

THE MARYLAND

familydoctor

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The official journal of the Maryland Academy of Family Physicians

CONTINUING TO WEATHER THE STORM.... PERSPECTIVES ON THE HEALTH CARE REFORM DEBATE

What Will It Take to Fix Maryland's Health Care System? ...One Opinion

Fight Back... Have You Dropped Your Lowest Payor This Year?

Health Care Reform: Planning Now for Practice Later

Members Weigh In on the Debate

ALSO...

AAFP Positions on
Health Care Reform

Summertime Was FM
Time for Interested
Medical Students

2009 Assembly: A Look
Back...and Ahead to 2010!



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“The Last of the Mohicans” The Vanishing Traditional Family Practice in Maryland

by Elizabeth G. Schlenoff, M.D.



AS THE YEARS SINCE I last voiced concern about bad things on the horizon for Family Medicine in our state have quickly passed, the “storm” we are trying to “weather” has become, in turn, a rain shower, a downpour, a hail storm, a blizzard and now (in the midst of national controversy) a blinding fog. Maryland family physicians are the penultimate example of how sound and simple ideas can be twisted and obscured, until they cannot be recognized by even their authors (see Summer 2006 edition “Weathering the Storm” at www.mdafp.org or contact the MAFP office for a copy; upon availability, at 410-747-1980 or info@mdafp.org).

Thanks to Dr. John Shutta, the 2006 edition of the “survival” series included a member survey, which he instituted and which was conducted in the fall of 2005. It brought into stark focus the very real possibility that Maryland was in big trouble even if retention and replacement of its family physician work force could hold on for a mere five years. It further clarified that our state had much lower reimbursement than the national average. The former president of MedChi, Dr. Ronald Sroka, a family doctor, wrote in his President’s Message in the Fall 2008 edition of *Maryland Medicine* of the urgency to act

My deep and abiding concern is that our supply of family doctors is so low (quoted at 40,000 in primary care nationwide this year) that even with favorable, sweeping reform in our interest, it is too late to build our base numbers up to the 50 percent of all American physicians needed to make the oft politically discussed “health care delivery system” possible.

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to correct the “toxic environment for our profession.” Another recent article quoted Baltimore primary care physicians as the worst reimbursed in a national study of more than 100 major U.S. cities, with two other Maryland cities in the bottom five.

Time and time again, I see the astonishment on the faces of our Academy leaders when they hear from us about our uniquely onerous condition. Many of my closest colleagues from the Maryland Academy (more each year) have retreated to positions that are purely administrative or limited (such as “boutique” style) practices, or are skipping to other states in order to unite practice satisfaction with financial comfort. I added and continue to add additional services to my traditional practice that carry a cash incentive. I do this in order to avoid bankruptcy, not to put cash in my pocket. I, not unlike Dr. Sroka, have been forced to eliminate employed associates because the reimbursement I could offer them could not compete with other model options. Solo practice for 7,500 patients in addition to ancillary work has made me an absent spouse and parent, an unhealthy person (after 30 years I no longer have time for exercise, let alone sleep) and, for the second straight year, without a dime in personal salary. As quoted by another attendee at MAFP’s 2009 annual conference, my medical practice is my very expensive hobby (You might check out an article featuring my various endeavors to be published in the Dec 2009, *Baltimore Business Journal*.)

So why do we do it? Why do family doctors stay in Maryland and endure hardship and humiliation? In fact, why would any medical student choose this specialty at all, even to practice in another state? There can be only a few answers, and they include sheer stubbornness, the fantasy that new horizons in health reform will rescue us soon, masochism or, my personal favorite, true and undying

love and passion for what we family doctors do!

Unfortunately, our dwindling numbers nationally and locally reflect the reality of a crisis larger than our own. My deep and abiding concern is that our supply of family doctors is so low (quoted at 40,000 in primary care nationwide this year) that even with favorable, sweeping reform in our interest, it is too late to build our base numbers up to the 50 percent of all American physicians needed to make the oft politically discussed “health care delivery system” possible. I long to crash through my TV set screen and into a room of Washington committee members and scream “You cannot reform what does not exist!”

I recall the uplifting words of Academy president Larry Fielding a few years ago when he referred to a group of federally funded studies designed to solve the mystery of why our nation spends phenomenally more money on health care than any other nation, yet we are embarrassingly low in our international ranking of healthy nations. To my best recollection, he stated that of all studies combined, the only consistent variable derived from the collection was that the health of a given population is dependent on the number of primary care doctors per capita.

My fear is that by the time our legislated brave new world becomes reality, there will be precious few of us still in the trenches to pass our years of collected wisdom on to new recruits to our specialty. My patients also share this fear. When I finally disengaged from United Healthcare this year, my former patients reported that very, very few Maryland primary care doctors accepted it, and most ended up going a few miles up the road to Pennsylvania to find an open practice. Even then, the average wait to be seen as a new patient was well over four months. Many of these stranded (and sick) patients have been paying out of pocket to see me either as an interim measure or because

the ‘cattle chute’ treatment they received elsewhere was so unsatisfactory they were willing to pay for the kind of care on which they had come to rely.

I was asked by one of the physicians who interviewed me for University of Maryland Med School in 1973 whether I would still chose the field of medicine if medicine became socialized in this country. Taken by surprise, I simply blurted out “Will I still get to take care of patients?” I guess the answer was good enough.

For those of you who still want to ‘take care of patients’ in Maryland, my hat is off to you. For those of you who remember when that took up all but a tiny part of your practice day, I weep with you. For those of you who are choosing to practice the kind of Family Medicine that truly serves your communities, the way you were trained and to the fullest of your abilities, I rejoice with you. For the students who still ignite with excitement and passion as they plan their family practice, I salute you and your courage.

My cell phone is available 24 hours a day. Mr. Obama, please call me! I want you to know that given half a chance, the family physician is the answer to health care in this country. Patients know we are their advocates, their friends and will stand shoulder to shoulder with them to fight for their health, even if this comes with great personal sacrifice.

Please Mr. Obama, don’t let family physicians become the “Last of the Mohicans” of American medicine! Do this for the sake of all Americans. Do not be swayed and distracted by political interests or power. Help us leave this storm behind us and emerge into a climate that fosters our special skills and commitments to “relieve pain and suffering,” such as we promised in our oath. ■

Dr. Schlenoff is a long-time member of the MAFP Editorial Board. She edits this, her 4th edition. Her solo practice is in Monkon.

executive director



Maryland Chapter Hosts the 2009 Southeastern Family Medicine Forum

by Esther Rae Barr, CAE

THE MARYLAND ACADEMY OF Family Physicians was pleased and honored to serve as the host chapter for the 2009 AAFP Southeastern Family Medicine (SEFM) Forum held August 20-22, 2009, at The Historic Inns of Annapolis in Maryland's beautiful capital city. Joining the Maryland Chapter's representatives were chapter leaders and executives from the Alabama, Georgia, Florida, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, South Carolina, Virginia and West Virginia chapters. Also attending were senior leadership and staff of the American Academy of Family Physicians. They included AAFP EVP and Past President Dr. Doug Henley, Board Member Dr. David Avery and Vice Speaker Dr. John Meigs. We are excited that such an illustrious group convened in Maryland!

The Southeastern Family Medicine Forum meets annually to discuss problems and successes of mutual interest, share concerns and express ideas for the purpose of avoiding duplication of efforts, learn what is working and bring to the fore specific issues in the region. Discussions are generally

related to chapter administration, research, education, residency training, legislation, funding, economics and other issues affecting the specialty of Family Medicine and AAFP chapters. The annual meeting is structured but informal to permit open discussion and exchange of ideas.

In 2006, Maryland Chapter representatives attended, as guests, in St. Augustine, FL. The chapter joined the group in 2007 with the understanding that we would host an upcoming annual forum meeting (rotates annually among the current 12-chapter group). Subsequently, we attended the 2007 and 2008 Forums in Asheville, NC and Roanoke, WV respectively. The 2010 meeting is set for Nashville, TN.

The 2009 program was timely, pertinent, informative, interactive and well-received. It included topics on health care reform, advocacy, family physician workforce, rural health issues, the Patient Centered Medical Home, disparities in health care, Family Medicine education, funding of CME programs and round-table discussions on a variety of areas focusing on chapter operations. We had a good mix

of presenters and were fortunate to have several sponsors. The social event was a hit (dinner cruise on the Severn... weather cooperated nicely!)

A special highlight was the appearance of Dr. Alexander Dobbs, who in his presentation "Colonial Life & Colonial Medicine," discussed his childhood and medical training, his service to General George Washington's army, what it took to be a physician/surgeon and the state of medical practice in the late 1770s. History buffs in attendance were especially taken by Dr. Dobbs, whose presentation was informative and entertaining. He succeeded in captivating the audience. Dr. Dobbs is portrayed by MAFP member Dr. N. Joseph Gagliardi.

