Conference on Practice Improvement: Constructing the Medical Home

November 5-8, 2009
Kansas City Marriott Downtown • Kansas City, Missouri

FINAL PROGRAM

Sponsored by

AMERICAN ACADEMY OF FAMILY PHYSICIANS
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SOCIETY OF TEACHERS OF FAMILY MEDICINE

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CONFERENCE GOALS...*What This Year's Conference Will Offer You and Your Team!*

(1) Offer practical skills, information, and resources that will enable attendees to create the patient-centered medical home in their offices.

(2) Enhance interdisciplinary education and team development that supports practice improvement, and produces optimal self-management support.

(3) Encourage the creation of interest groups and networks for the exchange of good ideas and best practices in the transformation of outpatient medical care.

Conference Schedule

Thursday, November 5

11 am-7:30 pm ***Basie Ballroom Foyer***	Conference Registration
Noon–5 pm ***Bennie Moten A-B***	***Preconference Workshop*: "Building the Patient-centered Medical Home: An STFM, AAFP, TransforMED Learning Collaborative"** *Elaine Skoch, RN, MN; Shelly Phinney, MBA, TransforMED, Inc., Leawood, Kan* Back by popular demand, this "Learning Collaborative" will tackle the specifics of implementation of the various elements of the patient-centered model of care. This interactive workshop will address "how" the framework of the patient-centered model enhances what practices are currently doing, and will provide strategies for practices to move forward in their implementation of the medical home elements. Patient engagement, processes for performance improvement within the practice and requirements for medical home recognition will be covered. As an added bonus, your registration fee for this workshop includes ongoing communication with each other and access to TransforMED's medical home network "Delta Exchange." *Pre-registration Required*: Please check with the Conference staff for more information.
5–5:30 pm ***Mary Lou Williams A***	**First-time Attendees' Orientation**
5:30–7:30 pm ***Basie Ballroom A***	**Opening Reception with Exhibits and Posters**

Friday, November 6

7 am–5:30 pm ***Basie Ballroom Foyer***	Conference Registration
7–8 am ***Basie Ballroom A-B***	**Continental Breakfast with Exhibitors and Poster Presenters**
7 am–3 pm ***Basie Ballroom A***	Exhibits and Posters Open
8:15–9:45 am ***Basie Ballroom B-C***	**Greetings and Announcements:** Linda Stogner, MD, 2009 Conference Chair, and Terrence Steyer, MD, STFM President **General Session: "Communication, Relationship, and Efficiency: Building Individual Mastery Through Teamwork"** ***Larry Mauksch, MEd, University of Washington Family Practice Residency, and Cici Bean Asplund, MD, East Wenatchee, Washington***
9:45–10:15 am ***Basie Ballroom A***	Refreshment Break in Exhibit Hall
10:15–11:45 am	Concurrent Educational Sessions *(see room assignments with session abstracts.)*
11:45 am–12:45 pm ***Basie Ballroom A***	**Boxed Lunch in Exhibit Hall**
1–4:40 pm	Concurrent Educational Sessions *(see room assignments with session abstracts.)*
2:30–3 pm ***Basie Ballroom A***	**Refreshment Break: Last Chance to Visit Exhibits and Posters!**
6 pm	**Dine-out Groups** (sign-up sheets are posted on the conference "Message Board".) *Groups will leave from the hotel lobby at 6pm. Dinner reservations are for 6:30pm.*

Saturday, November 7

7 am–5 pm ***Basie Ballroom Foyer***	Conference Registration
7–8 am ***Basie Ballroom B-C***	**Continental Breakfast with Special Interest Roundtables**
8:15–9:45 am ***Basie Ballroom B-C***	**Greetings and Awards Presentation:** Herbert Young, MD, Director, AAFP Division of Scientific Activities Perry Dickinson, MD, STFM President-elect **General Session: "Putting the Patient in the Patient-centered Medical Home"** ***Joseph Scherger, MD, MPH, Eisenhower Medical Center, Rancho Mirage, California***
9:45–10 am ***Basie Ballroom Foyer***	Refreshment Break
10–11:30 am	Concurrent Educational Sessions *(see room assignments with session abstracts.)*
11:30 am–1 pm	Lunch on Your Own
1–5:10 pm	Concurrent Educational Sessions *(see room assignments with session abstracts.)*
2:40–3 pm ***Basie Ballroom Foyer***	Refreshment Break

Sunday, November 8

8–11 am ***Basie Ballroom Foyer***	Conference Registration
8–8:30 am ***Basie Ballroom Foyer***	Coffee Service
8:30–9:30 am	Concurrent Educational Sessions *(see room assignments with session abstracts.)*
9:30–9:45 am ***Basie Ballroom Foyer***	Refreshment Break
9:45–11 am ***Basie Ballroom C***	**General Session: "The Patient-centered Medical Home: Real-world, Practice-level Transformational Change and Initiatives to Support These Efforts"** ***Donald Klitgaard, MD,*** *Myrtue Medical Center Clinics,* ***Harlan, Iowa***
11 am	Conference Adjourns

Conference General Information

Hotel and Conference Location

Kansas City Marriott Downtown
200 West 12th Street
Kansas City, MO 64105
Hotel Phone: 816-421-6800

Ground Transportation

Super Shuttle provides service between the Kansas City International Airport and Kansas City Marriott Downtown. A SuperShuttle ticket counter and ticketing kiosk is located next to each baggage claim area. Purchase tickets before proceeding to the outside curb boarding location. Shuttle hours are 4:58 am–6:28 pm. Pickup time is every 30 minutes at :28 and :58 of each hour. Shuttle cost is $17 One Way/ $29 Round Trip. For reservations, call 800-258-3826. Reservations are not necessary unless traveling after 6:28 pm. For shuttle return to airport, you should plan to leave the hotel 2 hours prior to flight. Taxi: Taxi service is available to the airport for approximately $25-30.

Car Rental

Budget Rent A Car System, Inc. Conference rates begin at $36 per day or $137 per week.
Make your reservations at 800-772-3773 or www.budget.com. (Convention Code (BCD#) U063655)

CME/CEU Credit

PHYSICIANS: "This activity has been reviewed and is acceptable for up to 18.75 Prescribed credits by the American Academy of Family Physicians. "This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through joint sponsorship of American Academy of Family Physicians and Society of Teachers of Family Medicine. The AAFP is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians." "The American Academy of Family Physicians designates this education activity for a maximum of 18.75 AMA PRA Category 1 Credit(s) ™. Physicians should only claim credit commensurate with the extent of their participation in the activity."
NURSES: The conference was submitted to the Kansas State Nurse's Association Council on Continuing Education for review. Please check with staff at the conference registration desk for complete details regarding credits.

Conference Syllabus Online Materials

Easily reference the valuable information you learn at the conference using the Family Medicine Digital Resources Library. In an effort to make presenter handout materials more readily available to all conference attendees, as well as other AAFP and STFM members who are not able to attend the conference, we encourage all lead presenters to upload their presentation materials to the new Family Medicine Digital Resource Library (FMDRL) at www.fmdrl.org.
This service developed by STFM provides peer-reviewed educational materials, works-in-progress, and conference materials to anyone searching by topic and/or author on the Web. The mission of FMDRL is to support and enhance the sharing and collaborative development of educational resources among family medicine educators through a digital library that includes resources for all levels of family medicine education.
Conference presenters and attendees are encouraged to visit the FMDRL site at www.fmdrl.org. Simply select the upload button to place your presentation materials online or the browse button to search for materials, then follow the easy, online instructions.

Conference Acknowledgments

2009 Conference Supporters

● Special recognition is extended to **Pfizer Inc** for their overall support of the 2009 conference.

2009 Conference Partners

The conference acknowledges and thanks our partners, **National Research Network** and **TransforMED**, for their assistance and support in planning and promoting this year's conference.

The National Research Network (NRN) is a new conference partner for 2009!

The NRN is a national practice-based research network for family medicine that conducts research and quality improvement projects in physicians' offices and family medicine residencies nationwide. By combining the NRN annual meeting with the Conference on Practice Improvement we expect to learn from those who already attend this valuable and progressive conference, while we hope that new friends and colleagues will find our NRN sessions lively and thought-provoking. The NRN is excited about this collaboration and looks forward to future collaboration with this conference. During the conference the NRN will be hosting three seminars and two lecture presentations. These presentations are identified in the program by a small NRN logo. All conference attendees are invited to attend whether or not they are members of a practice-based research network.

Watch for NRN members and staff, those wearing NRN ribbons, to learn more about involvement in a practice-based research network as well as discuss developments in health care, review recent findings, and learn about new studies being conducted by the NRN.

To learn more about **National Research Network**, visit www.aafp.org/online/en/home/clinical/research/natnet.html

To learn more about **TransforMED**, visit www.transformed.com

2009 Steering Committee & National Advisory Planning Committee

The conference extends a special thank you to the members of the National Advisory Committee for their ongoing support and assistance in planning this year's conference.

Bruce Bagley, MD*
Donald Bosshart, EdD
Rick Botelho, MD
Michele Boutaugh, BSN, MPH
Stacy Brungardt, CAE*
J. Anthony Cloy, MD
Robert Edsall, MA, MPhil
Lori Foley
Randall Forsch, MD, MPH
Francesca Frati, MLIS
Melody Goller, CMP
Linda Gonzales-Stogner, MD*
Mary Hartwig, PhD, APN
Caryl Heaton, DO*
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Carrie Nelson, MD*
Cindy Noble, PharmD
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Ray Rosetta, CMP
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Roger Shewmake, MD*
Richard Streiffer, MD
Greg Thomas, PA-C, MPH
Lena Vasquez, MD
Thomas Weida, MD
Betty Westmoreland
Herbert F. Young, MD, MA*

*Steering Committee Member

Medical Economics

2009 *Medical Economics* Award for Innovation in Practice Improvement

"Guided Care"

Chad Boult, MD, MPH, MBA
Baltimore, MD

Guided Care is a model of proactive, comprehensive health care provided by physician-nurse teams for people with several chronic health conditions. It is a type of medical home for the growing number of older adults with multiple chronic conditions. This model is designed to improve patients' quality of life and care, while improving the efficiency of treating the sickest and most complex patients.

In Guided Care, a registered nurse based in a primary care office works closely with 3-4 physicians and health information technology (HIT) to provide state-of-the-art care for 50-60 chronically ill patients. Following a comprehensive assessment and an evidence-based care planning process, the Guided Care nurse educates and empowers patients and families, promotes self-management, monitors conditions monthly, coordinates the efforts of health care professionals, smoothes transitions between sites of care, and facilitates access to community resources.

A three-year, multi-site, randomized controlled trial of Guided Care involving 49 physicians, 904 older patients and 308 family caregivers recently concluded in eight locations in the Baltimore-Washington, D.C. area. Results from the trial indicate that Guided Care improves patients' quality of care, reduces the use and cost of expensive services, reduces family caregiver strain, and improves physicians' satisfaction with chronic care. Resources are available to help practices adopt Guided Care, including an implementation manual, guidance on selecting HIT, an online course for physicians and other practice leaders, an online course for registered nurses, and a Certificate in Guided Care Nursing from the American Nurses Credentialing Center of the American Nurses Association.

The trial was funded by a public-private partnership of the Agency for Healthcare Research and Quality, the National Institute on Aging, the John A. Hartford Foundation, the Jacob and Valeria Langeloth Foundation, Kaiser Permanente Mid-Atlantic States Region, Johns Hopkins HealthCare, and the Roger C. Lipitz Center for Integrated Health Care.

Please Note:
"***Guided Care***" will be highlighted at a poster presentation in the Exhibit Hall on Friday. Also, Dr. Boult will present "S7: Guided Care: A Path to the Medical Home for Patients with Multi-morbidity" on Saturday afternoon.

General Sessions

Friday, November 6
8:15–9:45 am

"Communication, Relationship, and Efficiency: Building Individual Mastery Through Teamwork"
Larry Mauksch, MEd, University of Washington Family Practice Residency Program, and Cici Bean Asplund, MD, East Wenatchee, Washington
Moderator: *Linda Gonzales-Stogner, MD*

Transforming primary care requires sustained healing relationships with patients and with team members. Practice groups need to work in vital, creative, and supportive climates to successfully negotiate the challenges of system change. We will consider how strengthening patient communication skills can be reinforced by effective teamwork. Our exploration will include the personal journey of a family physician. It begins with feeling burned out and frustrated juggling overwhelming demands and arrives at renewal through learning and teaching communication skills and teamwork. We will also examine educational experiments within a large, rural multi-specialty group, with medical students and with residents.

Larry Mauksch, MEd, is a senior lecturer in the Department of Family Medicine at the University of Washington. He trains medical students, residents, mental health interns, and practicing physicians in interviewing skills, team development, and the diagnosis and management of mental disorders in primary care. He is the past chair of the Collaborative Family Health Care Association and a former chair of the Society of Teachers of Family Medicine Group on Physician-Patient Interaction. Mr. Mauksch's areas of research include examining educational strategies to enhance team and clinician communication to improve patient satisfaction, health outcomes, and efficiency, and ways to integrate behavioral health and primary care services. He is the principal investigator of the Paired Observation and Video Editing (POVE) project, to disseminate an intensive training in communication skills to nine medical schools. He is a consultant and trainer for several large health care organizations, helping them develop more effective and efficient patient-centered systems of care.

Cici Asplund, MD, FAAFP, is a family physician in East Wenatchee, Washington. She was a recipient of the Parke/Davis Teacher Development Award in 1984. She serves as a Washington Academy of Family Practice Eastside Trustee and on the Board of the WAFP Foundation. She is involved in local clinical information systems design and implementation projects, as well as a project to renew local family medicine clerkship opportunities. She has been part of WVMC's "Listening Well" core project team since its inception in 2006.

General Sessions

Saturday, November 7
8:15–9:45 am

"Putting the Patient in the Patient-centered Medical Home"
Joseph Scherger, MD, MPH, Eisenhower Medical Center, Rancho Mirage, California
Moderator: Roger Shewmake, PhD, LN

Patient activation is a key component of the chronic care model and an essential part of the Patient-centered Medical Home. Activated patients participate in self-management of their care with their physician and care team. A body of evidence from randomized trials shows that greater patient self-management results in better health outcomes. The health information technology tools of the personal health record and patient portal for communication allow the patient to become far more in control of their care than the traditional care model.
We may be moving away from the traditional paternalism of physician control of care to a partnership where the patient is in control of their care and the physician-led care team becomes coaches and advisors. Family medicine is well suited to lead in this process of care transformation.

