 million over six years using telemedicine. The study followed 3,000 congestive heart failure patients receiving in-home monitoring of weight, blood pressure, heart rate, and pulse oximetry. Readmissions dropped by 44% for these patients, boosting savings. Although this study represented a small sample size, the savings realized were significant—just using common telemedicine tools. As telemedicine expands and services become more accessible, cost savings presumably will grow.

Drivers

Several factors are driving the telemedicine explosion, and convenience may be the biggest. A patient can sit in their living room and consult with a dermatologist who can view the problem area. A cardiologist can review monitor readings from their office while the patient is at home. Diabetics can check blood sugar levels and upload the results for their physicians to monitor.

Cost effectiveness makes telemedicine an attractive alternative to traditional healthcare models. Telemedicine allows physicians to consult with more patients within a smaller timeframe. This increases revenue for the physician, saves patients money on travel expenses, and decreases patients' time away from work and family.

Consultations also can be more efficient for all parties involved. Rather than sending x-rays or medical records to another provider through the mail, images and documents can be sent electronically. The consulting physician can conduct an electronic visit with the patient. This convenience decreases the potential for noncompliant patients (especially with regard to specialist follow-ups), saves time, and increases physician-to-physician collaboration.

Rural communities with limited means to access healthcare still benefit from telemedicine. Someone living 200 miles from the nearest urban area needs to see a dermatologist, but does not have the means to travel the requisite distance. Telemedicine offers that individual an opportunity to speak with a specialist through a computer screen. These patients may end up being treated for something within a couple of days—even hours—for an ailment that, 20 years ago, may have gone undiagnosed for several years.

Drawbacks

While technological advances have helped drive telemedicine, technological failures can be one of its biggest drawbacks. Networks are subject to interruptions, delays, system overloads, or other technical difficulties. Because telemedicine is wholly dependent on working technology, its effectiveness is severely hampered when technology fails.

Privacy, security, and confidentiality are other potential problems. Even when healthcare providers take necessary security precautions, hackers may still access electronic communications—and HIPAA extends to the patient's living room. It's important to take necessary precautions to ensure telecommunications are as protected as possible. Use encrypted emails, consult with cyber-security experts when setting up your telemedicine practice, and develop a well-written consent form that addresses the risk factors of telemedicine.

It also is important not to overlook physical interactions between physicians and patients. Sometimes patients need a physical exam for an effective diagnosis (e.g. broken bones). Seeing patients in person helps establish a trusting, cooperative relationship that may be challenging to build electronically. Both parties may be more engaged if conversations are conducted in-person. This may be less of an issue if you only use telemedicine for established patients. It is still a good idea to suggest an annual in-office examination.

Mobile Apps

Mobile app use is booming. According to one estimate mobile app revenue will reach $13 billion in 2015, with a compounded annual growth rate of 40% over the next six years. The implications are equally enormous.

In January the FDA approved an app for glucose monitoring via a mobile device. This app allows healthcare providers to track patient glucose levels via a smartphone or tablet.

Mobile apps can be used for anything from monitoring patients remotely to facilitating physician/patient communication. A brief review of cardiology related mobile apps revealed several that allow physicians to demonstrate, illustrate, or show videos to patients to help explain certain conditions. Mobile apps also can provide decision support for physicians or help with diagnoses.

Dermatology apps can help patients track moles and other skin lesions to document changes. One app, developed by University of Michigan physicians, includes a skin cancer risk calculator. Another dermatology app claims to be 70% accurate in predicting the severity of a mole; dermatologists are about 85% accurate according to the same article.

Risk Management Considerations

Increased availability and real-time data are key telemedicine benefits. But while these two factors seem to foster patient/physician communication and nurture that relationship, they also may increase your risk exposure.

If you offer electronic availability to your patients, consider how it could negatively impact you when something doesn't go as planned for a patient. A plaintiff's attorney could present to a jury your claim to be available, and then state the patient didn't receive the type of response promised. The attorney could assert your failure to be immediately available directly led to the patient's negative outcome.

Real-time data also can present challenges. On one hand, it may increase your effectiveness as a healthcare provider. However, it also can create professional liabilities, particularly in the event of a claim. Consider: If you receive real-time blood sugar results from a patient and fail to notice a large spike or depression, could you be held liable for a negative outcome? A juror might look at this information and ask, "Why didn't the doctor notice this sooner?"

These examples highlight the importance of full disclosure and informed consent when it comes to telemedicine. It is important patients and healthcare providers are aware of both the advantages and limitations telemedicine presents.

Services providing online consultations to the general public, like "HealthTap," "InteractiveMD," or "MYidealDOCTOR," are another area of liability concern. While these sites are great for patients and provide immediate access, physicians need to consider certain risks before participating:

- Are you licensed to provide medical care in the state the patient is contacting you from?
- Are you required to be licensed in the state the patient is contacting you from?
- How can you track and follow up with patients if necessary?
- How will calls be documented?
- If a liability claim arises, in which state will you have to defend yourself?
- How can you verify treatment recommendations?
- Will your service provider be involved in any way if you have a claim filed against you? (Review your contract with your provider.)
- Does your state's medical board prohibit this practice across state lines?
- Does the patient's state prohibit this practice?
- Are you allowed to prescribe any medications?
- Is the service HIPAA compliant?

Before entering into any agreement, be sure to thoroughly research and consider all of the pros and cons. You also may wish to consult with your insurance agent to determine if your current policy covers internet-based services.

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