Many thanks and special acknowledgement to the conference planning committee; MAFP President Dr. Yvette Rooks, who expertly MC'ed the event (along with AAFP Chapter Affairs Manager Nancy Fisher); Dr. Bill Hakkarinen; and Dr. Jos. Zebley. The Maryland Chapter met its goal... doing itself proud as 2009 SEFM Forum host. ■



MAFP's own Phay Goods and The Magestic Notes perform during the dinner cruise.



At the 2009 SEFM Forum welcome reception: (l-r) Dr. John Mitchell, Dr. Yvette Rooks, Beth Embry, April Bass, E. Caroline Mason and Dr. Bill Hakkarinen.



AAFP Executive Vice President Dr. Doug Henley brings the group up to date on AAFP's position and activities relative to health care reform.



18th Century physician and surgeon Dr. Alexander Dobbs was our special presenter during the 2009 SEFM luncheon.



What Will It Take To Fix Maryland's Health Care System?

by John A. Shutta, M.D.



MARYLAND'S FAMILY PHYSICIANS HAVE the lowest published median income in the nation at \$103,400, according to MDAFP's November 2005 survey. In 2000 we had four residency programs turning out 33 trained FPs per year. Most of our graduates stayed in Maryland to practice Family Medicine. Holy Cross and

Prince Georges County Hospitals have since closed their programs and University of Maryland downsized to eight residents per year. Franklin Square Hospital also has eight residents per year for a current total of 16 residency trained grads per year, or less than 50 percent of just nine years ago. In 2007, we only matched for three of those 16 slots.

What happened? Most of Maryland's population, and thus its physicians, are concentrated in the Baltimore – Washington D.C. suburbs. Rents and office staff salaries are typically in the 80+ percentiles, consistent with most other large cities. Outlying counties have to compete with these salaries. Maryland's private health insurance industry is dominated by two payors whose pay scale for physicians is in the 22nd percentile nationally. Primary Care gets squeezed most since each claim is relatively small compared with those of the specialists. Our grads typically accumulate an average of \$150,000 in medical school debt. They can make that or more annually to start by choosing urgent care or hospitalist positions or by leaving the state. Only 15 percent of our medical school graduates go into primary care compared with 50 percent in other developed countries. They also have lower health care costs *and* better outcomes ...imagine that!

Current incentives available to Maryland doctors include 2 percent quality assurance bonuses to get that A1c below 7 percent; or LDL less than 100 in diabetic patients, for example; or \$44,000 in uncertain EHR grants paid out retrospectively as \$11,000 per year over four years if you meet certain functionality requirements. There is a move to offer student loan repayments to practice primary care in Maryland. However, when we're already earning \$40,000 less annually than the national average, this plan will only benefit those residents who are already committed to staying in the area for personal reasons such as family ties or spousal employment. It's

extremely difficult for smaller struggling practices to invest in EHRs or "medical home" implementation in this environment.

So what will work in Maryland? A 10 percent increase in perhaps 20 primary care billing codes will increase your gross paycheck by about 30 percent, assuming an average office overhead of 65 percent. Approximately 80-90 percent of your revenue is derived from your top 10 billing codes: 99213, 99214, vaccine administration, EKGs, physicals as well as initial and subsequent hospital and nursing home care, well woman and child care. How would a long overdue 30 percent raise affect *your* job satisfaction after 15 years of declining or flat revenue streams?

North Carolina medical assistance has implemented a \$2.50 per member per month care management payment to its primary care physicians. That may sound meager, but suppose that was implemented by all payors whose subscribers signed up for a primary care physician. If you have 3,000 active patients, that's \$7500 per month or \$90,000 extra revenue per year! That will go a long way toward purchasing an EMR, transforming your practice into a 'medical home' model, college tuitions and job satisfaction.

At the time of this writing, House bill HR3200 offers primary care physicians a 5-10 percent increase in Medicare payments in 2010, a revision or appeal of the sustained growth rate formula (scheduled to cut your Medicare payments 21 percent in 2010) and provisions for promoting the 'medical home' concept and making primary care more attractive to medical students. The AMA and AAFP have expressed support, with some reservations and recommendations. There are no provisions for tort reform (which would likely result in the death of the bill at the hands of the legal profession) and HR3200 would likely cost billions until there are enough primary care physicians to minimize all the additional urgent care and emergency room visits by newly insured patients. Massachusetts, the first state to mandate "health care for all," is currently experiencing these problems and major budget deficits. However, HR3200 will go a long way toward bringing primary care recruitment and incomes closer to that of the specialists, and it will bring the private payors to the table to boost your revenues and help you afford EHR and "medical home" conversions.

We need to show our support for this bill. ■

Dr. Shutta has been in the private practice of Family Medicine in Frederick County, MD, for 24 years. He serves MAFP as its current treasurer and editor of the monthly MAFP E-Bulletin.



Fight Back...Have You Dropped Your Lowest Payor This Year?

by John A. Shutta, M.D.

IN 1999, THE CEO of a major health insurance company when interviewed by a financial magazine was asked how he made so much money consistently for his shareholders. He said, quite simply, that he takes advantage of the fact that doctors are poor business people and they don't want to terminate relationships with their patients. You know, for the most part, he's right! He makes \$30 million a year to do that. I would add: doctors are forbidden by law to discuss fees or to collective bargain to level the playing field.

So are we part of the problem? Could we be responsible for the low rates we complain so much about? When was the last time you negotiated a 3 to 6 percent annual increase from a third party payor? If you have an office manager, do they do this annually for you? With each insurer? If the laws of supply and demand really do work and family doctors really are in short supply in Maryland, why aren't we at the top of the national family physician

Typical excuses to not negotiate are time constraints, not knowing how to go about it or "My insurers won't negotiate with a small practice." My response is: So you'd rather work harder for less money?

As a solo practitioner, my office manager and I review and negotiate my contracts annually. Typically, 80 percent of our revenues are derived from only 10 or so CPT codes: 99213, 99214, 90471, 90472 and others, depending on your practice's age range, gender, whether you do EKGs, well child care, adult physicals, well woman exams, hospital rounds, allergy shots, procedures, etc. Your billing staff can help you list them. Then ask your billing staff or office manager to list the amount that your insurer pays you for each of those 10 codes. Include Medicare as a benchmark, or floor, and flag those that pay less than Medicare. It's a real eye opening experience. The low payors stand out like a sore thumb! Chances are they're the same ones for many of us. If

200 of their patients, a termination letter will generate a phone call within 30 days. If you don't hear from them within that time frame, call them and ask to speak with your provider representative and make sure they got the letter.

If you've never done this before, start small. Pick an insurer covering less than 10 percent of your patient base or revenue – one that you can afford to drop. And don't accept their first offer or a shifting of payments, i.e., they'll pay you more for 99213, but less for EKGs and physicals. Knowledgeable practices realize that an insurer doesn't just have one fee schedule for an area, but dozens due to negotiations with various practices. In fact, insurers will often offer you one of these next higher schedules to minimize the number of fee schedules they have out there.

Take the time to read your contracts before you sign them. This may sound tedious, but they are basically similar and after a few you'll be able to pick out the

If we all gave the same payor 90-days termination notice as intent to re-negotiate before the October-November open season... get the picture???

pay scale instead of at the bottom? Our Maryland Academy of Family Physicians' (MAFP) November, 2005, income survey placed us squarely at the bottom of every published survey, with a median FP annual income of \$103,400. We had an amazing response rate of 52 percent to our survey (survey results in the Summer, 2006, edition available at www.mdafp.org).

we all gave the same payor 90-days termination notice as intent to re-negotiate before the October-November open season... get the picture?

If you call the insurer to negotiate, they usually tell you they can't increase your rates at this time. If you're in good standing, however, i.e., cost effective, good patient reviews and have at least

bad terms. For example, never sign a contract that requires you to give more than 90 days notice to terminate. I've seen contracts with six or even 12 months notice provisions. Both accepted 90 days. Cross out the unacceptable terms with single black lines and make your changes and

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We are the specialty that truly cares about the patient and their family's physical, mental and spiritual health. Even governments realize that FPs provide that care in a very cost effective way.

initial them in the margins. The American Academy of Family Physicians (AAFP) and MedChi legal departments have already reviewed many of these contracts and are usually willing to discuss recommended changes with you, if you are a member.