Joseph Scherger, MD, MPH, is vice president for Primary Care at Eisenhower Medical Center in Rancho Mirage, California and clinical professor of Family and Preventive Medicine at the University of California, San Diego. He is medical director for Quality and Informatics for Lumetra. His main focus is on the redesign of office practice using the tools of information technology and quality improvement. He was chair of the Department of Family Medicine and the associate dean for Primary Care at the University of California, Irvine. He served as founding dean of the Florida State University College of Medicine. He was elected to the Institute of Medicine of the National Academy of Sciences and received the Thomas W. Johnson Award for Family Practice Education from the American Academy of Family Physicians. He is a past president of the Society of Teachers of Family Medicine. He has served on the Board of Directors of the American Academy of Family Physicians and the American Board of Family Medicine.

Sunday, November 8
9:45–11 am

"The Patient-centered Medical Home: Real-world, Practice-level Transformational Change and Initiatives to Support These Efforts"
Don Klitgaard, MD, FAAFP, Myrtue Medical Center Clinics, Harlan, Iowa
Moderator: *Carrie Nelson, MD, MS, FAAFP*

The Patient-centered Medical Home model of care has generated much discussion nationally as a key compon-ent of effective health care reform. This presentation will address how an individual practice can undertake radical practice redesign while still continuing to effectively care for the patients it serves. We will explore what organizational skills, especially in the areaof leadership, are needed at the practice level to facilitate transformation. We will also discuss how state academies and other local, state, and regional stakeholders can support practices in their efforts to implement the PCMH model of care.

Don Klitgaard, MD, FAAFP, is the medical director of the Myrtue Medical Center clinics in Harlan, Iowa, where he has been the physician champion as their practice participated in the AAFP's TransforMED National Demonstration Project. This 2-year project was designed to support and study the implementation of the Patient-centered Medical Home model of care in real-world practice settings. Dr Klitgaard's practice is actively evolving into a Patient-centered Medical Home, having implemented advanced access scheduling, an EHR with e-prescribing, many office process redesigns, and chronic disease and population management with in-office health coaches and disease registries. He enjoys practicing full-scope primary care medicine including outpatient, inpatient, ER, OB, nursing home, and procedural services such as endoscopy and C-sections. Dr Klitgaard has previously served as the new physician member on the AAFP Board of Directors and is currently President of the Iowa Academy of Family Physicians.

Concurrent Educational Sessions

Session Formats

Seminars
Purpose: To give practical information and methods to enhance practice improvement through health information and patient education efforts. Seminars include a combination of presentation and active involvement of participants. 90 minutes.

Lectures
Purpose: To provide a forum for focused didactic presentation and discussion of a topic. These topics may include clinical, research, administrative, or education issues. 60 minutes.

Papers
Purpose: To present research or programs for educating health professionals or patients. 30 minutes.

Posters
Purpose: To provide an opportunity for one-on-one discussion of a presenter's innovative project or research in practice improvement through health information or patient education. Visit with poster presenters at the Thursday evening reception, and at breakfast, lunch, and refreshment breaks on Friday.

Special Interest Roundtable Discussions
Purpose: To share information, experiences, and ideas at Saturday's breakfast roundtables. Leaders will briefly present the topics and then facilitate discussion. 60 minutes.

Concurrent Educational Sessions' Scheduling:

The Conference Steering Committee considered a variety of "hot topics" related to the Patient-centered Medical Home while developing this program, as well as the variety of interests of conference attendees. Please note that sessions related to the following PCMH topics have been scheduled throughout the conference:

- **National Committee for Quality Assurance (NCQA)**
- **Using registries and care coordination**
- **Finance and business**
- **Information technology/electronic health records**
- **Team development**
- **Patient experience**
- **Teaching and tools**
- **Care design**

Is Your Practice Already a Patient-Centered Medical Home?
You may be closer than you think.

TransforMED's Medical Home IQ (MHIQ): Find out where you stand on the journey to becoming a Medical Home by measuring your practice against the TransforMED Medical Home IQ Assessment's 9 core sets of competencies or "modules."

"Road to Recognition" -- Your Guide to NCQA Medical Home: Recognizing that no two homes are alike, this guide was developed to help you choose the level of medical home recognition that you wish to achieve and determine which NCQA elements your practice will document to achieve your goal.

To find out how YOU can become a PCMH, visit: www.aafp.org/pcmh.

Concurrent Educational Sessions

Disclosure: It is the policy of the AAFP that all CME planning committee/faculty/authors/editors/staff disclose relationships with commercial entities upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interests and, if identified, they are resolved prior to confirmation of participation. Only these participants who have no conflict of interest or who agree to an identified resolution process prior to their participation were involved in this CME activity.

Room Assignments: Room assignments for each session are listed in "bold, italics" following each abstract.

Friday, November 6

10:15–11:45 am

SEMINARS

S1: Communication, Relationship, and Efficiency in Teams: Educational Strategies and Tools
Larry Mauksch, MEd, University of Washington Family Practice Residency; Cici Bean Asplund, MD, East Wenatchee, Washington
Abstract: This session provides nuts and bolts follow up to the earlier General Session presentation. For individuals and teams to benefit from using peer coaching, observation forms, and teaching videos, it is important to employ specific implementation strategies. This special session will offer details about using these educational tools and describe common pitfalls and barriers when learning new skills in residency and community practice settings.
First Seminar Objective: Set up a peer coaching model for residents or practicing physicians.
Second Seminar Objective: Use the Patient Centered Observation Form (PCOF) in practice training, including how to access an online web training module in PCOF use.
Third Seminar Objective: Create teaching tapes using peer role models.
Meeting Room: Julia Lee A-B

S2: Quality Management in the Real World: Foundation, Tools, and Implementation
Scott Fields, MD, Harry Taylor, MD, Jennifer Lochner, MD, Oregon Health & Science University
Abstract: One of the transformational aspects of the Patient-centered Medical Home is the use of population-based practice analysis to help improve systems of care. The opportunity to develop a meaningful quality program exists in a more robust manner due to the implementation of electronic health records. Yet just having an EHR does not guarantee the effective utilization of data to improve systems. For this to occur, practice leaders must have an understanding of the fundamentals of quality management; of available tools to reinforce system change, such as a balanced scorecard; and of the methods to integrate the program into an active clinical practice. Participants will actively gain an understanding of these fundamentals, while planning their own balanced scorecard and strategies for implementation in their practice.
First Objective: Define quality, and explain a set of core theories and processes used in quality management.
Second Objective: Develop a clinician-focused balanced scorecard and practice-focused balanced scorecard.
Third Objective: Implement a data-based quality program within their clinical environment.
Meeting Room: Bennie Moten B

(Seminars continued on next page…)

S3: Learning Collaboratives and Patient-centered Medical Homes: Learning From Our Collective Experience With Practice Transformation

David Walsworth, MD, FAAFP, College of Human Medicine, East Lansing, Mich; David Weismantel, MD, Rebecca Malouin, PhD, MPH, Michigan State University

Abstract: The Patient-centered Medical Home (PCMH) may be one of the best means to restore primary care and reform the American health care "system." Around the country, practices, physician organizations, payors, purchasers, and state programs are implementing plans to "certify" PCMH and what benefits these certified practices will receive. Practices may participate with multiple certification programs with multiple, often disparate, requirements and rewards. Practice must determine the costs involved with multiple transformative processes and what the return on investment may be. Many practices exist in larger organizations that have considerable inertia for change. This session also seeks to share successful and unsuccessful strategies and tools that participant practices have used in moving their organizations toward a PCMH.

First Objective: Share their methods of determining the cost of participating in a practice transformation through a learning collaborative process.

Second Objective: Share their methods of determining the return on investment of participating in a practice transformation through a learning collaborative process.

Third Objective: Share their methods of obtaining and maintaining organizational approval and support for practice transformation through a learning collaborative process.

Meeting Room: Bennie Moten A

S4: E-visits and an Online Portal—The Nuts and Bolts of How to Do It

John Bachman, MD, Mayo Medical School, Rochester, Minn

Abstract: This is for participants who wish to move from communicating with patients by telephone to using the Web. It is led by a speaker from Mayo Clinic's Department of Family Medicine. This group, by the date of the seminar, will have conducted more than 2,500 online consultations and been paid for half. It will focus on the theory and practice of how to incorporate this into a practice. The issue of tools, how to incorporate this into your workflow, and how to change your culture will be addressed. Participants who are working in this area are encouraged to bring their stories and problems to the session.

First Objective: Use e-visits and portals to generate revenue or communicate lab results and other information.

Second Objective: Change the culture and workflow of their practices to incorporate the web.

Third Objective: Solve problems in the area of the Web.

Meeting Room: Mary Lou Williams B

S5: Motivate Healthy Habits: Using Web 2.0 & 3.0 Technologies to Develop Personal Evidence

Richard Botelho, MD, University of Rochester

Abstract: Using Web 2.0 & 3.0 technologies (such as LinkedIn and NING), you can learn how to become the researcher of your own health behavior change. Using reflective and collaborative learning exercises, you create meaningful experiences about healthy behavior change that you can share with your colleagues online. Goals: Develop personal evidence about deep change that overcomes the limitations of evidence-based guidelines that address surface change. Method: Participate in real and online groups to improve your own health habits. Outcome: You can replicate this learning process for your residents, practitioners, and staff and create a health-promoting culture within your practice setting. In turn, your practice setting can create similar learning programs for your patients, using a variety of delivery methods such as group visits and peer learning groups.

First Objective: Overcome the limitations of scientific evidence and develop personal evidence about healthy behavior change.

Second Objective: Use collaborative self-guided change learning exercises to go beyond surface change to explore surface change.

Third Objective: Share learning experiences of developing personal evidence with your colleagues online.

Meeting Room: Mary Lou Williams A

S6: Results of 5 Years' Progress Implementing and Teaching Patient-centered Medical Home: University of Utah's "Care By DesignTM"

Julie Day, MD; Duane Palmer, MBA; Susan Terry, MD, University of Utah

Abstract: The University of Utah's Community Clinics are a 10-site delivery system caring for 120,000 active patients with 300,000 visits per year. Our model for the Patient-centered Medical Home, known as "Care by DesignTM" (CBD), includes core elements of Appropriate Access, Care Teams, and Planned Care supported by a robust EHR. This seminar will describe the development of CBD, status of implementation across the network, and successes and challenges of the rollout between 2003 and 2008. It will present data showing improvement associated with CBD implementation in patient, provider, and staff satisfaction, efficiency, primary care and overall financial performance, and clinical quality. It will also describe use of CBD as the basis for education of medical students and residents in training and for research.

First Objective: Describe the core elements of an operational model for the Patient Centered Medical Home (PCMH) known as "Care by DesignTM" (CBD).

Second Objective: Discuss opportunities and challenges of creating PCMH's within an existing multisite, multidisciplinary University-owned clinic system.

Third Objective: Describe use of CBD as basis for medical student and family medicine resident education, and for practice based research.

Meeting Room: Jay McShann B

S8: Implementing Pharmacist Support to Reduce Cardiovascular Risk and Chronic Kidney Disease Monitoring Through Information Technology

Wilson Pace, MD, University of Colorado Health Science Center; Chester Fox, MD, University of Buffalo; Laura Hansen, PharmD, University of Colorado Health Science Center

Abstract: Pharmacist-based interventions have repeatedly demonstrated the ability to improve medication adherence. Clinical pharmacists are a logical member of the PCMH, but it may be difficult to physically locate a pharmacist within each primary care medical practice. Technology should allow pharmacists and physicians to work as a team from a distance. We will explore the data required, integration into the PCMH, and the building of trust to create an effective team. Chronic kidney disease (CKD) is a growing problem in the United States. Early recognition and intervention may be able to slow progression and improve quality of life. We will explore the integration of an evidence-based clinical decision support system that includes CKD recommendations into the PCMH.

First Objective: Incorporate the evidence behind pharmacist-based interventions for medication adherence and early interventions for chronic kidney disease.

Second Objective: Develop processes to integrate clinical pharmacists, working at a distance, or chronic kidney disease guidelines into a PCMH, including examining risks and benefits to patients as well as efficiencies or in-efficiencies of these activities.

Third Objective: Develop metrics that can be applied within a primary care office to measure success and guide further improvements in the integration of pharmacists or chronic kidney disease guidelines into the PCMH.

Meeting Room: Jay McShann A

AAFP National Research Network

S9: Group Visits: Build It and They Will Come—Sustaining Tips and Avoiding Foreclosure

Konrad Nau, MD, Angela Oglesby, MD, Justin Glassford, MD, Sarah McLaughlin, MD, West Virginia University Rural FMR, Harpers Ferry, WV

Abstract: Most medical practices ponder and procrastinate for months to years before they take the plunge and build their first group medical visit. Learn valuable "contractor tips" learned by the P4 Project WVU Rural Family Medicine Residency Program in our journey into medical group visits as a teaching clinic. Stock up on planning, implementation, teaching, evaluation, and billing tools. Make group visit mania the highlight of your family medical home week, and learn tips to sustain your group visit program and avoid foreclosure.

First Objective: Identify five common types of medical group visits, strategies to overcome start-up barriers and techniques to establish momentum for getting your clinic team involved in group visits.

Second Objective: Utilize patient-centered agendas and shared group lab and vital sign visuals to keep your group visits personalized and motivating.

Third Objective: Evaluate the ACGME Competencies that are achieved by residents and medical students co-conducting medical group visits, as well as the status of patient and provider satisfaction with medical group visits in their clinics.