On the flip side, does the insurance company care about an individual patient? Would *they* be sending you and the patient reminders for annual mammograms, colonoscopies over age 50 and expensive immunizations if they weren't mandated to track these parameters and submit their annual "score" to the federal government? We are the specialty that truly cares about the patient and their family's physical, mental and spiritual health. Even governments realize that FPs provide that care in a very cost effective way. That's why other countries are more cost effective with health care dollars and have better outcomes. Fifty percent of their physician workforces are primary care doctors! Keep up the quality care you provide your patients every day, but negotiate your contracts! You must be part of the solution, not part of the problem. ■

Dr. Shutta has been in the private practice of Family Medicine in Frederick County, MD, for 24 years. He serves MAFP as its current treasurer and editor of the monthly MAFP E-Bulletin.



Health Care Reform: Planning Now for Practice Later

by Merrell R. Sami, M.D.



HEALTH CARE REFORM IS an impending change that will affect every Family Medicine resident in training today. An informal survey of the residents in our program revealed recognition of a need as well as an expectation for some form of change

in the near future. Change, however much needed, is anticipated with anxiety, both by this resident and others. Contributing to this anxiety is continued limited access to health care, decrease in quality of care, difficult practice choices and imminent medical school loans. As with any fear, the key is to face it, understand it, then deal with it. To face the potential change to come is the only choice for any physician who wishes to practice in the United States of America, so it is more productive to move on to understanding.

The proposed federal reform legislation is difficult for residents and patients to understand, especially in the original, convoluted and very specific proposed letter of the law. After reviewing a comparison published by the Kaiser Family Foundation, it seems that the proposal offered up by the Senate HELP Committee and the House Tri-Committee share the same spirit of change

to entice them to reduce their rates, thus allowing for more people to afford insurance.

Once this affordable, competitive system is in place, it is proposed that the way to enforce its purpose is to penalize those who do not choose coverage through one of these options. This penalty would apply to individuals and businesses that can afford but choose not to be covered or provide coverage. The penalty would then be directly invested in a general "pool" to cover the health care costs of those who are not insured.

The current debate for and against this plan is often framed by political, economic and social justice perspectives, all of which add to the discussion but are lacking in the detail of practical application in the daily lives of patients and the physicians who care for them. So, while in theory the current plan makes sense, its nature is reactive and hence begs an alternative analysis/solution method, such as problem-based critical thinking.

Problem-based critical thinking is a skill that every physician learns in medical school. It is most often applied in Family Medicine because no other specialty manages multiple problems of a single patient simultaneously. Since problem-based critical thinking is what we do every day with every patient, we should address the issue of health care in the same manner; breaking it down into its elements and treating the cause(s) in order to eventually get a favorable result.

Since problem-based critical thinking is what we do every day with every patient, we should address the issue of health care in the same manner; breaking it down into its elements and treating the cause(s) in order to eventually get a favorable result.

and even the overall philosophy of how to bring about much needed reform. The universal goal of both groups is to provide each American with health care. The way they have agreed to do this (except for some differing numbers for various cutoffs) is by setting up a "state-based American Health Benefit Gateways" program that will essentially function as an affordable health insurance company and would potentially allow small businesses and individuals to purchase coverage. This program is also meant to be competitive with established insurance companies in order

A shared concern by government, physicians and patients is the cost of health care. According to the National Coalition on Health Care, we, as a nation, have decided to spend 16.7 percent of GDP on health care in 2009. As physicians, we have learned to flinch at the word "cost" because it implies that somehow money is being prioritized above the well-being of the patient. Rather than flinch at the word, however, we as primary care providers

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should quantify and redefine it. After all, cost is a most compelling measurement when it comes to health care reform legislation.

Factoring cost into the context of the daily workings of primary providers and patients reveals many of the deficiencies of our current system, such as:

- Too many emergency department visits for preventable disease due to lack of access to preventive routine health care by primary care physicians = increased cost of health care.
- Too many patients getting their primary care through the emergency department due to shortage of primary care physicians as well as access through insurance = increased cost of health care.
- Too many tests leading to too many more tests which result from lack of coordinated primary care = increased cost of health care.

The common theme among these issues is too much misuse of very good resources due to lack of appropriate prevention and coordination of care. Although we are spending a lot of money on health care because it is a priority of the American people, we have created a system that is too expensive to be sustained in the long run, leading to decreased access to more and more Americans. From the perspective of this family physician, the course of our current system flows as follows:

- Too few family physicians = decreased coordination of care = multiple repeat tests by specialist = increased cost.
- Too few family physicians = lack of access to preventative care = emergency department visits.

These deficiencies keep us from our goal: providing all individuals with affordable access to preventive, well coordinated care. Affordable does not necessarily need to be free, nor does it need to be government run; however, it might mean government regulated, at least for a time. The current system is laden with good resources, such as specialists and advanced diagnostic and therapeutic technology, which are both inefficiently overused. This inappropriate use of resources is leading to the public assistance programs becoming too expensive to be sustainable by the government. Compounded with these costs are high overhead costs placed by the current private insurance industry, making coverage too expensive to be affordable for a lot of Americans. And the result is too many people without access. Although competition might work, the ideal solution might need to be more direct.

The key to a sustainable change may be in the purse strings of the health care industry, some of which are pulled by the government through taxes and tax breaks. It is possible for the government to pull these strings to entice insurance companies to cover more of the population, leaving the number of uninsured low enough to be a sustainable burden on the government. Insurance companies could receive tax breaks for offering a certain minimum percentage of their customer base lower cost insurance on the basis of income levels (lower income/no income families who would otherwise be covered by Medicaid) or age (elderly patients who would otherwise be covered by Medicare). With Medicaid and Medicare spending on the decline due to the sharing of the responsibility to insure the lowest income Americans, the government can then offer financial incentives to participants who might need a little subsidizing to afford the more affordable plans, as well as to physicians who provide intensified preventive and coordinated care according to an objective set of standards (i.e., number of ED visits for patients for preventable causes of disease, appropriateness of diagnostic tests ordered, compliance with guidelines). With such a sustainable model of health care for Americans, the ever decreasing Medicaid reimbursement rates will cease. Without the threat of constant cuts in reimbursement, fewer family physicians will need to divide their time among other activities to supplement their income.

My biggest fear is not being able to provide my patients with the care they need to lead healthy lives, despite our many medical advances and great quality health care. My next biggest fear is not being able to practice as a family physician because I will not be able to afford it due to ever increasing reimbursement cuts. Both fears are rooted in a system that is currently broken because it fails too many and costs too much money. One logical answer seems to be to share the responsibility of coverage for Americans among those who are invested in the American health care system: physicians, insurance carriers, government and individuals, as opposed to just the government. There are several challenges to be overcome simultaneously, the toughest of which will be to continue to provide efficient and quality medical care and extended coverage. ■

Dr. Sami is a PGY1 at the Franklin Square Hospital Center Family Medicine Residency.



Members Weigh In on the Debate

by Esther Rae Barr, CAE

AS MANY MEMBERS MAY recall, in the fall of 2005, the Maryland Academy of Family Physicians (MAFP) conducted an income survey of its members. Generally, the purpose of the survey was to see where Maryland family physicians' income levels stood in relation to published national averages (from AAFP and other sources). The survey response rate was remarkable, with 52 percent of active members responding (average is about 10-15 percent). The data collected was telling, indicating that as bad as it is nationwide, it's worse in Maryland!

MAFP's survey results factored into the workforce study contracted a few years back by MedChi and the Maryland Hospital Association. That study led to the creation of the Governor's Task Force on Physician Workforce and Reimbursement, which reported its recommendations to the Maryland General Assembly during the 2008 legislative session.

The 2005 survey results were published in the summer 2006 edition of this publication. With the general theme "Weathering The Storm," the edition was edited by MAFP Editorial Board member Dr. Elizabeth G. Schlenoff. The edition is posted at www.mdafp.org, or readers may contact the MAFP office for the article (410-747-1980 or info@mdafp.org).

Continuing to Weather the Storm

With the U.S. political shift, along with all that has occurred in the health care arena and calls for system reform, the MAFP Editorial Board felt it time for an

update edition, thus this fall, 2009 publication, edited again by Dr. Schlenoff. At the time of printing, the debate was beyond "heating up"... it was "white hot!" Because the climate is changing quickly, some of what you find here may be dated upon reading.... we'll do our best to keep members up-to-date with intermittent broadcast e-mails and the monthly E-Bulletin (also posted at www.mdafp.org).

Members Weigh In

One nice byproduct of the volumes of information being transmitted to members from AAFP and MAFP is that family docs are "talking" to each other and contacting the Academy. MAFP happily provides a vehicle for member-to-member communication. With the permission of the authors, I am sharing comments from several members reacting to AAFP's positions and expressing their views on the various primary care aspects of federal health care reform legislation (pending at this printing with the recent report that any action on the legislation must occur by December 31, 2009). See p. 15 for AAFP's late-summer position paper. What are your thoughts? I and MAFP leadership would like to know.

Printed in order of receipt:

My truncated views on the current bill are the following as it relates to the primary care provisions:

1. *Support for the payment incentives to primary care providers especially those in resource poor areas. Although not large sums of money other specialties*

are likely to see their re-imburements drop.

2. *Support the medical home project. This is an important concept that may be the future of medicine, and we need objective data to know how and if it will work.*
3. *Support the "Accountable care organization pilot." This would give us evidence-based information on how to deliver quality and cost effective care to patients. This evidence-based system could be utilized as a starting point for discussions and used as a bargaining tool on TORT reform. Practicing rational care could exempt physicians from litigation or panels of experts could judge cases based on guidelines, instead of malpractice today, which is based on emotion and ignorance.*
4. *Fully support the Teaching Healthy Centers as a way to recruit and train more FM physicians and provide superior care to our patients.*
5. *Support the "Goal of Primary Care workforce training." We need to place a major emphasis on this, especially on the value of family docs compared to the other branches of health care providers.*

Greg Taylor MD, Baltimore

What's the rush? Why would anyone want to make decisions about one fourth of the economy without due diligence. At this point it is impossible to do due diligence without the

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information. Clearly, we need changes in the system. Correcting the insurance problems, pharmaceutical problems and the mal-distribution of physician payments along with tort reform will correct the vast majority of the current problems. Do you think that the populace would be interested in the program if they realized that the program will cover the illegals? Additionally, any illegal who gets here gets covered. Adding 10 to 30 million to the insured rolls without additional primary care physicians will, at least, strain the system and, at most, collapse the system. Remember, the budget bill already established the Office of Medical Information Technology, which is going to be tasked with monitoring medical records to be sure that patients receive the care deemed best by your federal government. Lack of funding will dictate the level of care allowed.

Why not lay the entire plan out before the public, including physicians, and allow comment, discussion and molding of the bill to fit the 'real' needs of the people. That is real democracy.

Bill Jones, M.D., Davidsonville

Bravo Greg. I really like your idea on expert panels for tort reform. It would be nice if this were part of any government option.

Bill, thanks for your comments. I don't mean to blame people, but I really believe the number one driver of health costs is our lifestyles - overweight, smoking etc. If we don't come up with creative ways to address our destructive behaviors, no plan will succeed.

My personal obsession is teen pregnancy. So many of our social and budgetary

problems (medical assistance, crime and corrections, public school problems) could be solved if we could get a handle on this. I work with my adolescent patients, but its a drop in the bucket.

Ken Kochmann, M.D., Cockeysville

Since a few patient's daily ask me what I think of the health care debate, I'm attempting to read through the 1018 pages of House Bill 3200. I'm currently stalled at page 432. One initial observation is that this bill is going to provide coverage for preventive health services, but only those that are grade A or B from the "task force for clinical preventive services" or vaccines or those things appropriate for medical assistance recipients (page 28 initially, then page 765). It goes on to describe on page 937 that this task force is renamed the "US Preventive Services Task Force." So I'm assuming they are going to follow the same guidelines they presently do. If that is the case, according to this bill, there is no mention for screenings that have a C, D or I rating. Not that I think that anyone should be doing D rated screenings, but many I and C rated screenings that are otherwise recommended by other groups are excluded from coverage in this bill.

These include PSA/ prostate cancer screening, skin cancer screening or counseling, Diabetes screening, except for those with high blood pressure, iron deficiency screening in infants 6-12 months of age, counseling or behavior modifications to promote weight loss, osteoporosis, screening for those less than age 60, Glaucoma screening, COPD screening with spirometry, testicular cancer screening in young males, lipid disorders in young children, speech or language delay screening in children less than age 5, counseling about the use of seat belts, lead screening in children age 1-5.

The problem with this approach is that the task force and government in general are going to have a problem keeping up with the changes in medicine in a timely way.

Joseph K. Weidner, Jr. M.D., Rising Sun

My view is that there are many things that are not perfect about the bill that is emerging in Congress. Certainly it could use improvement. (For example, I would love to see tort reform addressed.) However, universal access is by far the most important health reform we need, and it is vital that we stand behind that goal.

As a family doc working in a community health center in Howard County (Maryland's wealthiest county), I see scores of patients each month who have no insurance, many have significantly poorer health because of it. I find it truly shameful that a country as rich as ours does not assure health care access to its citizens, as almost all other first world nations do. No one should have to choose between bankruptcy and needed health care. Furthermore, a civilized society should protect the health of its people by promoting early evaluation and treatment; far too often our system results in illnesses that have progressed to advanced stages, requiring emergency treatment.

I sincerely hope that we as family physicians recognize that this is a vital moment in history, and that the opportunity to achieve universal access may not come again for decades. I am also hopeful that we will not allow our concerns about the imperfections in the bill to prevent us from strongly supporting its progress. We need to be squarely on the side of patients on this one, and that means standing up for universal access.

Kerri Alperovitz-Bichell, M.D., Annapolis ■



AAFP Positions on Health Care Reform

THE AAFP GOVERNMENT RELATIONS and AAFP Communications Committees have compiled the following information into one document as a resource for you and your members. Please note that in addition to this summary, links are provided to more in-depth Academy information. Remember that legislators value, and are swayed by, powerful patient care stories from physicians in day-to-day practice.

Where the AAFP Stands on Health Care Reform

The AAFP believes the key to designing a new health care system is to reemphasize the centrality of primary care by:

- Increasing payment for primary care services;
- Redesigning the manner of primary care delivery modeled on a patient-centered medical home;
- Aligning financial incentives to support this system; and
- Reinvigorating the primary care workforce.

Health Care Coverage for All

In response to a directive from the 2005 Congress of Delegates, the AAFP Board of Directors appointed a task force to update the Academy's health care coverage for all policy (adopted in 2007).

The report (http://www.aafp.org/online/en/home/policy/policies/h/health_care.html) lays out the following principles:

- Everyone should have health care **coverage**, including catastrophic protection;
 - Everyone should have a **patient-centered medical home**; and
 - Health care should be a **shared responsibility** of individuals, employers, government and the private and public sectors
- Coverage

Everyone in the United States should have health care coverage. This will be achieved only if Congress enacts legislation requiring health care coverage for all, with a primary care benefit design featuring the patient-centered medical home and a payment system to support it.

Patient-Centered Medical Home

The patient-centered medical home, as described in the Joint Principles of the Patient-Centered Medical Home (<http://pcpcc.net/content/joint-principles-patient-centered-medical-home>), should be the basis of the health care system. Patient-centered medical homes will be designated by a process such as the Physician Practice Connection – Patient Centered Medical Home

(<http://www.ncqa.org/tabid/631/Default.aspx>) recognition program of the National Committee on Quality Assurance (NCQA).

Payment

The payment structure should be based on the following blended payment model:

- **Fee-for-Service**
Fee-for-service payments should continue for face-to-face visits. These payments will reflect the value of primary care services. (Payments for care coordination services that fall outside of the face-to-face visit, as described below, should not result in a reduction in payment for face-to-face visits.)
- **Care Coordination Fee**
Each practice designated by a patient as his or her medical home will receive a monthly per-patient fee for care coordination services. The fee will increase at each level of medical home designation. The care coordination fee will reflect the value of patient-centered care coordination provided by physician and non-physician staff outside of the face-to-face visit, and coordination of care within a given practice and between consultants, ancillary providers and other health care providers. The care coordination fee should: support adoption and use of health information technology for quality improvement and provision of enhanced communication access, such as by secure e-mail and telephone; recognize the value of physician work associated with remote monitoring of clinical data using technology; and take into account differences in each practice's patient population. Further, the payment model will be supported by better coordination of care associated through the patient-centered medical home.
- **Pay for Performance**
A performance-based payment will recognize achievement of quality and efficiency measures that are developed and updated with appropriate physician input.

Increasing Payment for Primary Care Services

Medicare should include a substantial primary care payment increase in 2010 as a powerful signal of its intent to transform health care around patient-centered primary care. We suggest that total Medicare payments for services provided by primary care physicians should be increased by as much as 10 percent on

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January 1, 2010, and then be followed by further annual increases in subsequent years.

(<http://www.aafp.org/online/en/home/policy/policies/p/physicianreimburs.html>)

Reinvigorating the Primary Care Workforce

In a primary care based system, workforce policies must ensure a strong cadre of family physicians, other primary care physicians and non-physician clinicians who are integral to a high functioning health care team. The U.S. must establish a national workforce commission to recommend the right numbers and distribution of physicians. Section 747 in the Public Health Service Act, the only federal program that trains family physicians (and other primary care providers), should receive \$215 million and there should be loan repayment and scholarship programs for those entering primary care. Graduate medical education should be changed to make sure the program pays for physician training in care management, working in teams, supervision of nursing students and quality improvement.