Meeting Room: Lester Young B

Friday, November 6

1–2:30 pm

SEMINARS

S10: Integrating EBM and QI in a Community-based Family Medicine Residency
Douglas Rose, MD, Beth Fox, MD, MPH, East Tennessee State University
Abstract: The move toward the Patient-centered Medical Home requires the use of skills from many aspects of health care. Two of these skill sets include evidence-based medicine and quality improvement. This session will review the basics of EBM and QI (Plan-Do-Study-Act), demonstrate how to utilize these skills in a community-based residency program, and development of an EBM/QI curriculum.
First Objective: Develop a PICO question and understand the steps in conducting a focused literature search.
Second Objective: List the steps of the PDSA cycle and develop a QI project based on this model.
Third Objective: Introduce these concepts into a medical education curriculum.
Meeting Room: Bennie Moten A

S11: Leading From Conflict to Consensus: Individual Gifts, Shared Goals
Nathan Regier, PhD, Next Element Consulting, LLC, Newton, Kan
Abstract: This seminar introduces the Process Communication Model (PCM), a contemporary model for team alignment and conflict resolution. The PCM outlines six personality types, each with specific and predictable strengths, language style, motivational needs, and negative attention behaviors. Participants will be shown the implications for aligning teams around a common goal, leveraging diverse approaches and perspectives toward unified results-oriented behaviors. Participants will have immediate and practical tools to approach decision-making and conflict more productively. While the focus of this seminar will be on creating more productive medical teams, participants will also be able to draw parallels for patient care, adherence to treatment, litigation, and patient satisfaction.
First Objective: Describe the six different patient and provider personality types, including their unique character strengths, how they prefer to connect with others, how they are motivated, and how they sabotage individual and team productivity when in distress.
Second Objective: Describe six predictable patterns of conflict between patients and providers, doctors and nurses, and among leadership teams in healthcare.
Third Objective: List six ways to reduce conflict and align different stakeholders towards shared performance goals.
Meeting Room: Mary Lou Williams B

S12: Assessment of Patient-centered Medical "Homeness" in Practices and Residency Curricula: Are We Homes Yet?
Perry Dickinson, MD, Bonnie Jortberg, MS, RD, CDE, University of Colorado Health Science Center; Nicole Deaner, MSW, Colorado Clinical Guidelines Collaborative, Lakewood, Colo
Abstract: Assessment of key components of the Patient-centered Medical Home (PCMH) in a residency practice is an essential element of the process of becoming a medical home. This seminar will discuss the assessments that have been developed as part of the Colorado Family Medicine Residency Practice and Curriculum Improvement Project. The main objective of this project is to transform the nine Colorado family medicine residency programs and 10 residency practices into a PCMH through practice improvement and curriculum redesign. The core surveys, with theoretical underpinnings based on the Chronic Care Model and various models for the PCMH, include the Practice Staff Questionnaire, the PCMH Clinician Assessment, a template for interviews of key informants from the practices, and a practice self-assessment of the NCQA PPC-PCMH criteria.
First Objective: Describe the methods used to develop the assessments for both practice improvement and curriculum redesign.
Second Objective: Discuss other surveys available for assessing aspects of the PCMH.
Third Objective: Describe how the results of the assessments have been utilized in the residency practices as a tool for practice improvement and curriculum development.
Meeting Room: Mary Lou Williams A

S13: Achieving Team Results: Best Lessons From Top Teams in Family Medicine
John Coumbe-Lilley, PhD, Ewa Matuszewski, BA, Practice Transformation Institute, Troy, Mich
Abstract: The Patient-centered Medical Home requires that every patient has their care coordinated by their personal physician. The delivery of care is to be conducted by a team of health care and administrative professionals in ways that increase quality, improve medical outcomes, and reduce costs. This session is designed to introduce attendees to what the best teams do to provide outstanding quality of care and to recognize how their own teams can improve using best practices in family medicine and beyond. Attendees should expect to be fully engaged in an interactive session using case study examples, exercises, and action planning.
First Objective: Identify the critical success factors in team formation and development.
Second Objective: Describe the impact of team improvement strategies.
Third Objective: Contrast practices used to enhance team performance.
Meeting Room: Jay McShann B

S14: Practice Inquiry: A Strong and Flexible Foundation for the Medical Home
Kimberly Duir, MD, Contra Costa Regional Medical Center FPR, Berkeley, Calif; Lucia Sommers, DrPH, University of California, San Francisco; Nancy Morioka-Douglas, MD, MPH, Stanford University
Abstract: We lose family physicians and students too often as they confront the anxiety produced by the vast complexity of patient problems in ambulatory practice. If continuity of care is important, do we have an obligation to consider furnishing the medical home in a way that sustains learners and clinicians, as well as patients? Practice Inquiry is a small-group learning and change process focused on case-based clinical uncertainty that can support and grow clinicians over a lifetime of practice. Our seminar will present a brief overview of the model, allow participants to experience Practice Inquiry, then debrief in small groups, and finally consider the potential usefulness of Practice Inquiry as a sustaining foundation to the medical home.
First Objective: Describe the elements that distinguish practice inquiry from other QA/QI and CME efforts that they have experienced.
Second Objective: Identify the role of clinical uncertainty in defining the "learning edges" for practice improvement among residents and practicing clinicians.
Third Objective: Analyze the challenges and opportunities in establishing Practice Inquiry groups in their home institutions.
Meeting Room: Jay McShann A

S15: Establishing Resident-led Mini-group Medical Visits: Overcoming Challenges and Evaluating Successes
Arnold Goldberg, MD, Melissa Nothnagle, MD, Kim Salloway, MSW, Jerome McMurray, MA, Brown Medical School Family Practice, Pawtucket, RI
The Mini Group Medical Visit (MGMV) concept evolved from the larger group medical visits model for improving delivering chronic disease care in the medical home. We developed a program in which third-year residents, working with an interdisciplinary team, facilitate a group medical visit with three to four patients from their own panel of diabetic patients during their continuity office session. The curriculum provides residents with education, mentorship, and feedback on leading MGMVs. We will present the MGMV curriculum and evaluation process. Participants will role-play a resident-led MGMV. We will discuss challenges to implementing MGMVs and the strategies developed to overcome them. We will share all of our evaluation tools and up-to-date evaluations and data of the results.
First Objective: Develop the skills needed to perform and implement a mini-group medical visit program in a family medicine residency program.
Second Objective: Establish mini-group medical visits within the medical home of a resident's future practice.
Third Objective: Evaluate mini-group medical visits in terms of resident and patient outcomes and satisfaction.
Meeting Room: Lester Young B

(Seminars continued on next page…)

S16: Development of the AAFP-NRN Collaborative Care Research Network and New Tools for Diagnosis of Bipolar Disorder

Deborah Graham, MSPH, American Academy of Family Physicians, Leawood, Kan; Benjamin Miller, PsyD, University of Colorado Health Science Center; Rodger Kessler, PhD, University of Vermont

Abstract: Collaborative care is a term used to describe different models of behavioral health in primary care. Integrating mental health services into primary care is a successful avenue for treating the health needs of the whole person. The AAFP NRN has developed a sub-network, the Collaborative Care Research Network (CCRN), whose goal is to investigate how to make collaborative care work more effectively by studying, evaluating, and improving new ways to care for primary care patients. Participants in this session will brainstorm research topics that are important to collaborative care and can be studied in PBRN setting. In addition, we will discuss the design and feasibility of an NRN study that focuses on the testing of tools for the diagnosis of bipolar disorder in primary care.
First Objective: Understand the goals and objectives of the AAFP CCRN.
Second Objective: Discuss potential studies that are important to collaborative care and are feasible in a PBRN setting.
Third Objective: Discuss the design and feasibility of a study which tests new tools for the diagnosis of bipolar disorder in primary care.

Meeting Room: Lester Young A

AAFP National Research Network

Friday, November 6

3–3:30 pm

PAPERS

PA1: Third-year Medical Students' Application of Literacy Knowledge

LuAnne Stockton, BA, BS, Susan Labuda-Schrop, MS, Brian Pendleton, PhD, Northeastern Ohio Universities College of Medicine; Janet Raber, BSN, RN, Summa Health System Family Practice, Akron, Ohio

Abstract: Literacy can have a profound impact on health. Patients with literacy challenges are susceptible to serious medical errors if they do not understand their illness or treatment properly. However, there is little formal medical education on the subject of literacy during the undergraduate medical years. Medical students should be taught to educate all patients appropriately, taking into account basic literacy principles and facts. At our medical school, second-year students receive a didactic presentation regarding literacy. In the third year, students have an assignment to evaluate a patient education handout. We compared students' assessments with rater assessments and compared students' literacy knowledge as measured by a literacy quiz to their assessments. We will report our findings thus far in our study.
First Objective: Discuss the impact of literacy and health literacy on patient care.
Second Objective: Identify teaching strategies for incorporating literacy education into undergraduate medical education.
Third Objective: Discuss potential educational strategies for involving medical students in the application of effective patient education techniques.

Meeting Room: Bennie Moten B

PA3: Medical Home in Practice: Harnessing Technology to Provide Patient-centered Prospective Care

Zsolt Nagykaldi, PhD, Cheryl Aspy, PhD, James Mold, MD, MPH, University of Oklahoma

Abstract: As the number of recommended preventive services continues to increase, clinicians struggle to maintain a balance between immediate patient concerns and the time required to address prevention. It is clear that without effective and timely clinical decision support, integrated into a comprehensive care delivery approach, and without patient-centered tailoring of recommendations, primary care clinicians' performance in this area is likely to stay sub-optimal. Delivery of primary, secondary, and tertiary preventive services will increasingly require sophisticated information processing and much greater patient involvement. Despite the importance of patient-centered delivery approaches, however, limited information is available on the impact of integrated health information technologies (HIT) on the delivery of patient-centered, prospective care in primary care settings. We have developed and tested a Web-based patient Wellness Portal as a component of a comprehensive preventive care delivery approach. Implementation of the Wellness Portal helped us translate and put the principles of the medical home concept into practice.
First Objective: Identify areas and methods for the implementation of health information technology to improve patient-centeredness and tailoring of prospective care in primary care settings.
Second Objective: Demonstrate approaches to activate, inform, and empower patients with medical information and make them active participants in their own care.
Third Objective: Communicate lessons learned about clinically integrated use of web-based Personal Health Records (PHRs) and patient-practice interaction.

Meeting Room: Mary Lou Williams B

PA4: Instant Messaging: Communication Tool to Enhance the Medical Home

Grant Greenberg, MD, MA, Helen Costis, MS, Randall Forsch, MD, MPH, University of Michigan

Abstract: Communication between clerical staff, nurses, medical assistants, and physicians is essential for the function of any practice. We used instant messaging (IM) technology at all levels of our large academic family medicine practice. Qualitative data regarding positive and negative aspects of communication were solicited. Overall, use of IM enhanced communication to facilitate patient access, referrals, communication between providers regarding urgent issues, and clarification of orders reducing risk for error. Negatives include the need to have computer access and concerns about time spent on IM taking away from other obligations. Innovative methods of communication that supercede physical barriers and can occur without wasted effort enhances many aspects of the overall efficiency and function of our practice, leaving more time to spend on patient care.

First Objective: Acquire skills to observe the types of communication that occur regularly in their own practices, including identifing areas of wasted effort that if addressed could enhance patient satisfaction with the care received, staff job satisfaction, and provider satisfaction and efficiency.

Second Objective: Identify innovative methods of applying available technology to solve identified problems in communication pathways within a practice.

Third Objective: Identify advantages of IM technology that could be applied to their practice, as well as gain an understanding of potential downfalls.

Meeting Room: Mary Lou Williams A

PA5: Practice Improvement: Medical Student and Resident Education Using a Diabetes Registry

Richard Younge, MD, MPH; Jason Hove, BA, Columbia University

Abstract: Columbia-NY Presbyterian's residency family practice center, a teaching site for the third-year Primary Care Clerkship, will use a diabetes registry to teach students and residents Patient-centered Medical Home and Practice-based Learning and Improvement principles. Registry demographic and diabetes quality of care data will inform resident diabetes PDSA projects. Medical students will complete a short essay on diabetes improvement based on review of the registry. We will compare quality indicators for our 500 diabetic patients and the number of resident PDSA projects before and after registry implementation. Student diabetes care improvement essays will be analyzed for comments regarding registries. The registry supports PDSA evaluation, facilitates teaching about improvement techniques, and prepares medical students and residents to implement quality improvement strategies in residency and practice.

First Objective: Discuss the relevant uses of a diabetes registry within the context of the Patient-centered Medical Home.

Second Objective: Determine effects of a diabetes registry on practice-based learning and improvement (PBLI).

Third Objective: Describe a method for educating and involving medical students and residents in diabetes PBLI to introduce them to this aspect of the Patient-Centered Medical Home.

Meeting Room: Jay McShann B

PA6: Improving the Patient Flow Process at the Morehouse Medical Associates Comprehensive Family Health Care Center

Dolapo Babalola, MBBS, Morehouse School of Medicine

Abstract: The purpose of this project is to improve patient flow at the Morehouse Medical Associates Comprehensive Family Healthcare Center by 30% above the present baseline over a 6-month period. The pre-pilot study revealed a total wait time of 122 minutes. Interventions were made to the practice, which showed an improvement in patient flow at the Comprehensive Family Healthcare Center by reflecting in a decreased total wait time to 98 minutes in the second study (pilot) and increased patient satisfaction. This demonstrated a 20% improvement from the initial study.

First Objective: To study patient's wait time in the outpatient clinic, with the goal to identify the factors that affect increase wait time and recommend ways of minimizing the delay.

Second Objective: Enhance patient and physician relationship with the aim to promote patient's satisfaction and retention.

Third Objective: Increase revenue and decrease overhead at the Comprehensive Family Healthcare Center.

Meeting Room: Jay McShann A

(Papers continued on next page…)

PA7: Physician Hospital Organizations Patient-centered Medical Home Initiative With Independent Practicing Physicians

Nancy Hourigan, MBA, CIPA WNY Independent Practice Association, Inc., Buffalo, NY; Richard Ruh, MD, Orchard Park Family Practice, Orchard Park, NY

Abstract: CIPA will review its plan to have 160 offices accredited by NCQA over the next 36 months. CIPA's plan is to use its CI program to including registries, EHR, office-based disease management, our virtual pharmacy, and nutrition programs to assist independent practicing physicians in achieving PCMH designation. This practice improvement lecture will first provide participants with a detailed outline and work plan setting forth the critical pathways necessary to support our goal of having all primary care physicians within the network achieving NCQA accreditation and, second, will set forth the redesign work necessary for a small, independent practice to transition to a PCMH.
First Objective: Plan and design a comprehensive PCMH initiative within an integrated delivery system.
Second Objective: Integrate information technology, office based disease management, registry programs, office-based human resources and patient education to achieve PCMH designation.
Third Objective: Increase their understanding of the key clinical and service processes underlying the PCMH.