(<http://www.aafp.org/online/en/home/media/releases/newsreleases-statements-2009/merritthawkins-physicianshortage.html>)

Medical Liability

The current medical liability system fails both patients and health care providers. Liability reform must be equitable and it must quickly compensate those truly injured in the course of medical care, without needlessly diverting health care dollars.

By reducing liability insurance premiums and exorbitant legal fees associated with lengthy litigation, and by ending the need to practice defensive medicine, we can decrease the cost of health care.

(<http://www.aafp.org/online/en/home/policy/policies/p/professionalmedicaliability.html>)

Support for Choice of Public and Private Health Plans for Consumers

The AAFP supports including a public health plan option in health reform legislation. AAFP has consistently called for health system reform that ensures health care coverage for all and, to the extent that a public plan would ensure that – and adhere to several conditions for fair competition – the AAFP would accept a well-crafted public plan. A public plan option must compete fairly with the private insurance industry to ensure that patients have comprehensive, affordable health coverage. In order to maintain a level playing field among private insurers and a public plan, the AAFP calls for legislation that:

- differentiates the public option from Medicare and its payment rates;
- does not require physicians to participate;
- requires public and private plans to adhere to the same rules and regulations, including those that address reserve funds; and
- precludes a public plan from gaining unfair advantage in enrolling uninsured or low-income beneficiaries who would qualify for subsidies in the new marketplace.

(<http://www.aafp.org/online/en/home/media/releases/newsreleases-statements-2009/public-and-private-health-plans.html>)

http://www.newamerica.net/publications/policy/modest_proposal_competing_public_health_plan

Support for U.S. Senate HELP Committee Proposal

Statement by Dr. Ted Epperly, AAFP President, June 12, 2009

(<http://www.aafp.org/online/en/home/media/releases/newsreleases-statements-2009/affordable-health-choices-act.html>)

“Americans have talked about, criticized, pondered and worried about health care for more than two decades. Policy makers, economists, lawmakers and patient advocates have called for health care reform for more than 15 years. The introduction of the Affordable Health Choices Act marks the beginning of action. The American Academy of Family Physicians commends the Senate HELP Committee for crafting a proposal that promises to meet many of the nation’s health reform goals. This proposal would implement the most important elements of sustainable and meaningful health care reform: the use of the patient-centered medical home and an emphasis on preventive services and chronic care management.”

AAFP Response to Senate HELP Committee Regarding the Affordable Health Choices Act: (http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/aach062209.Par.0001.File.tmp/AAFPResponseToHELPCommittee062209.pdf)

Support for U.S. House of Representatives Health Reform Proposal

Testimony by Dr. Ted Epperly, AAFP President, before U.S. House Ways and Means and Energy and Commerce Committees – Week of June 22, 2009

(<http://www.aafp.org/online/en/home/media/releases/newsreleases-statements-2009/waysandmeansandenergyandcommercecommittee-testimony-epperly.html>)

“As the nation has learned through the years, simply paying for more of the same fragmented, uncoordinated, procedure-based

health care will not make us healthier and certainly will not contain the accelerating costs of health care. Thus, we believe that making primary care the foundation of health care in this country is critical.”

Such reform must redesign the way primary medical care is provided to patients by establishing a patient-centered medical home model that enables every patient to have a personal physician, aligns financial incentives to support such a model, and implements policies that ensure the adequacy of the nation’s primary care workforce.

To that end, the AAFP supports the provisions in draft legislation currently being debated by the Ways and Means Committee.

Among them:

- a health insurance exchange where Americans can one-stop shop for a private or public health care plan, compare benefits and prices, and choose the option that best meets their own needs;
- guaranteed availability and renewability of health coverage and the prohibition of preexisting condition exclusions and denials;
- required coverage for individuals and provisions that allow individuals to maintain their current coverage, if desired;
- elimination of the debt accumulated by Medicare’s sustainable growth rate;
- a 5 percent bonus for primary care services and up to 10 percent bonus for those services provided in health professions shortage areas;
- inclusion of comparative effectiveness research;
- graduate medical education policies that expand primary care training positions, emphasize community-based training, and provide a specific funding stream that gives incentives to increase the number of practicing primary care physicians;
- a system in which all payers — not just Medicare and Medicaid — pay for physician training, especially primary care; and
- provisions that create a Primary Care Student Loan program and that budget \$215 million for Section 747 of Title VII in the Public Health Service Act.

Primary Care Speaking With One Voice

AAFP, American College of Physicians and American Osteopathic Association – representing more than 330,000 physicians – join together to call for primary care reform – June 18, 2009

(<http://www.aafp.org/online/en/home/media/releases/news-releases-statements-2009/primarycarereform-aafp-acp-aoa.html>)

Joint Letter to President Obama and Committees of Jurisdiction Regarding Health Care Reform – June 23, 2009 (http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/reform-6-23-09.Par.0001.File.tmp/JointHealthReformLetter-June23.pdf)

Medicaid

The AAFP is pleased that the Medicaid/CHIP title provides for a substantial expansion of coverage to the uninsured. In particular, we are supportive of the fact that the bill increases Medicaid payments for primary care services to be at least equal to Medicare payments for these services by 2012. We also support the CMS-run Medicaid Medical Home Demonstration Program and payments for Graduate Medical Education, which would place Medicaid GME payments in statute for the first time.

We also are pleased that the legislation allows for expanded coverage of proven, evidence-based preventive services, such as services graded “A” and “B” by the U.S. Preventive Services Task Force, vaccines recommended by the Centers for Disease Control and Prevention, smoking cessation medications and smoking cessation counseling for pregnant women.

We do have some serious concerns regarding the primary care payment provision. The increased payment for primary care services extends to non-physician providers without the differential payment that Medicare uses to acknowledge the difference in training of physicians. In other words, non-physician providers would be paid the same as physicians by Medicaid for providing primary care services.

For Updated Information ...

The following resources are available for members:

1. *AAFP News Now* (<http://www.aafp.org/online/en/home/publications/news/news-now.html>), the Academy’s member news publication, is your go-to resource for articles with the latest information we’re providing to all members.
2. When Congress is in session, *Washington Update* (www.aafp.org/update) is a weekly report from the Government Relations team that includes updates on federal and state issues, PAC events, and grassroots activities.
3. *SpeakOut!* (<http://capitol.aafp.org/aafp/home/>). Visit *Speak Out* for current action alerts related to health care reform.
4. *AAFP Connect for Reform* (aafp.org/connect4reform). *AAFP Connect for Reform* is the Academy’s new e-advocacy campaign designed to bring members inside the health care discussion and debate as it unfolds from Washington – to energize family physicians to stay informed and get involved.
5. The *AAFP Media Center* (<http://www.aafp.org/online/en/home/media.html>) provides a central place for you to access all statements/news releases issued by the Academy. While these statements are attributed to AAFP leadership and will have already been distributed to the news media, they may be helpful in providing members with background on the AAFP’s positions. ■



Family Physicians Gathering Strength

A Look Back....

MAFP'S 2009 ANNUAL CME Assembly took place June 17-20 in Ocean City. The program was outstanding, with those in attendance getting the most up-to-date information in the therapeutic areas discussed, as well as updates on legislative, economic and practice management issues. Ocean City continues to be a popular location for the annual conference. The MAFP board has voted to return to the location and to the facility in 2011. ■



MAFP President Dr. Yvette Rooks with Bob Paff of Integrated Benefits Corporation during the MAFP Trade Show.



(l-r) Drs. Deborah Weinreich and Robin Bissell follow along on their laptops (handouts were posted electronically for the convenience of those wishing to access presentations on site).



MAFP Past President Dr. William Jones presents the MAFP Lifetime Achievement Award to Dr. John B. Umhau, Jr., given posthumously. Mrs. Janet Umhau accepted the award on behalf of the Umhau family, many of whom were in attendance at the Installation and Awards Luncheon. **

Noteworthy is that out of 31 faculty presentations at the 2009 Assembly, 14 were delivered by family physicians! They are:

- Bruce Bagley, M.D.
- Jeffrey J. Cain, M.D.
- William T. Dando, M.D. *
- Kevin S. Ferentz, M.D. *
- N. Joseph Gagliardi, M.D. *
- Nancy Beth Grossman, M.D. (2 talks)
- Daniel L. Handel, M.D. *
- Eva S. Hersh, M.D. *
- Kenneth W. Lin, M.D.
- Michelle May, M.D.
- Adebowale G. Prest, M.D. *
- Vivienne A. Rose, M.D. *
- Verlyn P. Warrington, M.D.

* MAFP Member

** See Fall, 2008 edition for "In Memory: John B. Umhau, Jr., M.D., MAFP's 31st President."



AAFP Director Dr. Jeff Cain (l) of Denver, CO, installs new MAFP officers who were present in Ocean City (l-r): Drs. Tracy Wolff, John Shutta, Yvette Oquendo, Ramona Seidel and Bill Jones.



MAFP President Dr. Yvette Rooks presents to AAFP Director Dr. Jeff Cain a commemorative gift from MAFP.



MAFP President Dr. Yvette Rooks with 2009 MAFP Special Recognition Award recipient Dr. Kevin Ferentz and his three sons (l-r) Jacob, Zachery and Noah.

Looking Ahead to 2010!



MAFP 2010 Annual CME Assembly & Trade Show
 Wednesday, June 23-Saturday, June 26
 Westin Hotel
 Annapolis, MD

Please mark the dates and plan to attend. The 2010 Scientific Assembly Committee has met and is off to a great start in planning another quality CME program and exciting event that you won't want to miss. We guarantee a terrific learning experience that will help you to meet your educational and practice goals. Back in Annapolis, but at a completely new facility, we promise a memorable annual meeting. Watch for details at www.mdafp.org or contact MAFP at 410-747-1980 or info@mdafp.org. ■

A Message for Healthcare Providers Who Diagnose and Treat Patients with High Blood Pressure From

The Maryland State Advisory Council on Heart Disease and Stroke

More "Simple Strategies" to Help Your High Blood Pressure Patients Achieve and Maintain Recommended Levels of Control

According to the National Council on Patient Information & Education, (NCPIE,) only about 50% of patients with chronic conditions are adherent to their medication regimens. The good news is that there are some steps that you can take to help your patients take their blood pressure medications regularly and properly:

- ◆ Simplify the regimen as much as possible; once-daily dosing is easiest for the patient.
- ◆ Make sure that the patient understands exactly how and when to take the medication you are prescribing. The direction to "take one pill every day" can be confusing. Should it be taken in the morning, the afternoon, the evening, at bedtime? Should it be taken upon an empty stomach or after a meal?

And

- ◆ Be sensitive to the possibility of impaired hearing. Ask the patient to "explain back" what you have said and reinforce with very simple "take-home" directions.

[Watch for More "Simple Strategies" Next Edition](#)

Volume 1, number 2, May 2009

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Celebrate the MAFP Foundation!



Summer Means Family Medicine to Many Medical Students

The sole mission of the Maryland Academy of Family Physicians Foundation is to support medical student initiatives in order to foster and perpetuate the specialty of Family Medicine in Maryland. Following are reminiscences from students who, during the summer months of 2009, participated in Family Medicine rotations or attended the AAFP National Conference of Medical Students in Kansas City. We thank them for their interest and contributions to this segment.

2009 National Conference of Family Medicine Students and Residents MAFP Student Delegate Report

by Sarah Lusk, MS IV
Johns Hopkins University School of Medicine

THE 36TH NATIONAL CONFERENCE for Family Medicine Students and Residents was titled "Health Policy: Building a Better Health Care System." The conference provided an incredible opportunity to learn more about health policy, as well as the ways in which family physicians can advocate for their patients and their communities. It was also a wonderful time of networking and meeting students and residents from across the country. By participating in workshops, attending the Student Congress and serving on a Reference Committee, I had the opportunity to work with other students interested in Family Medicine and to further develop my own leadership skills.

One particularly interesting session was entitled "Getting Your Message

Heard on Capitol Hill." It was lead by Stephanie Vance, an expert in advocacy. She not only provided many helpful tips for working with elected officials to bring about policy change, but also offered students the opportunity to practice their lobbying skills. Her vast experience in the political arena allowed her to simulate situations that physicians might be in if they were lobbying for change. She then gave us feedback and suggestions for being more effective. During one memorable portion of the session, she had students walk with her all over the room while they explained their position and asked for policy change, simulating a brief opportunity one might have with a senator on their way to a meeting. The most important thing I took from this session was the importance of making "the ask;" specifically asking for what you want. The opportunity to learn and practice these skills was critically important to many of us who want to affect change on the local and national level.

Serving as the student representative from Maryland to the AAFP Student Congress, I had the opportunity to learn

more about the process of organized medicine, while voting on issues presented to the Congress in the form of resolutions. This year I chose to become even more involved in the process by serving on a reference committee. During our committee's hearing, students spoke on a variety of issues from health care for refugees to banning the use of cell phones while driving. It was amazing to see so many passionate student leaders making their voices heard.

After the reference committee heard testimony and had the opportunity to ask questions, we had our business session, during which we came up with recommendations to the Student Congress. The next morning, during the final business session, we presented our recommendations to the entire group. It was interesting to see that, although two of our recommendations were heavily debated, in the end the students voted to do what our committee had recommended. The fact that we were able to reach a consensus as a small group that the larger group agreed on was exciting.

It was an honor and privilege to represent Maryland at this important conference. The opportunity to network with other student leaders and learn more about how family physicians can advocate for their communities made me even more excited to be applying to residencies in Family Medicine. It was an amazing experience and I look forward to taking what I learned and applying it in my future career.

Comments from other students attending the 2009 National Conference, each from the University of Maryland School of Medicine:

The experience I had at the 2009 National Conference was life-altering. It inspired me to see the wonderful collection of faculty, administrators, residents and fellow students who all share my passion for primary care. The wide array of lectures and skills workshops was remarkable. It drove home the point that a family physician can truly be integral in every part of medicine. For example, the lectures and workshops I attended included a musculoskeletal clinic where we went over the common knee injuries and their physical exam findings, maternal care and childbirth, planning for an international health rotation and EKG interpretation. No other specialty in health care would have such an all-encompassing experience! I also thoroughly enjoyed the Exposition Hall. It was awe-inspiring (and just a little overwhelming) to see the number of exhibits. Since I am preparing to apply for residency, I focused mainly on the exhibits of the multitude of residency programs. It was fascinating to hear how different the experiences can be at the various programs, while still providing a good foundation for practicing as a family physician.

While the whole experience was remarkable, two moments from Kansas City stand out above all others for me. The first was when I spent an evening walking around downtown Kansas City with some of the fellow students and residents. Being able to step outside of the learning environment and experience Kansas City with its rich and eclectic atmosphere was wonderful. It gave us all the opportunity to interact as people, not just members of the health care field. The second experience was when I met up with one of the residents that I had a fantastic interaction



Maryland Chapter students attend the 2009 AAFP National Conference of Medical Students (l-r) Melissa Wisner, Jessica Lue and Mary Desi.

with on one of my third-year rotations. She played a significant role in my decision to pursue Family Medicine as a career. I appreciated the opportunity to meet up with her and let her know how much she impacted me in a positive way.

Finally, it seems to me that the National Conference changes everyone who attends it. Since I've been back, everyone I've come across who attended this year, as well as many people who have attended in years past, have said to me, "You went to Kansas City? Isn't it amazing?" And it really was.

Mary Desi, MS IV

Thanks to the MAFP Foundation for facilitating the scholarship process for the National Conference. I returned a couple weeks ago from the conference and I was refreshed by the excitement of all the participants and speakers for Family Medicine. During my experience, I was able to see a multitude of residency programs and see some of the changes in Family Medicine education and in the health care policy for America. I especially enjoyed the "Health Care for the Homeless" talk, as I am interested in underserved urban medicine. It was an excellent opportunity to meet some residents and program directors of residencies around the country.

Jessica Lue, MS IV



Kathleen Daly, Cacey Rice, Allisha Liggett and Danielle York.

National Conference was a wonderful experience. I cannot think of a better venue in which to learn more about family medicine. I left the conference feeling rejuvenated and even more excited about choosing family medicine as a career. It is something that every student who is considering becoming a family physician should do. It is also so nice to have the support of the MAFP Foundation.

Casey Rice, MS IV

Missouri was honestly a place I never thought I would visit in my life. I had barely made it off the East Coast over the course of my life. The National Conference for medical students was in Kansas City, however, and I had been told it was an event not to be missed for anyone considering the field of Family Medicine. I imagined the days would be filled with seminars reiterating the perks of family care and restful evenings contemplating which residency programs I should consider.

The moment I arrived though, I realized I indeed was not in Kansas anymore. The city was clean, fresh and full of life. The first morning of the conference I was enlivened by Dr. Epperley's speech regarding health care reform and the play-by-play analysis he gave of health care legislation. The first day I entered

continued on page 22

the main floor of the convention center where the residency fair was to be held I was in awe. Over an area the size of a football field, residency programs from all across the country were represented, each eager to chat up their program and region of the country.