Meeting Room: Lester Young B

PA8: "Want to Increase Colorectal Cancer Screening In Your Practice? Here's How!"

Richard Wender, MD, Thomas Jefferson University

Abstract: Colorectal cancer is the third most commonly diagnosed cancer and the second most common cause of cancer death in the United States, and much of this suffering and death could be prevented by screening. A physician's recommendation is one of the most consistently influential factors in colorectal cancer screening, yet few practices currently have mechanisms to assure that every eligible patient gets this recommendation. To address this challenge, the National Colorectal Cancer Roundtable (NCCRT) has created a new resource, "How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's Evidence-based Toolbox and Guide." Participants in this program will learn about the evidence-based tools and strategies that are outlined in this guide and how to incorporate these life-saving approaches in their teaching and practice.
First Objective: Educate students, residents, and patients on the benefits of prevention and early detection achieved through screening for colorectal cancer.
Second Objective: Recognize common barriers to colorectal cancer screening encountered in clinical practice, and utilize appropriate strategies to identify and address these barriers.
Third Objective: Adopt tools from the guide in their teaching and their practice to increase attention to screening and colorectal cancer screening rates.

Meeting Room: Lester Young A

PA9: The AIM-HI Approach to Presenting Fitness in a Central Role in Primary Care

Deborah Graham, MSPH, Angela Lanigan, MPA, American Academy of Family Physicians, Leawood, Kan

Abstract: Obesity continues to increase in the United States. Family medicine practices play a vital role in encouraging patients to lead healthy lives through physical activity, healthy eating, and emotional well-being—that is, through fitness. We will present the Americans in Motion-Healthy Intervention (AIM-HI) approach to fitness, which focuses on facilitating a conversation between the clinician and patient. Fitness is presented in a central role as "the treatment of choice" for general prevention and management of chronic conditions. AIM-HI also encourages clinicians and staff to become active participants in making simple changes in their own lifestyles. In addition, we will present the evaluation of this program, a randomized controlled trial designed to test this patient-centered intervention in 24 primary care US practices.
First Objective: Explain the Americans in Motion-Healthy Interventions (AIM-HI) approach to fitness
Second Objective: Explain the concept of fostering a "Healthy Office" environment
Third Objective: Understand the preliminary results of the evaluation

Meeting Room: Bennie Moten A

Friday, November 6

3:40–4:40 pm

LECTURES

L1: E-visits, Online Personal Health Records, and Patient Web Portals: Will Our Patients Use Them?
Richelle Koopman, MD, MS, University of Missouri-Columbia
Abstract: The chronic care model suggests that online health resources can help create the "informed activated patient." Indeed, the emphasis on Internet health resources is large and increasing. However, how many of our patients are prepared to access these resources? And if they are prepared, what motivates them to do so, and what would prevent them from doing so? As the primary care physician shortage becomes a reality at the same time as we are "shoring up" our medical homes, health care providers need to understand how the Internet can be an effective patient communication and knowledge tool. We will highlight trends in patient online access, examine the concept of eHealth literacy, and review the evidence concerning patient readiness to engage in online health activities.
First Objective: Synthesize information on current trends in online access, health literacy, and electronic health literacy as the contemporary setting for patient use of online health resources.
Second Objective: Describe promoters of patient use of online health resources.
Third Objective: Identify potential barriers to patient use of online health resources.
Meeting Room: Bennie Moten B

L2: Improving Chronic Disease Care With the Use of Automated Real-time Performance Reports
Karl Kochendorfer, MD, David Mehr, MD, MS, University of Missouri-Columbia
Abstract: Information technology to facilitate chronic disease care plays a key role in the medical home. The University of Missouri's Department of Family and Community Medicine and the Cerner Corporation partnered to develop a toolkit of applications to facilitate care and enable providers to assess their clinical performance in caring for chronic conditions. We recently introduced automated real-time performance indicators to 10 clinics. For diabetes care, physicians can view eight performance measures and compare to national benchmarks or other providers and submit their data to CMS for incentive payments. We will discuss development and implementation issues (eg, selecting measures and updating primary care provider information) and provide baseline and 6-month follow-up data to illustrate the potential of such systems to improve chronic disease care.
First Objective: Select quality measures to facilitate coordinated chronic disease care during and outside the office visit using a team-based approach.
Second Objective: Predict obstacles that might interfere with the implementation of Quality Measures generated from information systems for a Patient-Centered Medical Home.
Third Objective: Identify issues in enabling electronic medical records to provide automated Performance Reporting and electronic submission to the Centers for Medicare and Medicaid Services (CMS) and other payers.
Meeting Room: Bennie Moten A

L3: Quality Improvement Project Designs Using Chronic Disease Registries
Joshua Stubblefield, DO, Broadlawns Family Practice, Des Moines, Iowa
Abstract: With 80% of health care dollars spent on chronic disease and the Institute of Medicine's call for health care reform, quality improvement, particularly with chronic disease management, has become a necessity. The medical home model is designed to promote improved outcomes through chronic disease registries, care management teams, and a quality improvement atmosphere. I hope to illustrate by examples the importance of chronic disease registries as part of a medical home EHR for improving outcomes. Not only can accurate data reflect on our current practices (practice-based learning), but it can stimulate innovation in improving our practices (systems-based practices). I intend to share the significant outcomes we achieved as a family medicine residency through quality improvement projects with our diabetic population.
First Objective: Discuss the importance of chronic disease registries (CDRs) as part of a medical home EHR and what to look for when purchasing a system.
Second Objective: Discuss how the data generated by a disease registry can be used to stimulate quality improvement (QI) projects within your practice or residency program.
Third Objective: Provide examples of how care managers, health coaches, and multidisciplinary teams can be utilized within a busy practice setting to facilitate improved outcomes in chronic disease management through CDR QI projects.
Meeting Room: Mary Lou Williams B

(Lectures continued on next page…)

L4: Who Is in Your Neighborhood? The Patient-centered Medical Community
David Willis, MD, Greater Ocala Health Information Trust, Inc., Ocala, Fla
Abstract: Many providers and practice groups are adopting electronic health records (EHRs) as part of their evolution to Patient-centered Medical Homes. With EHRs being a large part of this transformation, decision makers should take care to not isolate themselves with systems that do not interact with other providers in their medical community. The newly adopted EHRs must not be merely electronic versions of our limited paper-based systems. This lecture proposes to discuss the interoperability elements of EHR systems to educate decision makers to chose systems that are interoperable with developing models for information exchange. Current and developing patient-centered medical communities are possible when those models and electronic systems embrace patient-centeredness and work to enhance the patient-provider relationship.
First Objective: Commit to the importance and value of a connected Patient-Centered Medical Community.
Second Objective: Explore the options and opportunities for medical record interoperability.
Third Objective: Evaluate the interoperability of EHR solutions.
Meeting Room: Mary Lou Williams A

L5: Improving Resident Competence in Multidisciplinary Team Care and Intensification of Therapy for Diabetes
Victoria Gorski, MD, FAAFP, Fabienne Daguilh, MD, Montefiore Medical Center, Bronx, NY
Abstract: A clinical and education team from the Montefiore Residency in Family Medicine participated in the American Association of Medical Colleges' Chronic Care Collaborative. An outcome of this activity was development of a multidisciplinary team whose goal is to provide an approximately 6-week program of intensification of therapy for people with diabetes who are not at target for A1C and blood pressure and/or LDL cholesterol. Residents spend four sessions with the team during cardiology rotation. The team has been successful in helping patients get to target and stay there, and the residents have met the objectives for their educational experience with the team.
First Objective: Improve care for people with diabetes with literature on "clinical inertia" and on health care systems changes
Second Objective: Describe a multidisciplinary team structure and process that has led to improved markers of diabetes care for a group of patients not "at target" for their care.
Third Objective: Describe a set of learning objectives for residents participating in an educational experience with a multidisciplinary team that uses a biopsychosocial approach to improving care for people with diabetes.
Meeting Room: Jay McShann B

L6: Patients: The Ultimate Change Agents. Floyd Family Medicine Residency Program Success Story
Saria Carter Saccocio, MD; Neeru Chopra, MD, Rome Family Practice, Rome, Ga
Abstract: Through the GO! Diabetes national pilot program, our residency participated in a patient-centered approach to improve the quality of care delivered to patients living with diabetes. By utilizing METRIC, our initial quality measures indicated significant deficiencies of documented annual microalbumin levels, foot exams, and Pneumovax immunization rates. We recognize that for a proactive redesign system change to be successful, a team-centered approach is essential. In addition to enlisting all members of the health care team, we implemented two tools—a diabetes registry and group visits. As a result, our 6-month clinic report card demonstrated an improvement in Pneumovax rates, foot exams, and annual microalbumin levels by nearly three-fold.
First Objective: Demonstrate the importance of system change through incorporating total team involvement when implementing a patient-centered approach to the treatment of a chronic disease, such as diabetes.
Second Objective: Consider specific examples of practice redesign utilized in various chronic disease models.
Third Objective: Implement specific tools, namely chronic disease registries and group visits, to improve quality of care for patients living with diabetes.
Meeting Room: Jay McShann A

L7: Patient-centered Medical Home Preparedness for Medical Decision-making: Patients and Clinicians Together Use Shared Decision Making Tools

John King, MD, MPH; Peggy Carey, MD, University of Vermont

Abstract: Central to the Patient-centered Medical Home (PCMH) is effective patient-clinician communication made possible through informed and activated partners in care. Participants will explore use of visual "natural frequency-based" decision making tools for clinician and patient to prepare for efficient, parallel, and value-based decisions that take into consideration real benefits and harms of available medical and lifestyle interventions. Use of these visual tools in the PCMH are a novel and underused way to inform both clinician and patient how to grasp the magnitude of benefits and harms. Once informed and prepared, both patient and clinician can fully explore shared decision making. This session will use PowerPoint, video demonstration, and hands-on sessions. Review of our pilot project using the tools during a patient encounter will be shown and discussed

First Objective: Describe the useful characteristics of decision-making tools in the PCMH.

Second Objective: Improve patient care experiences with benefits to both clinicians and patients of visual natural frequency-based decision tools.

Third Objective: Identify, access, and use decision tools in the offices.

Meeting Room: Lester Young B

L8: Using Electronic Medical Records to Assist In Patient-centered Diagnosis and Disease Management

James Gill, MD, MPH, Delaware Valley Outcomes Research, Newark, DE

Abstract: Electronic Medical Records (EMRs) have the potential to improve quality of care by putting guidelines at the point of care, and providing tools to assist in diagnosis and management. However, few users take advantage of this EMR functionality. This presentation will demonstrate EMR tools that assist in diagnosis and management of both acute and chronic conditions. Tools for diagnosis and management of headache disorders will be highlighted. Also demonstrated will be forms for management of depression using the PHQ-9 tool, and forms for management of hyperlipidemia that incorporate NCQA guidelines for risk-based management. We will also discuss how these tools can enhance the functionality of a patient-centered medical home through team-based disease management, and can help offices move toward "meaningful use" of their EMR.

First Objective: Understand how EMR forms can be used to improve diagnosis and management of headache disorders and other conditions.

Second Objective: Understand how EMRs can facilitate patient-centered care by incorporating patient symptom questionnaires into the process of diagnosis and monitoring.

Third Objective: Understand how EMR tools can facilitate features of the patient-centered medical home such as a team-based approach to care.

Meeting Room: Lester Young A

L25: Care Management: The Transition to Meeting NCQA Standards for PCMH

Clyde Satterly, MD, MBA, Lynn-Beth Satterly, MD, MS, SUNY Upstate Medical University

Abstract: Several practices have EHRs in place, and many more will implement them in 2009 and beyond. This presentation will focus on how one practice is developing its care management using evidence-based medicine within NCQA Guidelines over a 2-year period. Attendees should come away with a better understanding of what steps they can take to improve their care management thus moving them closer to fulfilling the core features of the PCMH. Information covered will include practical advice for both those getting started and those on their way in this process. In addition, inefficiencies and pitfalls will be shared. Participants will be invited to share their experiences with care management and their transition to the Patient-centered Medical Home.

First Objective: Be proficient in the current NCQA standards of the patient-centered medical home and what part care management has in these.

Second Objective: Use new skills to take initial steps toward development of care management strategies whether they have paper-based records or EHRs.

Third Objective: Put to use lessons learned by this practice.