Being surrounded by colleagues who were equally excited about Family Medicine and the delivery of optimal health care to those in need was comforting. After long days of chatting up different residency programs and finding my list of potential programs for the fall rampantly growing, we spent nights enjoying the hospitality and culinary wonders of the Midwest. I left National Conference with renewed confidence in my decision to ultimately pursue Family Medicine, and with anticipation for the journey ahead.

Danielle York, MS IV

UM Family Care Tract Students Tell of Their Summer 2009 Experiences

Each summer a number of students entering their 2nd year of medical school participate in the University of Maryland Department of Family and Community Medicine's Family Care Track (FCT), whereby they spend a concentrated period of time gaining experience with Family Medicine in an urban setting. The experience proves inspiring and life-changing for many students, particularly as they consider future specialty choices. Interested readers may request the article, "Increasing Student Interest in Family Medicine and Urban Health Care: The Family Care Tract" by contacting the MAFP office at info@mdafp.org or 410-747-1980. Following are comments from several 2009 FCT students:

Family Medicine is a specialty of diversity and communication; a challenge to present knowledge clearly and concisely

to a wide range of patients addressing a huge scale of medical concerns. Spending eighty hours this summer learning and employing this art was an exercise in professionalism and knowledge, but, most importantly, people skills. Family physicians spend a great deal of time listening and analyzing and, at the same time, making the patient feel comfortable enough to open up and share their story; building a trusting relationship. Over the course of my time, I continued to practice my history-taking and began the next step of physical exams as well as practicing my presentations, including a plan. While this is only the beginning of my journey, this summer, working alongside many different family doctors with a variety of styles, I learned that the patient provides the most information. It is the task of the family physician to synthesize the story and work with the patient to design a realistic solution to the problem.

Jennifer Feige

I had an extremely rewarding experience this summer during my Family Care Tract Externship. I was exposed to the broad range of patient care involved in Family Medicine. Moreover, I saw firsthand the positive impact that family physicians can have in their patients' lives as both advocates and the gateway to the complexities of the health care system. The externship reaffirmed my interest in Family Medicine, as well as my commitment to serve the Baltimore community in the future.

Kathryn Greuter

By the time school ended for the year, I had had enough of books, notes and the library and was ready to practice what it is I came to school for: seeing patients. Therefore, I couldn't have been more excited to begin my Family Care Track shadowing hours. It was a joy to talk with the wide variety of patients seen

every day in the family practice clinic in downtown Baltimore, to hear their stories and to help (even if it was just a tiny bit) any way I could. Of course there were times I fumbled over my words and wasn't sure exactly what question I should be asking next, but overall, I can't stress enough how much this program has helped my confidence in walking into an exam room. Once that confidence had been reached, the nerves can be put aside, allowing me to be more focused on the patient. Finishing the externship in August was a great way for me to get back into the swing of things and get excited for the new school year to begin. I look forward to shadowing throughout the year, hopefully learning more in the classroom and exam room each day.

Kaci Haines

I thoroughly enjoyed my experience as a Family Medicine extern. While didactic lectures teach the science underlying medicine, this externship taught me the importance of the human aspect of health and disease. I have learned to focus on the patient, and not just the ailment they present with. Over the span of a few months, I have been able to establish rapport with numerous patients, especially those whom I have been able to meet with over several visits. My ability to conduct a patient history has improved, in addition to my communication skills in relaying information to my mentor and peers. Over a wide demographic, I have observed what it is like to live life with hypertension, diabetes mellitus and chronic pain—the symptoms, drug treatments, lifestyle choices and emotional toll that they take. Understanding what it feels like to live with chronic disease has had a bigger impact on me than solely comprehending the fine scientific details.

David Levitt

The Family Care Track Program at the University of Maryland, especially the summer rotation, has brought relevance to the information I learned during my first year of medical school and given me a wealth of practical clinical information that can only be acquired through mentored clinical exposure. I have gained intimate knowledge of the existing challenges faced by doctors and patients today, such as issues related to treatment adherence, navigating health care and insurance systems and large patient loads. Additionally, the program has allowed me to witness and participate in patient-centered, holistic care. It really highlighted the value of familiarizing yourself with all aspects of patients' lives in order to facilitate true "healing" and treatment. In many cases in the clinic this summer, I found that information obtained by simply asking a few questions about a patient's occupation, what his/her home life is like, what he/she does for fun, etc. has been fundamental in identifying patients' health problems, risk factors and effective treatment options. I believe this program has given me an unadulterated glimpse into family practice, which has increased my enthusiasm and commitment to pursuing a medical career in Family Medicine.

Mary Terrie Macalalad

While fumbling with a new stethoscope, listening to heart and lung sounds, taking blood pressures, learning the names of the most common medications and disease symptoms was all new and awkward, it was also strangely familiar. I had been there before, on the other side of the stethoscope, hearing words I did not understand. Previously, I had been comforted by my own primary care doctor; now I was doing the comforting and the listening. It was my first recognition of how personal and reciprocal the patient-doctor relationship is, something I could not appreciate when my only experience

was as a patient. Now, each patient I encountered was my teacher and let me know what put them at ease, what made them uncomfortable, what made them laugh and what made them agitated. On several occasions I saw the same patient for a return visit and, on the second meeting, we had instant connection, far better than the first time we met. It was also a pleasure to work with the staff at University Family Medicine. Who better to teach these skills than someone who is already an expert at making a patient feel comfortable and cared for? I realized that the interpersonal element of a family doctor's work is not necessarily an innate skill, but it is learned and enhanced through every encounter. This made me grateful that my first prolonged clinical experience was at the Family Medicine clinic where the caring and humane element of medicine is so highly regarded.

Mattan Schuchman

Family Practice Rotation: Reflective Piece

by Monica Kanal, OMSIII
Philadelphia College of
Osteopathic Medicine

This article was submitted by Melly Goodell, M.D., on faculty at the Franklin Square Hospital Center Department of Family Medicine Residency and medical director, Healthcare for the Homeless Baltimore County. Ms. Kanal rotated through the program in January, 2009.

"I'm sorry, but your son tested positive for sickle cell anemia." Her face fell, and she looked at her baby, just in his twelfth day of life, with a mixture of dismay and confusion. The tears began to fall as we explained what this diagnosis meant. My attending left the room for a moment. I stood there, awkwardly trying to help this family understand that all was not lost. "Is my brother going to die from this?" asked his 14 year-old-sister. I fumbled for a good answer to that question, after which I politely excused myself. I searched for a patient handout that appropriately outlined the causes and prognosis for this disease. I reentered the room, armed with this information and a bit more confidence. My attending followed. We continued to help our patient's family overcome their initial shock.

continued on page 24

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A few days earlier, J had come to the office with a chronic stomachache. Though he was only 31 years old, he had a sordid history of incarceration, IV drug use and alcohol consumption that left him sitting on our table like a sad child. In reality, he was sad. His life was complicated by unmanaged bipolar disorder and he had been diagnosed with Hepatitis C. He was never able to seek treatment because he no longer had a home. His mother had brought him to the visit and she repeatedly chastised him for drinking excessively. He gazed at the floor quietly while we tried to direct our visit to his major concerns: a stomachache and the inability to afford care for his illnesses.

At first glance, these two scenarios are markedly different. The first presents a solid family structure faced with genetic

disease, while the other is a tale of instability and its unfortunate physical and mental consequences. A second glance, however, brings a different perspective; it is not uncommon to be presented with such a varied population in the realm of primary care. Ultimately, these patients are not all that dissimilar. They are united by the fact that they come to their medical home seeking an advocate to carry them through the highs and lows of their lives.

Some believe primary care is a sea of runny noses and quick checkups, but a few days in an actual practice shows something quite to the contrary. To me, the wide variety of patients encountered in the primary care setting remains one of the most striking and exciting aspects of primary care, be it in family practice or

internal medicine. From OB checkups to terminal cancer, primary care physicians strive to provide the most well-rounded care they can, recognizing that "patient care" is not simply listening to lungs and checking reflexes. Patient care means finding the best resources to get patients the outcomes they seek, whether those outcomes include medical assistance or the use of a doula for the birth of a child.