Meeting Room: Big Joe Turner B

Saturday, November 7

10–11:30 am

SEMINARS

S17: Innovations from Mayo Clinic in Practice Improvement
John Bachman, MD, Steven Adamson, MD, John Wilkinson, MD, Victor Yapunuvich, MD, Mayo Medical School, Rochester, Minn
Abstract: Mayo Clinic's Department of Family Medicine will present its progress in the following areas: (1) Online consultations with specialists, (2) Telemedicine to homes of chronic disease patients, (3) e-visits with patient through a portal, (4) Documenting chronic disease patients using an EMR, (5) implementing retail clinics with nurse practitioners through a local group.
First Objective: Use the internet for consultations both with patients(either through a web portal or a telecommunication link) and with specialists.
Second Objective: Consider advantages and disadvantages of establishing their own retail clinics in their community.
Third Objective: Document chronic diseases in an electronic medical record so that it shows continuity
Meeting Room: Bennie Moten B

S18: How to Incorporate Motivational Interviewing Into Your Practice
Chester Fox, MD, SUNY at Buffalo; Cheryl Aspy, PhD, University of Oklahoma; Brian Manning, MPH, Janet Ann McAndrews, BS, American Academy of Family Physicians, Leawood, Kan
Abstract: In the Wagner Planned Care Model, a prepared proactive patient productively interacting with an office geared to chronic care results in better clinical outcomes. A good method to create activated patients who take responsibility for their own health is through motivational interviewing (MI). MI is not a skill that is taught in medical school. This session will describe what MI is, give the participants a chance to practice it on each other through a role-playing exercise, and then a breakout session will be held to discuss facilitating factors and barriers that would help or hinder them from incorporating this in practice
First Objective: Use Motivational Interviewing to enhance fitness in the areas of nutrition, exercise and emotional well-being.
Second Objective: Implement motivational interviewing.
Third Objective: Incorporate motivational interviewing in their practice and be aware of barriers to doing this.
Meeting Room: Bennie Moten A

S19: Getting to Win-Win: Engaging Nonphysician Health Care Professionals on the Patient-centered Medical Home Team
Daniel Bluestein, MD, MS, Patricia Bach, PsyD, RN, Rita Klahr, MSN, CFNP, Eastern Virginia Medical School
Abstract: Team-based care and thus team development is central to the Patient-centered Medical Home (PCMH). PCMH outcomes can be enhanced by teams that include nonphysician health professionals, engagement of whom is facilitated by team models that enfranchise them as stakeholders and partners. Accordingly, this seminar defines strategies for achieving interdisciplinary cooperation in practice. To begin, contributions of nonphysician professionals to PCMH implementation will be delineated using a case-based approach. Principles of interdisciplinary team structure, function, and leadership are reviewed next. Following an "ice-breaker," breakout groups will identify potential barriers to interprofessional cooperation, such as reimbursement, differing professional training and models of practice, interprofessional rivalry, and others. Breakout groups will then prioritize barriers and brainstorm solutions. The larger group will reconvene to summarize findings and for concluding discussion and wrap-up.
First Objective: Identify contributions of non-physician healthcare professionals to PCMH implementation.
Second Objective: Review principles of interdisciplinary team structure, function, and leadership.
Third Objective: Brainstorm potential solutions for barriers to interprofessional cooperation.
Meeting Room: Mary Lou Williams B

S20: Community Collaboration to Transform Care Delivery to Improve Outcomes of Chronic Diseases
Mary Ellen Benzik, MD, Integrated Health Partners, Battle Creek, Mich
Abstract: Calhoun County Pathways to Health (CCPTH) is a multi-stakeholder initiative addressing chronic disease in Calhoun County. This coalition of employers, health plans, physicians, consumers, and community agencies developed a mission to "improve the health of Calhoun County citizens by transforming the health care delivery system and health care experience." Through grass roots ownership, each stakeholder addresses its role in transforming health care. The multi-stakeholder Leadership Team of CCPTH meets monthly to evaluate progress, assess areas for growth, and discuss funding issues. The Consumer Advisory Council addresses barriers to care from the patient perspective. The Employer/Health Plan Advisory Council examines the role of benefit design in impacting chronic disease care. The Physician Advisory Council is charged with the transformation of care at the practice level.
First Objective: Explain the elements of the Chronic Care Model, as well as its relationship to the Patient-centered Medical Home.
Second Objective: Transform care at the practice level utilizing the IHI Breakthrough Series methodology.
Third Objective: Identify key stakeholders, as well as a framework for collaboration to improve healthcare quality in the community setting.
Meeting Room: Jay McShann B

S21: Beyond Lean: Theory of Constraints for the Patient-centered Medical Home
Robert Gray, MD, Bat Shunatona, MD, OMNI Medical Group, Tulsa, Okla
Abstract: "All improvement is change, but all change is not improvement." Successfully implementing a Patient-centered Medical Home (PCMH) requires transformative change in entire systems, not incremental improvements in parts of a whole. Many existing improvement methodologies (Lean, Six Sigma, and TQM) often lead to local, not systemic optima, with uncertain cost-benefit ratios. A "Theory of Constraints (TOC)" approach consists of a set of logical thinking processes and methods that can diagnose complex systems as well as provide clarity on what to do next. TOC focuses on the issues that are holding the system/processes/people back (the "constraints") so that changes made have a high probability of system improvement. This seminar will provide both didactic instruction in TOC concepts, and interactive practice with several TOC tools.
First Objective: Describe the foundations of TOC and know how it compares with other improvement methodologies such as Lean, Six Sigma, and Total Quality Management.
Second Objective: List and describe the four applications of TOC.
Third Objective: Be conversant with TOC change management tools.
Meeting Room: Jay McShann A

S22: Advancing Cardiovascular Health By Enhancing Patient Provider Dialogue
Randell Wexler, MD, MPH, FAAFP, Ohio State University; Dr. Andrew Pleasant, PhD, Canyon Ranch Institute, Tucson, Ariz; Jason Dees, MD, New Albany, Mississippi
Abstract: Effective communication is a key factor in the Patient Centered Medical Home, where patients and clinicians are partners in making treatment decisions and open communication is encouraged and supported. Despite progress over the past 50 years, cardiovascular disease remains the number one cause of death in the United States. This seminar will provide techniques for advancing cardiovascular health by demonstrating how to enhance the dialogue between patients and health care providers. The core component is an innovative communication skill building tool than can be customized for both patients and providers (specifically doctors, physician assistants, nurses) based on completion of an online self-assessment. The self-assessment, along with a number of useful communications resources, is free at: www.timetotalkcardio.com.
First Objective: Determine the importance and clinical impact of the current dialogue on cardiovascular disease management and the patient-centered medical home
Second Objective: Engage patients and their health care team in a solution to improve the dialogue through skill-building training to advance patient-provider communication.
Third Objective: Encourage health care providers to become champions for CC.
Meeting Room: Lester Young B

(Seminars continued on next page…)

S23: Interventions Resulting From AIM-HI QI Project: Dissemination to Workplace Settings and Shared Medical Appointments

James Galliher, PhD, American Academy of Family Physicians National Research Network, Leawood, Kan; Elizabeth Stewart, PhD, TransforMED, Leawood, Kan

Abstract: Data from the "Americans in Motion-Healthy Interventions" (AIM-HI) QI project recently conducted within three practice-based research networks showed improvement in health behaviors of family medicine practice staff. This proposal explores another possible benefit: improved organizational health. Preliminary data indicate workplace wellness programs can enhance communication and teamwork and reduce levels of chaos and dysfunction. This same QI project resulted in several study practices implementing shared medical appointments (SMAs) for patients with selected medical conditions (eg, obesity, diabetes). The research literature documents that such visits can lead to enhanced patient recommended treatment adherence and outcomes as well as efficient ways to increase practices' reimbursement for visits addressing patient lifestyle changes.
First Objective: Describe and explain the primary concepts and hypotheses behind the two proposed projects and speak to their utility in real life practice.
Second Objective: Provide suggestions and feedback to improve feasibility in real life settings.
Third Objective: Utilize the evaluation methods and provide suggestions and feedback to improve feasibility in real life settings.

Meeting Room: Lester Young A

AAFP National Research Network

Saturday, November 7

1–2 pm

LECTURES

L9: The Secret Sauce of a Successful Medical Home

Joseph Scherger, MD, MPH, Eisenhower Medical Center, Rancho Mirage, Calif

Abstract: A successful medical home is able to provide superior quality of care, outstanding service to patients, and lower overall health care costs. The Secret Sauce is a combination of providing continuous access to communication and care, being proactive in care management, and activating patients for greater self-management. This lecture presentation will present a blueprint for achieving a successful medical home.
First Objective: Visualize the successful Patient-centered Medical Home.
Second Objective: Begin the construction of a Medical Home using the three "secret sauce" ingredients.
Third Objective: Accomplish the "holy grail" of quality improvement, service improvement and cost reduction.

Meeting Room: Julia Lee A-B

L10: [Canceled]

L11: Wiring, Data, and Coordination: Building Quality Performance Into the Medical Home

Thomas Gavagan, MD, MPH, NorthShore University Health System, Glenview, IL; Stephen Persell, MD, MPH, Northwestern University; Sue Levi, RN, BSN, MBA, NorthShore University Health System, Skokie, Ill; David Baker, MD, MPH, Northwestern University; Pat Leonard, RN, MS, NorthShore University Health System, Evanston, Ill; Nancy Dolan, MD, Northwestern University; Thomas Smith, CIO, David Holub, MD, NorthShore University Health System Glenview, Ill

Abstract: Primary care is being challenged to redesign the medical home to improve quality, access to care, and patient satisfaction. The authors are using an EHR to create the needed practice redesign, performance improvement, and care coordination in two high-performance academic organizations. The aim is to create an accurate quality measurement system that can be used to support many chronic disease and preventive care quality improvement goals simultaneously. Key elements include utilization of computerized clinical decision support practice-wide, and individual physician performance measurement with feedback, and focused academic (EBM) detailing or care management to resolve barriers identified through exception reporting. Additional elements to be discussed include use of a Web-based patient portal, chronic disease management, and e-prescribing.

First Objective: Identify how a commercial EHR can serve as the platform for several related quality measurement and quality improvement activities.

Second Objective: Use specific features of the intervention, including electronic quality measures and clinical decision support, use of standard order sets linked to best practice alerts to improve efficiency, easy documentation of medical and patient reasons for not ordering tests or prescribing essential chronic disease medications, and use of electronic data to target patients who need outreach because of quality deficits.

Third Objective: Implement this kind of system and achieve successes after one year.

Meeting Room: Bennie Moten A

L12: Community-wide Quality Improvement Using Microsoft Access Diabetes Registry Reporting

Paul Dake, MD, McLaren FMR, Flint, Mich

Abstract: We chose a Microsoft Access-based Diabetes Registry conceived and developed by one of our faculty as the data repository for generating physician-specific reports for both faculty and residents. Dates and values for HgA1c, LDL, BMI, and systolic and diastolic blood pressures are logged as often as quarterly, while microalbuminuria, GFRs, and diabetic foot exams are entered semi-annually and retinal exams annually. Classes, though not doses, of all available diabetic medications are also tracked, with date started. Data contributed to the Registry by other practices allow comparison of measures across practices, leading to sharing of best practices, including results for patients participating in group visits.

First Objective: Describe the process of building a Microsoft Access database for chronic disease monitoring.

Second Objective: List 4 advantages of reporting health care quality data from a Microsoft Access-based Diabetes Registry over similar data lodged in a Microsoft Excel spreadsheet.

Third Objective: State how, even in the absence of an electronic medical record, maintenance of a disease registry like ours can allow certification of the practice as a Patient-centered Medical Home.

Meeting Room: Mary Lou Williams B

L13: Maintaining Patient Continuity in a Residency Program Using Advanced Access

Arnold Goldberg, MD, Donna Dupuis, RN, BS, Brown Medical School Family Practice, Pawtucket, RI

Abstract: Advanced Access has distinct advantages for timely patient access in primary care. In a practice that has mainly full-time providers, continuity is an attainable goal. Primary care desires to be the personal medical home for our patients, and with this it is natural that we want to provide continuity for our patients. Seeing your own physician is an ideal that we strive to provide. A residency practice with mainly part-time physicians would seem to have grave difficulties using Advanced Access in providing continuity. Programs have examined this and shown that continuity was maintained; however, recent studies have questioned that this goal can be a reality. I will offer practical solutions demonstrating how our residency, which has Advanced Access since 2003, maintains continuity.

First Objective: Know basic principles of an advanced access scheduling system.

Second Objective: Adapt the advanced access scheduling system to a residency practice so as to maintain individual physician continuity.

Third Objective: Learn how to adapt the advanced access scheduling system to a residency practice to maintain individual physician continuity.

Meeting Room: Mary Lou Williams A

(Lectures continued on next page…)

L14: Point of Care Tools for the Medical Home

Alison Lauber, MD, Medical College of Georgia FPR, Augusta, Ga

Abstract: Point of care (POC) tools allow the busy clinician to access EBM in real time and access many useful patient self-care Web sites. We have introduced the use of POC tools to our predoctoral students beginning in the second-year physical diagnosis and PBL curriculums by utilizing a Web-based bookmark page of pre-screened links, with more traditional sources such as Up to Date, DynaMed, and Ovid. The page contains sites marked to assist with EBM, physical exam, patient education, guidelines, calculators, and videos. Choice of sites, ease of update, evaluation, and transition to use in junior clerkship use will be presented issues of "competition" with less vetted sites accessed through Google. POC technology choices such as PDAs versus notebooks and smart-phones will also be reviewed.

First Objective: Review the development of a web-based bookmark page for student use of Point of Care tools in both pre-clinical and core clinical education.

Second Objective: Evaluate what works and why (and what does not) in terms of both POC tools and technology.

Third Objective: Discuss implementation of new programs and ways to enhance future projects

Meeting Room: Jay McShann B

L15: An Innovative Strategy for Same Day Access in a Family Medicine Clinic

Brenda Fann, MD, Rush-Copley FMR, Aurora, Ill; Carrie Nelson, MD, MS, FAAFP, Illinois Medical Director, Your Healthcare Plus, Chicago, IL

Abstract: Enhanced access to care is a PCMH principle. Same-day access is universally challenging in the traditional scheduling model. Open access scheduling is an option; however, continuity may decrease in a residency clinic. Our same-day access strategy applies the Lean model to eliminate barriers and avoids multiple areas of waste, inefficiencies, and increased downstream demand (ie, ER visits). This practical same-day access model doesn't sacrifice continuity and is applicable to any practice setting, including a residency family medicine center. Our policy, challenges, successes, and data will be presented.

First Objective: Use innovative strategy for same-day access in any practice setting, including a residency FMC.

Second Objective: Use the Lean model to eliminate office inefficiencies related to same-day access.

Third Objective: Gain the tools necessary for implementation in your family medicine clinic.

Meeting Room: Jay McShann A

L16: Home Blood Pressure Self-monitoring: Rationale and Dissemination of a Colorado Program

Bennett Parnes, MD, University of Colorado Health Science Center; Lauren DeAlleaume, MD, Denver Health Medical Plan Clinic, Denver, Colo

Abstract: The rationale and evidence for patient self monitoring of blood pressure at home will be presented, including essential aspects of the method of taking home blood pressure, the role in white coat hypertension, and the relationship between home readings and cardiovascular outcomes. A home blood pressure monitoring program that has been ongoing for 4 years in 26 practices within the SNOCAP network in Colorado will be discussed, including blood pressure results among the 3,000+ participating patients. Finally, input from the breakout session participants will be sought on how the Colorado program can be successfully implemented on a national scale.

First Objective: Present the value for home blood pressure monitoring for patients in their practices.

Second Objective: Present home blood pressure monitoring in initiating and changing hypertension therapy.

Third Objective: Accurately communicate home blood pressure readings between patients and clinicians.

Meeting Room: Lester Young B

AAFP National Research Network

Saturday, November 7

2:10–2:40 pm

PAPERS

PA2: Patient-centered Medical Home: A Measure of the Patient's Experience
Elizabeth Stewart, PhD, Marivel Davila, MPH, University of Texas HSC at San Antonio
Abstract: A new model for best practice in primary care is the Patient-centered Medical Home (PCMH). Attempts to define the PCMH emphasize its structural features rather than the patient experience. Therefore, we developed and evaluated the performance of a two-item "patient-centered practice experience" (PCPE) measure that combines elements of the IOM definition with a global subjective judgment of patient experience among 1,099 patients participating in a national demonstration project of PCMH implementation. The PCPE measure is strongly associated with key attributes of primary care and may be of great use in efforts to bring the patient perspective into PCMH evaluations.
First Objective: Explain the importance of measuring the patient-centered experience as part of the patient-centered medical home (PCMH).
Second Objective: Use a two question measure to evaluate the patient-centered practice experience (PCPE) of the patients in their practice.
Third Objective: Describe how the key attributes of primary care relate to the new PCPE measure.
Meeting Room: Bennie Moten A

PA10: Implementation of Voice Recognition in a Primary Care Setting
Richard Kim, MD, Michael Underhill, DO, Richard Engle, MD, Mayo Clinic Scottsdale FPR, Glendale, Ariz
Abstract: A program to implement Voice Recognition Software was piloted over a 6-month period in the Department of Family Medicine. Measures included cost effectiveness, efficiency, and staff satisfaction. By the end of the study period, a reduction of transcription cost was 50% in one particpant and greater than 99% for the others. It took 2050 encounters for staff to feel comfortable using software and an additional 15-30 minutes per day to complete notes. Accuracy before editing was 85%-90% and quality of notes when compared to regular transcription was good to excellent. Oveall, the pilot proved successful and is now being implemented department-wide.
First Objective: Recognize cost associated with transcription versus voice recognition, start up fees to include purchasing, IT support and staff training.
Second Objective: Recognize specific barriers to voice recognition software.
Third Objective: Implement a voice recognition program into their practice environment utilizing techniques learned in inital pilot study and ongoing efforts for department wide distribution.
Meeting Room: Mary Lou Williams B

PA11: Do Your Patients Get Appropriate Follow-up on Abnormal Pap Smears?
Amy Harrison, MD, MacNeal Family Practice Residency, Berwyn, Ill
Abstract: Depending on the patient population, 3%-15% of screening Pap smears may have epithelial cell abnormalities that require follow up (eg, Human Papilloma Virus typing or colposcopy). Residency practices and other large-group practices may have barriers to ensuring follow-up such as: disproportionate percentage of patients at risk, frequent provider turnover, lack of continuity, and inadequate physician knowledge. Our residency's clinical practice uses a database to track all abnormal Pap smear results and all subsequent follow-up. One physician manages the database and notifies the assigned primary about inadequate follow-up until it is complete or the patient can no longer be contacted. This session discusses our method and shows the participant how to set up a similar successful Pap smear tracking program.
First Objective: Identify reasons that abnormal Pap smear results may be difficult to follow up.
Second Objective: List the six major components that allow a tracking system to be successful.
Third Objective: Set up a system at their own program or practice that will allow them to ensure appropriate and complete follow up of all patients with abnormal Pap smears.
Meeting Room: Mary Lou Williams A

(Papers continued on next page…)

PA12: The Latin Model: A Stepwise Approach for Effective Communication With the Latin American Patient
Fernando Davalos, MD, University of Texas, Southwestern Medical School
Abstract: Latin Americans currently play a major role in the American Health care system: The US Census estimates that one fourth of the US population will be Hispanic in the year 2050. Acculturations, beliefs, lack of insurance, and language have been identified as the main barriers in the access to health care. Although language differences affect health outcomes, the true barrier between a physician and a patient is ineffective communication. Understanding some broad parameters of a culture is important to providing quality care to Hispanic individuals, families, and communities; however, patient care should be based on individuality and not cultural generalizations. We propose a stepwise approach (LATIN Model) to allow physicians to interact effectively with Latin American patients: Language, Accept, Teach, Incorporate, and Negotiate. We anticipate this model will develop effective and practical communication skills to improve patient outcomes.
First Objective: Identify the major barriers that Latin Americans face in accessing proper healthcare.
Second Objective: Describe the role of effective physician-patient communication in improving health outcomes.
Third Objective: Implement a new model (LATIN) for effective communication with Hispanic patients.
Meeting Room: Jay McShann B

PA13: The Medical Home and Rural Childhood Immunization Delivery in Family Medicine
Lyle Fagnan, MD, Oregon Health & Science University
Abstract: Immunizations are a fundamental component of children's preventive care and are promoted as a core component of the medical home. Little is known about rural clinicians' perspectives regarding immunization delivery, including feasibility and best practice models. We present the results of a mixed methods study including a statewide survey of rural Oregon primary care clinicians providing care for children and an in-depth analysis of 11 family practices. While 38% of rural clinicians reported delivering all childhood immunizations in their clinic, 44% report referring some children elsewhere for vaccinations, and 18% provide no immunizations. Leading reasons for referral include inadequate reimbursement, parental request, and storage and stocking difficulties. While some barriers may be difficult to overcome, others may be amenable to educational outreach and support.
First Objective: Describe the demographics of immunization delivery including where immunizations are delivered, what immunizations are given, reasons for referral outside of practice, limits on number of immunizations given at a single visit and the influence of presence of an acute illness.
Second Objective: Recognize opportunities to engage practices in quality improvement programs through partnership of a practice-based research network (PBRN) and a state immunization program.
Third Objective: Describe the components of early childhood immunization delivery to the Patient-Centered Medical Home Principles.
Meeting Room: Jay McShann A

PA14: Increasing Patient Visit Time: Lessons From a Suburban Community-based Practice
Donald Pine, MD, Park Nicollet Clinic, St. Louis Park, Minn
Abstract: This paper reports on a major change in practice strategy: longer visits for patients needing more time. Visits can be scheduled from 15 to 60 minutes depending on the problems to be addressed. This was a risky strategy, and a number of strategies were instituted to support this change. These strategies included visit planning, discussion about the agenda at the start of each visit, careful attention to coding, promotion of health maintenance exams, and discussion about a follow-up at each visit. Using speech recognition software has proved to be useful. Visits became more comprehensive and patient satisfaction improved. The fail rate has been low. Income has continued to be average. A key result was a significant improvement in my own satisfaction with medical practice.
First Objective: Improve patient visit time.
Second Objective: List benefits of increasing patient visit time.
Third Objective: Facilitate the transition to longer patient visits.
Meeting Room: Lester Young B

Saturday, November 7

3–4 pm

LECTURES

L17: Building the Primary Care Medical Home in an Academic Medical Center: Achieving NCQA Designation

William Jih, MD, Loma Linda University

Abstract: The NCQA has established a recognition program for practices who have achieved a Patient-centered Medical Home. The standards for recognition include integration of registries, information technology, and other means of health management to assure patients receive appropriate care when and where they need it. We will describe our processes for achieving NCQA medical home designation and point out the many challenges of achieving this designation in an academic medicine center that focuses on tertiary care above primary care. Current achievements and strategic plans for further development will be described.

First Objective: Use standards for achieving the NCQA Medical Home Designation.

Second Objective: Evaluate challenges to creating a Medical Home in the academic setting.

Third Objective: Take future steps necessary to continue the development of and improvement in the Patient Centered Medical Home.

Meeting Room: Bennie Moten B

L18: Using a Patient Registry to Improve Outcomes for Adult Diabetic Patients

John Anderson, MD, MPH, Sonya Glavin, MSN, FNP-C, Lori Postal, RN, MHA, Duke University Health System-Duke Primary Care, Durham, NC

Abstract: Managing a population of diabetic patients is challenging and has historically been done on an individual basis between patient and provider at interval visits. A patient registry allows for population management and is an important component to implementing the chronic care model and constructing the medical home concept. This project examines the impact of using a patient registry on clinical measures. Over a period of 2 years, more than 9,000 diabetic patients were tracked and adherence to guidelines monitored, using trend reports and control charts from data extracted from the registry. Utilizing a collaborative approach and embedded registry tools, the network focused on process improvement, which led to improvement in clinical measures, such as a 25% increase in patients with A1C less than 7.

First Objective: Identify the role of a patient registry in implementation of the Chronic Care Model.

Second Objective: Develop appropriate reports that display data for performance trending.

Third Objective: Identify role of population management and the chronic care model in constructing a medical home.

Meeting Room: Bennie Moten A

L19: The New Deal in Health Care: A Medical Home for All

Becky Dunlop, MSW, LSW, Aaron Lane, MD, Judy Mallozzi, LPN, Good Samaritan Hospital/Penn State University, Lebanon, Pa

Abstract: The PSU/GSH Family Medicine Residency Program (Lebanon, Pa) has a long history of caring for at-risk, special needs children and their families. Since 1993, the program has been identifying, tracking, and offering interventions to children ages 0-6 who are at risk of becoming "health care dropouts." From the initial four children identified from a pile of no-show charts, the Family Support Program has grown to care for more than 2,000 children with issues such as child abuse, deficient well-child care, medical neglect, domestic violence, teen pregnancy, frequent no-shows, parental incarceration, and parental D&A issues. Within the past 5 years, the AAP and AAFP's medical home programs were incorporated. The Family Support/Medical Home Program is now an integral part of this residency's required educational curriculum.

First Objective: Identify at least five types of special needs/at-risk children commonly seen in a family practice setting and understand why they are at-risk.

Second Objective: Quickly review a child's chart for three at-risk markers.

Third Objective: Promote the importance of community partnerships and the need to include this training in residency education.

Meeting Room: Mary Lou Williams B

(Lectures continued on next page…)

L20: The Patient's Perspective on Workflow

John Bachman, MD, Mayo Medical School, Rochester, Minn

Abstract: This session on workflow shows us examples of how patients move through a clinic. It uses movies to demonstrate the inefficiencies the patients encounter as they go through their visit. The workflow also shows us our bottlenecks and time wasters. Alternative workflows are shown, and the audience also will be encouraged to share their own workflows. Anyone attending may bring movies or PowerPoint presentations of a patient moving through the clinic. (Just use a digital camera or a movie camera starting with the patient making an appointment to when they are completed with all the work complete.) They should let Dr Bachman know so he may incorporate their presentations prior to the conference: bachman.john@mayo.edu. So, we will bring some popcorn and by using movies and pictures we will make the invisible visible and share methods of improving the patients' experience and our bottom lines.
First Objective: Know how workflow can be shown to groups to enhance a practice.
Second Objective: Value pictures and movies to demonstrate workflow.
Third Objective: Appreciate how certain enhancements to their practice and involving patients more will lead to improved productivity.

Meeting Room: Mary Lou Williams A

L21: Constructing a Patient-centered Medical Home Using Electronic Technological Enhancements—A Continuing Practice Improvement

Angelo Patsalis, MD, FAAFP, Henry Ford Health System FPR, St Clair Shores, Mich, Dwight Encinas, MD, Henry Ford Health System FPR, Hamtramck, Mich; Peter Tate, MHSA, Henry Ford Health System FPR, St Clair Shores, Mich

Abstract: In 2007, this group presented how it enhanced and improved on it's timeliness, efficiency, effectiveness, and enhanced patient communication, resulting in more empowered and satisfied patients by using their system's electronic enhancements. These same technological and electronic enhancements served as their building "chips" in creating a Patient-centered Medical Home (PCMH). This lecture presentation will show how they have used their resources in electronic technology in incorporating the principles and characteristics of the PCMH to their practice. In this lecture presentation they will show how they have strengthened their patients' ongoing relationships with their personal primary care physicians, coordinated and integrated care across all elements of the complex health care system, enhanced access, and assured quality and safety.
First Objective: Gain practical knowledge on how to use enhancements in electronic technology in creating a PC-MH.
Second Objective: Identify and create value adding steps as they incorporate the principles and characteristics of the PC-HM using advancements in existing electronic healthcare technology.
Third Objective: Use challenges, opportunities and meaningful negative experiences to implement electronic technological enhancements to their practice and in creating a PC-MH.

Meeting Room: Jay McShann B

L22: Making Quality Improvement Work in a Family Medicine Clinic

Kari Nimmo, BA, Michelle Brady, NP, University of Illinois at Rockford

Abstract: This lecture/discussion will describe how quality improvement concepts and tools can be applied in a family medicine clinic setting. Practical hands-on tools will be provided including best use and timing of fishbone charts, process decision program charts, and using simple run or control charts to track consistency of process and analyze stability. Participants will have the opportunity to actively discuss and relate concepts learned to their institutions. Participants are encouraged to bring projects to explore and overcome the challenges and frustrations of not reaching desired outcomes.
First Objective: Define Quality Improvement and best practices for implementing Quality Improvement in Family Medicine Clinics.
Second Objective: Describe the Plan Do Study Act method of measuring clinical performance focusing on sampling, implementation, and data display as it relates to Quality Improvement.
Third Objective: Identify ways to create a prepared proactive interdisciplinary team within the Family Medicine Clinic.

Meeting Room: Jay McShann A

L23: Planning, Implementing, and Measuring Collaborative Behavioral and Primary Care in the Patient-centered Medical Home

Benjamin Miller, PsyD, University of Colorado Health Science Center; Rodger Kessler, PhD, ABPP, University of Vermont; Frank deGruy, MD, University of Colorado Health Science Center

Abstract: Collaboration between primary medical care and behavioral health as part of the medical home is essential, but clarifying roles and successfully implementing such collaboration has been difficult. Addressing the health care needs of the whole person requires several disciplines to collaborate in the same practice. Carefully designing, implementing, and measuring collaborative behavioral medical care requires careful planning, design, implementation, and evaluation at the clinical, operational, and financial levels. This presentation will outline the necessary elements to plan and design a collaborative care program, implement it, and adopt metrics to evaluate the program. We will discuss the recent formation of a national collaborative care research network (CCRN), a subnetwork of the AAFP NRN, as a mechanism to nationally evaluate collaborative care effectiveness.

First Objective: Describe the role of collaborative care in the larger healthcare system and within the patient- centered medical home.