My family practice rotation has given me excellent hands-on training in the realm of patient advocacy. As much as I learned about the appropriate management of a variety of common conditions, I was able to see how the primary care doctor interacts with the family dynamic and leads patients to a more balanced and healthy life. To me, that is some of the best knowledge I could have ever obtained. ■

The advertisement features a red background on the left and a white background on the right. The text 'CHECK THE BOX!' is written in a large, black, handwritten font across the top. Below this, three lines of white text on the red background encourage donations: 'Help your state chapter and AAFP Foundation with one donation.', 'Make a \$50 contribution with your membership dues payment.', and 'Support good work at both the state and national levels.' The website 'www.aafpfoundation.org' is listed at the bottom left. On the right, a hand-drawn black box with a checkmark inside is shown, with a white marker tip at the top right corner. The AAFP Foundation logo is in the bottom right corner.

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News For and About MAFP Members

Appointments, Honors, Features, Special Achievements



Richard Colgan, M.D. of Annapolis, MAFP past president and current editor in chief of *The Maryland Family Doctor* has authored "Advice to the Young Physician: On the Art of Medicine."

Published by Springer, this text reveals the secret of how to make the transition from technician to healer, as taught by some of medicine's greatest teachers over the past 4,000 years. It is available on line at Amazon and Barnes & Noble websites. For more information go to www.advicetotheyoungphysician.com Dr. Colgan is associate professor and director of undergraduate education for the University of Maryland Department of Family and Community Medicine.

William Reichel, M.D. of Timonium reports that the 6th edition of his text was released in February 2009. Since 1999, when the book was named after him, "Reichel's Care of the Elderly: Clinical Aspects of Aging," he has been editor emeritus. The editors in the 6th edition are Christine Arenson, M.D., Jan Busby-Whitehead, M.D. Kenneth Brummel-Smith, M.D. James G. O'Brien, M.D. and Mary Palmer, Ph.D. The publisher is Cambridge University Press in Cambridge, United Kingdom. The 1st edition of the book was published in 1978. Dr. Reichel is affiliated scholar, Center for Clinical Bioethics, Georgetown University School of Medicine in Washington. He is past president of the American Geriatrics Society.

William D. Hakkarinen, M.D. of Timonium, MAFP past president and current senior delegate from MAFP to the AAFP Congress of Delegates, gave a presentation on the study, "Observations of Serum Albumin Levels in Disability Adjudication" on April 18, 2009, to the American Association from Social Security Disability Consultants Annual Meeting in Cincinnati, OH. He was a co-presenter to the Quad-Regional Conference of the National Association of Disability Examiners on May 7, 2009, in Niagara Falls, NY. Dr. Hakkarinen is a physician program specialist for the Maryland Disability Determination Services. In addition, his letter to the editor, "Don't let kids pump gas," appeared in the June 20, 2009, edition of *The Baltimore Sun*.

Sallie H. Rixey, M.D. of Baltimore, director, Franklin Square Hospital Center Family Medicine Residency, was quoted in "Medical summit looks at crisis in primary care" in the May 28, 2009, edition of *The Baltimore Sun*.

Kenneth R. Buczynski, M.D. of Oakland was featured in the front-page article "Rural medicine is his calling" in the June 29, 09 edition of *The Baltimore Sun*.

Melly Goodell, M.D. of Fallston, Medical Director of Healthcare for the Homeless of Baltimore County, was featured in a segment on health care financing on Baltimore station WBAL-TV on August 16, 2009.

The following MAFP members presented sessions during the 2009 Southeastern Family Medicine Forum, a regional conference where 12 AAFP chapters participated, hosted by the MAFP in Annapolis August 20-22, 2009 (see "executive director" p. 7): **N. Joseph Gagliardi, M.D.** (aka Dr. Alexander Dobbs): "Colonial Life and Colonial Medicine;" **William D. Hakkarinen, M.D.:** "Update on Disability Determination;" **Yvette L. Rooks, M.D.** (MAFP president): moderator, "The Medical Home and Addressing Health Disparities in the Southeast" and moderator, "What's New in Family Medicine Education?," which also featured **Richard Colgan, M.D.** and **Sallie Rixey, M.D.;** **Joseph W. Zebley, III, M.D.:** "Physiology of Normal Aging" and "The Maryland Physician Workforce Initiative."

Are You Receiving MAFP Electronic Communications?

In this age of the Internet, social networking, e-mail messaging, etc., MAFP has seen fit, on a more frequent basis, to communicate with its members via e-mail. These methods of communication allow for more timely conveyance of information than our quarterly publication or U.S. mail ("snail mail"). The AAFP is also moving more to electronic means of communication with members.

Are you getting our broadcast email alerts? Are you receiving the informative monthly MAFP E-Bulletins? If not, please contact the MAFP office with your email address (info@mdafp.org or 410-747-1980). Staff will take it from there and also inform AAFP.

Note: editions of this publication, as well as editions of the MAFP E-Bulletin, are posted at www.mdafp.org. ■

In Memory

The Maryland Academy of Family Physicians deeply regrets the passing of its member

Leslie R. Miles, Jr., M.D. (Cumberland)

MAFP has made a memorial contribution to the MAFP Foundation.

calendar



2010

- February 20 MAFP Winter Regional CME Conference
Sheraton Hotel
Columbia
- June 23-26 MAFP Annual CME Assembly & Trade Show
Westin Hotel
Annapolis

2011

- February 19 MAFP Winter Regional CME Conference
TBD
- June 23-25 MAFP Annual CME Assembly & Trade Show
Clarion Resort Hotel
Ocean City

AAFP Scientific Assembly Schedule

- | | | |
|------|------------------------|--------------|
| 2009 | October 14-18 | Boston |
| 2010 | September 29-October 3 | Denver |
| 2011 | September 19-21 | Chicago |
| 2012 | October 15-17 | Philadelphia |
| 2013 | September 23-25 | San Diego |

Note: MAFP did not submit for CME approval for the articles in this edition.

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- Chronic Disease Management

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Helping Physician Practices
Transition from Paper
Patient files to Electronic
Health Records
(EHR)



Your Single Source Solution Provider for EHR (Electronic Health Records) Implementation

Electronic Medical Office Solutions is a leading Health IT EHR Consulting Services organization. We provide consultation and technical assistance to physicians and medical practices in the transition of paper patient files to electronic health records.

Our EHR software solution (SOAPware 2008) is CCHIT certified and is targeted for small to medium size physician practices and healthcare facilities. Electronic Medical Office Solutions is a certified Health Information Technology vendor with the Maryland Health Commission and as part of Health and Human Services Demonstration Project we offer the DC metro (Maryland/ Virginia), Pittsburgh, PA area medical practices 10% discount on the implementation of EHR (Electronic Health Records) SOAPWare.

Contact us today for a free consultation and software demo

Electronic Medical Office Solutions, LLC

Professionals committed to the highest standards of ethics and integrity, we strive to exceed customer expectations with outstanding service.

EHR Software Modules Include:

- E-Prescribing
- HL7 Interface
- Scheduling
- EM Coding
- Health Maintenance
- Clinical Quality Measures
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More than 40% of African Americans have high blood pressure.¹



The solution could be behind door #2.



Talk with your patients about DASH.

Foods Emphasized in the DASH Eating Plan

- ✓ **LOW-FAT or FAT-FREE MILK, yogurt or reduced-fat cheese**
- ✓ **FRUITS**
- ✓ **VEGETABLES**
- ✓ **WHOLE GRAINS**

Lifestyle changes, including diet, are an important part of any plan to achieve and maintain a healthy blood pressure. In fact, **the DASH (Dietary Approaches to Stop Hypertension) Eating Plan** is recommended to both prevent and control high blood pressure.

The low-fat dairy-rich DASH diet was twice as effective at lowering systolic blood pressure among African-Americans as in Caucasians.² Dairy foods were among the top food sources of calcium, potassium and magnesium in the DASH diet.³ These three nutrients play an important role in blood pressure regulation.

The DASH diet may even lower blood pressure as well as some medications. Adults with mild hypertension who followed the DASH diet reduced blood pressure as much as a single antihypertensive medication.⁴



Let USDA's MyPyramid be your guide - www.mypyramid.com.

For DASH recipes and example calorie level menus, visit http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf.

For more tips, go to www.nationaldairycouncil.org.

For additional DASH resources and healthy recipes, go to www.3aday.org.



NATIONAL DAIRY COUNCIL®



eat right. American Dietetic Association



These organizations support 3-A-Day™ of Dairy, a science-based nutrition education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products to improve overall health.

1 American Heart Association; What About African-Americans and High Blood Pressure? <http://www.americanheart.org>
 2 Svetkey LP et al. Effects of dietary patterns on blood pressure. Subgroup analysis of the Dietary Approaches to Stop Hypertension (DASH) randomized clinical trial. Archives of Internal Medicine. 1999; 159: 285-93.
 3 Lin P-H, et al., Food group sources of nutrients in the dietary patterns of the DASH-Sodium Trial, J Am Diet Assoc, 103(4):