Second Objective: Use necessary components when integrating behavioral health into the patient-centered medical home.

Third Objective: Measure collaborative care models in primary care.

Meeting Room: Lester Young B

L24: Right Intervention, Wrong Setting? A Multi-site Evaluation of an Enhanced, Community-based Medication Reconciliation Program

Troy Trygstad, PharmD, MBA, PhD, Community Care of North Carolina, Chapel Hill, NC; Edward Bujold, MD, FAAFP, Family Medical Care Center, Granite Falls, NC; Neil Williams, PharmD, CPP, Medication Management, LLC, Greensboro, NC; Sandy Robertson, PharmD, Concord, NC; Dana Kinney, PharmD, Access II Care of Western North Carolina, Asheville, NC; Megan Rose, PharmD, Access III of the Lower Cape Fear, Wilmington, NC

Abstract: Context: Medication reconciliation is a JCAHO required activity but may lack effectiveness and coordination with ambulatory care. Objective: Determine if an enhanced medication reconciliation program that gathers, organizes, and shares with community-based providers drug use information from multiple sources (including patient home visits, medical chart, pharmacy fill history, and discharge summary) is feasible and produces a more accurate medication history for review at the first post-discharge clinic visit. Design: Comparison of discharge summary to a gold standard (combination of fill history, brown bag interview, clinic-based medical chart). Main Outcome Measures: Medication list concordance and number of potential drug therapy problems (PDTP). Results/Conclusions: Discharge summaries contain less than optimal or complete representations of patient drug use. Accurate and meaningful representations require additional medication use sources.

First Objective: Identify additional sources of drug use information.

Second Objective: Build practice-based processes to enable community-based Medication Reconciliation efforts.

Third Objective: Identify common drug therapy problems resulting from hospitalizations.

Meeting Room: Lester Young A

Saturday, November 7

3-4:30 pm

SEMINAR *(Moved from Friday morning to accommodate presenter's travel schedule.)*

S7: Guided Care: A Path to the Medical Home for Patients with Multi-morbidity
Charles Boult, MD, MPH, MBA, Johns Hopkins Bloomberg School of Public Health, Baltimore, Md
Abstract: Many primary care practices wish to become certified and receive supplemental management payments as medical homes, but they lack the ability to provide all required services. This session provides a description of the processes and tools available to implement the "Guided Care" approach to becoming a medical home. In Guided Care, a registered nurse who has completed a supplemental educational curriculum and is based in the primary care practice, works closely with several family physicians to meet the needs of 50-60 chronically ill patients at high risk for heavy health service utilization. Early results suggest that a Guided Care medical home improves quality of care, reduces cost, and produces high satisfaction in physicians and nurses. Other available technical assistance will be discussed.
First Objective: Describe how a Guided Care medical home operates and its demonstrated effects on important patient outcomes and the medical practices, and the experiences of physicians and nurses who have worked with the Guided Care model.
Second Objective: Describe how to implement a Guided Care medical home in a medical practice, and how to create high-functioning physician-nurse teams.
Third Objective: Use tools, resources, and technical assistance available to manage Guided Care teams to attain optimal outcomes through incentives, performance measurement, and continuous quality improvement processes.
Meeting Room: Big Joe Turner B

4:10–5:10 pm

LECTURES

L26: All for One, One for All: Barre Family Health Center's Approach to Improving Diabetic Care
Konstantinos Deligiannidis, MD, MPH, University of Massachusetts; Stephen Earls, MD, Courtney Jarvis, PharmD, Daniel Mullin, PsyD, Jeanne McBride, RN, BSN, MM, University of Massachusetts Medical Center, Worcester, Mass
Abstract: Diabetes, with its complications, is increasing in prevalence in the rural community that we serve. Prior care involved physicians trying to track patients to ensure necessary blood work was performed and specialist appointments were attended. However, this system was disjointed, with patients and their labs falling "through the cracks." With help from the Diabetic Collaborative, we have created a systems-based approach to tracking our diabetics and organizing their care. A registry was created, and our Health Center's laboratory, scheduling desk, nursing staff, and providers are all involved with ensuring labs are done, routine exams are done (eg, BMIs, monofilament testing), and education is performed. This involves an interdisciplinary approach to the pre-quarterly visit work. As a result, our diabetic patients are being more closely monitored.
First Objective: Use Barre Family Health Center's suggestions in planning and creating a systems-based approach to diabetic care and group visits.
Second Objective: Improve on diabetic care by considering pre-intervention data and intra-intervention data.
Third Objective: Discuss ways systems-based approaches can improve diabetic care in participants' offices.
Meeting Room: Bennie Moten A

L27: Charge Masters: A Core Approach to Revenue Enhancement for Your Practice
Lynn Schwenzer, MHSA,UMDNJ-Robert Wood Johnson FMR, Colonia, NJ
Abstract: Family physicians have to regularly review and update their charge master (fee schedule) to ensure they are keeping pace with changes in reimbursements and CPT codes. Very few physicians have learned the principles of creating functional business practices; there is a tendency for them to use poorly thought-out tools and resources borrowed from others. Attendees will describe their own experiences with charge masters, and we will cover the basics of using available resources for creating a Family Medicine Specific CPT code list, showing them where to find core fee schedule data for there own specific market area. We will use our experience in teaching this to our residents and our own experience in establishing practice procedures that simplify and rationalize the business aspects of medicine
First Objective: Describe the role of a charge master in maintaining a viable business.
Second Objective: Discuss the process of and resources for producing a useful charge master.
Third Objective: Outline a potential charge master-plan for their practice.
Meeting Room: Mary Lou Williams B

L28: Internet-based Patient Management Tool to Manage Chronic Kidney Disease in the Medical Home
Brian Arndt, MD, David Feldstein, MD, Jonathan Jaffery, MD, Richard Rieselbach, MD, University of Wisconsin
Abstract: This pilot study developed an Internet-based patient management tool to help primary care providers manage patients with stage 3 chronic kidney disease (CKD). The tool is comprised of three elements: (1) A physician-to-physician consultation tool to assist practices not yet fully implemented on an electronic medical record (EMR), (2) a CKD guideline checklist based on the Kidney Disease Outcomes Quality Initiative (KDOQI) guidelines to provide evidence-based clinical practice recommendations for stage 3 CKD and related complications, and (3) brief point-of-care educational modules integrated into the CKD guideline checklist. Phase two of this study will evaluate the effects of the tool on primary care providers' CKD knowledge, self-efficacy, and overall use of the CKD guidelines.
First Objective: Review basics of the Chronic Care Model that lead to improved patient outcomes through more productive interactions.
Second Objective: Identify ways health information technology can enhance communication between primary care and specialty care.
Third Objective: Brainstorm ways to implement evidence-based chronic disease guidelines into the current functionality of your medical record system.
Meeting Room: Mary Lou Williams A

L29: Engaging Residents in Quality Improvement: Improving Colorectal Cancer Screening in a Community Health Center Residency
Lucy Loomis, MD, MSPH, University of Colorado FMR, Denver, Colo; Suzanne Gomez, MD, Lowry Family Health Center, Denver, Colo; Brooks Flood, DO; Patty Brewis, RN, University of Colorado FMR, Denver, Colo
Abstract: Denver Community Health Services, a network of community health centers, instituted an initiative to improve cancer screening in 2008. Using lean production system analysis as the framework for improvement activities, the team addressed system- and team-based barriers. System-wide changes included development of cancer screening registries and of standard work to identify and either test or refer patients due for screening. One of the pilot clinics for the implementation of the change package is also a family medicine residency site, where the second-year residents chose colorectal cancer screening as their Patient-centered Medical Home project. We will describe how the residents worked with the rest of the clinic team to apply the system-wide resources and improve the colorectal cancer screening rates.
First Objective: Describe how lean production system analysis can be used as a framework to support quality improvement efforts.
Second Objective: Describe the major components of a change package to improve cancer screening rates, using registry data and point of care tools, in a large health center network.
Third Objective: Clarify the steps needed to implement change at the team level, and how to incorporate residents into the clinic process improvement team.
Meeting Room: Jay McShann B

L30: Use Caution When "u" Abbreviate Medical Information
Jennifer White, BA, US Food and Drug Administration, Silver Spring, Md
Abstract: One of the most common but preventable causes of medication errors is the use of ambiguous medical notations. Some abbreviations, symbols, and dose designations are frequently misinterpreted and lead to mistakes that result in patient harm. They can also delay the start of therapy and waste time spent in clarification. In an effort to promote safe practices, the Institute for Safe Medication Practices (ISMP) and the US Food and Drug Administration (FDA) recommend that ISMP's list of error-prone abbreviations, symbols, and dose designations be considered whenever medical information is communicated. ISMP and FDA have developed a comprehensive list of medical notations prone to misinterpretation and tools to help practitioners avoid them.
First Objective: Avoid the use of medical notations that can lead to medical errors.
Second Objective: Improve their medical practice through good prescription writing habits and avoidance of error-prone medical notations.
Third Objective: Improve prescribing practices within their medical practices on the overall health and well-being of their patients.
Meeting Room: Jay McShann A

(Lectures continued on next page…)

L31: Experiences in Developing a Patient-centered Medical Home Clinic: A Real Time Assessment

Patrick Devlin, MS, Physician Development Salem, Ore

Abstract: Faced with a current community deficit of 21 primary care physicians in its' service area and a projected shortage of 37 more in the next 5 years, Salem Health initiated a strategy to develop a new primary care clinic. The clinic, scheduled to open in September 2009, will be based on the Patient-centered Medical Home (PCMH) model. This presentation will use the Salem Health experience to lead participants in an examination of the evolving project concept, how the system is working with community partners to expand the model's use in varied practice settings, and how recently graduated residents are responding to recruitment efforts.

First Objective: Describe the experiences of Salem health as it moved through three distinct but overlapping phases in establishing the PCMH clinic.

Second Objective: Identify the characteristics of the PCMH model most appealing to new residents.

Third Objective: Identify open questions that will continue to drive the development and adoption of the PCHM concept in the non-academic environment.

Meeting Room: Lester Young B

Sunday, November 8

8:30–9:30 am

LECTURES

L32: [Canceled]

L33: Ten Steps to a Patient-centered Medical Home
Anton Kuzel, MD, MHPE, Virginia Commonwealth University
Abstract: This lecture discussion presents a practical, 10-step approach to achieving all features of a Patient-centered Medical Home (PCMH) over a 2- to 3-year period and without requiring special financing. The steps are easily achievable in most settings and assume a fee-for-service financing environment with Medicare rates or better. The presentation will include several examples of individual practices that have used most of these steps to achieve NCQA level 3 PCMH certification. The author is leading a "proof of concept" project in Virginia to demonstrate the feasibility, impact, and potential for dissemination of the model. This will be an interactive session, with presenter-audience dialogue about each of the 10 steps.
First Objective: State the logical and practical arguments for the ten-step model.
Second Objective: Determine the coding distribution of their own practice, compare it to national norms as well as to best practices, and be able to calculate the financial impact of making 99214 the most common E&M code for their practice.
Third Objective: State the systematic strategies whereby patients and nursing/medical assistant staff help to organize the office visit before the physician steps into the room, and similar strategies for communicating quickly and efficiently to the patient and the staff the work to be done after the visit is completed.
Meeting Room: Bennie Moten A

L34: EMR Dashboards and Registries: Helping the Team Take Action in the Patient-centered Medical Home
Jeffery Belden, MD; Karl Kochendorfer, MD; Sarah Swofford, MD; Rhonda Polly, APRN, University of Missouri-Columbia
Abstract: Our department has collaborated with our EMR vendor over the past 3 years to help produce a suite of software products that enable several key elements of the PCMH. A clinical dashboard screen, including dashboards for 12 chronic diseases, enables clinicians to see at a glance both relevant clinical information and quality performance measures to help patients manage their complex chronic illnesses. Our team of physicians and advance-practice nurses use a new patient registry tool that tracks and reports quality performance measures. With that immediate feedback, we can act during the office visit or contact a cohort of patients later to improve care quality. We have added evidence-based decision support at the point of care using care algorithms linked to the patient's clinical dashboard.
First Objective: Use the design principles we describe, the clinical dashboard (patient summary screen) to improve efficiency, effectiveness, and coordination of care for patients with chronic diseases.
Second Objective: Identify how evidence-based decision support can be integrated into the EMR, using patient's live data.
Third Objective: Identify how to select quality measures and manage cohort data to coordinate care outside the office visit using a team approach.
Meeting Room: Mary Lou Williams B

L35: The Referral Matrix: A Core Approach to the Being the "Trusted Resource"
Lynn Schwenzer, MHSA, UMDNJ-Robert Wood Johnson FMR, Colonia, NJ; Bennett Shenker, MD, UMDNJ-Robert Wood Johnson FMR, Freehold, NJ
Abstract: A fundamental tenet of a medical home is being the trusted resource for your patients' information and management needs. It is therefore essential to develop efficient and systematic ways of assisting your patients in navigating the complex rules and procedures of the health care environment. Keeping track of the insurance coverage rules, participating providers, diagnostic and therapeutic centers, and preauthorization processes is a nightmare for your patients and office alike. In this lecture, we will discuss how we utilize a Referral Matrix that is populated initially and maintained in real time so that everyone in the office has access to it and can use it to guide the patients' care within the rules of their specific health plans.
First Objective: Describe how a referral matrix can be an important tool in creating a sensible practice environment for both providers and patients.
Second Objective: Describe the role of a referral matrix in creating and maintaining the feeling for the patient that the PCP's office is a trusted resource.
Third Objective: Discuss the process of and resources for producing a useful referral matrix.
Meeting Room: Mary Lou Williams A

Scholastic & Research Posters

Poster presenters will be available to discuss their presentations during the times noted below.

Thursday, November 5: 5:30-7:30 pm
Exhibits & Welcoming Reception
Basie Ballroom A

Friday, November 6: 7 am-3:15 pm
Continental Breakfast, Lunch, and Refreshment Breaks
Basie Ballroom A

P1: [CANCELED]

P2: Nurse Case Management for an Urban Poor Population: The GAMP Chronic Disease Management Initiative
Joan Bedinghaus, MD, Medical College of Wisconsin
Introduction: Milwaukee's General Assistance Medical Program (GAMP) was a form of medical coverage for poor adults. We aimed to improve health outcomes of GAMP patients by providing nurse case management (NCM) services. Methods: Identified by billing data, 561 patients with primary care sensitive chronic illnesses were contacted; 105 enrolled and 55 completed 6 months of services. Study nurses kept detailed records using a database that facilitates analysis of multiple nursing domains. Biomedical data were extracted from patient medical records. Results: There were positive changes in patients' disease knowledge and self-management. There was no impact on glycohemoglobin, blood pressure, lipids, ER use, or hospital admissions. Conclusions: Low enrollment limited the study's power. NCM services benefited patients who completed 6 months of service, but many barriers to enrollment exist.

P3: Immunization Best Practices: Tips and Case Studies
Sondra Goodman, MS, American Academy of Family Physicians, Leawood, Kan
Immunization Best Practices: Tips and Case Studies showcase key lessons learned from AAFP Foundation Wyeth Immunization Award winners. The goal of this award program, which is administered by the AAFP Foundation and was established in 2005, is to increase childhood immunization rates and share best practices. Immunization Best Practices, summarized from 30 award-winning programs in 16 states, have been compiled into three Case Studies and five categories of Tips containing 22 specific recommendations. Increased compliance rates are based on the Recommended Immunization Schedules approved by the ACIP, AAP, and AAFP.

P4: Diagnosis and Treatment of Urinary Tract Infections in Women—A Primary Care Quality Improvement Project
Melanie Bernitz, MD, Columbia University
Our purpose was to identify the predictors of UTIs in our setting in order to minimize unnecessary cultures and antibiotic treatment. All charts with a diagnosis of urinary frequency, UTI, cystitis and dysuria, were evaluated over a 6-month period. Data-based practice changes were instituted and evaluated over two subsequent 6-month periods.
At baseline 91% of all patients had cultures sent; 56% of negative cultures were treated unnecessarily. Creating a protocol based on urine dip results reduced the number of urine cultures from 91% of visits to 64% of visits. We reduced the number of antibiotic prescriptions for negative cultures from 56% to 23%; further, the overall rate of prescriptions dropped from 71% to 55% of all visits. We changed our first line antibiotic based on local resistance rates.

P5: Saving Our Sight: Point-of-care Retinal Screening in Diabetes, A Quality Improvement Study
Lisa Doherty, MD, Robert Newman, MD, Doyle Cummings, PharmD, East Carolina University
Diabetic retinopathy is the leading cause of blindness in adults. Screening for retinopathy with early treatment can preserve vision and prevent blindness. Current guidelines recommend an annual dilated eye examination, but this is frequently not completed. Our objective was to identify patients in need of annual eye screening and provide retinal imaging via a nurse-based protocol and point-of-care digital retinal imaging machine. After 9 months, we have screened 182 patients and found a retinopathy prevalence of 24.3%, with 1.7% having proliferative retinopathy. All of the cases of retinopathy have been in minority patients, suggesting a racial disparity in screening. Our results show that point-of-care digital retinal imaging in the primary care office is an effective tool to identify patients with retinopathy requiring ophthalmologic evaluation.

P6: Creating a Patient-centered Medical Home Model Within a Community-based Academic Health Center
Peter Valenzuela, MD, MBA, Jamal Islam, MD, MS, Texas Tech University
Background and Objectives: The foundation of the Patient- centered Medical Home (PCMH) is the coordination of care through a primary care physician across all elements of the health care system. Although PCMH models are being developed throughout the country, there is limited data on models within community-based academic health centers. The aim of this project is to develop a PCMH model within an academic health center. Methods: Texas Tech Family Medicine Faculty Clinic will apply the PCMH model to treat 50 diabetic patients, 25 COPD patients, and 15 heart failure patients using National Committee for Quality Assurance (NCQA) measures. Patient satisfaction will also be evaluated. Results: The results should demonstrate moderate improvements in quality measures and patient satisfaction for patients enrolled in the PCMH model.

P7: Tips for Helping Smokers Quit
Donald Pine, MD, University of Minnesota-Methodist Hospital FMR, St. Louis Park, Minn
There is strong evidence that counseling and pharmacotherapy are effective and can be carried out briefly in the medical office setting. Clinicians and office staff have a trusting relationship with smokers, and cessation interventions build on this rapport. It is critical to proceed at the patient's pace and tailor the intervention to the individual. This poster includes tips for helping smokers who: (1) are concerned about weight gain with cessation, (2) need social support for cessation, (3) are planning to quit by "cutting down," (4) are living with another smoker, and (5) lack confidence in their ability to quit. Tips for organizing the office and training office staff to support the cessation intervention are emphasized.

P8: Utilization of a Multidisciplinary Approach Including the Use of a Chronic Disease Registry for Better Outcomes in Poorly Controlled Diabetic Patients
Ryan Van Maanen, DO, Joshua Stubblefieldi, DO, Carlos Alarcon-Schroder, MD, Lucas Brinkman, DO, Mahmoud Nikoueiha, MD, Cynthia Fisher, DO, Broadlawns Family Practice, Des Moines, Iowa
By recent estimates, diabetes mellitus affects approximately 23.6 million people in the United States and poses a major burden to society. Diabetics who can maintain better glycemic control have been found to have fewer macrovascular complications and less morbidity. Utilizing a medical home model in attempts to achieve better glycemic control in our patient population, we instituted a chronic medical disease registery for all our diabetic patients. We then identified patients with poorly controlled diabetes to see if instituting a multidisciplinary approach to management would impact objective measures of glycemic control and other markers of diabetes-associated morbidity. Results of our investigation are pending at time of submission.

P9: Improved Diabetes Markers With Implementation of a Chronic Disease Registry
Joshua Stubblefield, DO, Carlos Alarcon, MD, Lucas Brinkman, DO, Ryan Van Maanen, DO, Bibiana Ladino, MD, Mahmoud Nikoueiha, MD, Larry Severidt, MD, Waseem Khlaiq, MD, Broadlawns Family Practice, Des Moines, Iowa
The proposed model of the medical home is designed to improve chronic disease management and decrease health care costs by preventing hospitalizations and complications. Diabetes is one of those diseases that has evidence-based recommendations designed to decrease complications in the form of neuropathies, nephropathies, cardiovascular disease, and stroke. We found that our patients' outcomes improved significantly upon initiating a chronic disease registry that tracked our outcomes in blood pressure, cholesterol, and HgbA1c. Monthly report cards given to residents in their family medicine continuity clinic resulted in significant improvements in blood pressure and HgbA1c.

P10: The Biggest Loser: A Clinical Team Building Project Aimed at Helping Patients
Kat Shore, DO, Phoenix Baptist Hospital FPR, Phoenix, Ariz
Weight management is a key factor in the health of our patients. Recent weight loss literature has investigated the efficacy of diet and non-diet approaches to weight loss and has concluded that caloric reduction and maintenance of weight loss over time are the keys to success despite what program they used to initiate the loss. The challenge for practitioners remains: how to develop and deliver specific behavioral messages about weight management in an already busy clinic encounter. This QI project identified significant means and barriers to overcome weight loss issues. Educating, motivating, and sustaining health behavior change for the staff and physicians can increase the likelihood of success in the lives of our patients. Increased sensitivity to patient issues surrounding a particular health issue does create a bond between office staff and patients that may not have already existed for some.

(Posters continued on next page…)

P11: Increasing Rates of Pneumococcal Vaccination to Diabetic Patients in a Family Medicine Residency
Sarah Cole, DO, Mercy Family Medicine, St. Louis, Mo
Introduction: Pneumococcal vaccination reduces morbidity and mortality in patients with diabetes, yet many do not receive it. The purpose of this study was to improve delivery of pneumococcal vaccination to adult diabetic patients cared for by resident physicians. Methods: Using the Plan-Do-Study-Act model, seven strategies for increasing rates of pneumococcal vaccination rates in diabetic patients were introduced over 13 weeks. Electronic medical records were reviewed for care provided to diabetic patients by residents. Results: Delivery of pneumococcal vaccination to diabetic patients increased from 49% to 67%. Residents identified personal incentives, individual performance feedback, and didactic education as effective strategies for improved rates. Conclusions: Simple interventions directed toward resident physicians can increase rates of pneumococcal vaccination to diabetics cared for by residents.

P12: The Trickle Down of the Tickle: Clinic-wide Impact of Single PCTs Diabetic Foot Exam Decision
Randall Forsch, MD, MPH, Grant Greenberg, MD, MA, University of Michigan
Working toward a common goal is an important patient care team (PCT) function. To improve diabetic foot exam completion rates, one PCT decided on a simple method. Every time the prompt for the exam occurred, it would be completed regardless of the reason for patient's visit. This simple PCT effort increased the diabetic foot exam completion rate not only for the original PCT but also for the clinic as a whole by 36.8%. This demonstrates the effectiveness of simple PCT originated plans as well as the "trickle down" effect of clinical care pilots.

P13: Medication Reconciliation in Transitions: The Merit Program
Mary Hartwig, PhD, APN, Dosha Cummins, PharmD, BCPS, Tom Frank, PharmD, Ron Cole, MBA, FACMPE, Scott Dickson, MD, Elaine Gillespie, MD, Michael Mackey, MD, Joe Stallings, MD, Kasey Holder, MD, AHEC Northeast FMR, Jonesboro, Ark; Shane Speights, MD, University of Arkansas; Scott Laffoon, MD, AHEC Northeast FMR, Jonesboro, Ark
This project will develop and test a program of medication reconciliation titled MERIT (MEdication Reconciliation In Transitions). Goals are to (1) develop and implement a medication and diagnosis tracking system for patients that includes all known transition points, (2) incorporate responsibility for providing a safe medical home into the role expectations of each employee, and (3) teach medical residents the concept of a safe medical home. A licensed nurse facilitator will carry out and assist team nurses during the demonstration and pilot project, assist with system satisfaction surveys, and assist project directors with incorporating evaluations of MERIT into the protocols. Our aim is that the patient's medications list in the EMR will serve as the gold standard of reference concerning intended and actual pharmacy therapy.

P14: High Impact Toolkit for Improving the Patient Experience in an Academic Family Medicine Clinic
Thomas Balsbaugh, MD, Joann Seibles, MD, University of California, Davis FMR, Sacramento, Calif; Angela Gandolfo, MBA, University of California, Davis
Improving the patient experience requires a collaborative and innovative approach in realizing practice change. The UC Davis Family Practice Clinic and leadership team provide a comprehensive high-impact toolkit implemented to support redesign of our practice. The elements we use include a Team Huddle and the use of Practice Navigation resources. The Team Huddle concept supports an innovative approach to teamwork and communication, shared decision making, and education within a care team. Practice Navigation resources include welcome to practice letter, practice orientation materials, and our SmartCart. The toolkit offers resources that are applicable for use at all levels of practice operations by providers, learners, and support staff. These resources encourage a collaborative approach on personalizing the patient experience.

P15: COPD Screening
Anthony Coppola, DO, Broadlawns Family Practice, Des Moines, Iowa
Our general goal is to institute screening on a high-risk percentage of the population for COPD, by doing office PFTs. We'll apply this to anyone over 45 years old with a 10 pack/year history of smoking or greater. We'll then calculate how many new diagnoses of COPD we capture and how much revenue it generates for our office. This will ideally allow us to make this diagnosis earlier, intervene earlier, and allow us to improve quality of patient care.

P16: Effect of Open Access Scheduling on Patient Waits in a Family Medicine Residency Clinic

David Norris, MD, Anthony Cloy, MD, Shannon Pittman, MD, Glenna Rousseau, PhD, University of Mississippi Medical Center, Jackson, Miss

Excessive wait times are one of the most frequent complaints in primary care. Open-access scheduling has been frequently proposed as a means of reducing wait times. In this presentation, we will evaluate the effects of a new open-access scheduling system on patient wait times in two community-based clinics in a family medicine residency program. We will conduct analysis of wait time both pre- and post-implementation.

P17: Shared Medical Visits: Implementation in an Academic Medical Center Residency Practice

Linda Deppe, DO, Kelly Morton, PhD, Loma Linda University

Shared medical visits were piloted using a Rapid Cycle Improvement model (PDSA). Residents and faculty led the groups with assistance from preventive care graduate students. The visits focused on lifestyle change coaching for patients with diabetes, heart disease, hypertension, and hyperlipidemia. Recruitment of patients, no-show rates, and honest transmission of feedback from various participants were the most difficult barriers. Physician-patient continuity was important for attendance and patient satisfaction. We will share qualitative experiences of staff, patients, and resident physicians. In addition, we will offer information regarding clinical documentation and patient satisfaction tools as well as our journey with university compliance and scheduling. Finally, the utility of PDSA projects for residents to improve the shared medical visit pilot outcomes will be explored.

P18: The "No" Show to the "Yes" Show—How Our Team Transformed Our Practice

Albert Meyer, MD, Terry Gentry, BS, New Hanover Regional Medical Center, Wilmington, NC

The Coastal Family Medicine Center is the model practice site for the New Hanover Regional Medical Center Residency in Family Medicine founded by the State of North Carolina in 1996 with the purpose of training family physicians to remain in the southeastern part of North Carolina, an area characterized by a significant primary health care provider shortage. With excellent initial funding, the emphasis of the model family medicine center was on educational excellence over patient care excellence. New leadership provided the impetus to make a radical change. The poster provides an in-depth look at our transforming journey from a practice with a 20% NO SHOW rate and a NO SHOW attitude to a practice that is a YES show entity.

P19: Role of a Health Educator in a Community Clinic Setting

Sol Teresa Estebar, MD, Kirsti Weng, MD, Mark Sanders, MD, Leslyn Watson, NP, MSN, Marcie Levine, MD, Santa Clara Valley Medical Center-Silver Creek, Los Altos, Calif

Santa Clara Valley Health and Hospital System provides comprehensive medical services to a safety net population in Northern California. A clinic-based pilot program to redesign our primary care delivery model was established in our community-based Silver Creek site in September 2007. Among our initiatives is a greater focus on innovative strategies for patient education to improve patient understanding, health literacy, and disease prevention. A health education specialist is included in our staffing mix to assist in this effort.

P20: The Use of Simulation in Graduate Medical Education

Tochi Iroku-Malize, MD, MPH, Southside Hospital FMR, Islip, NY

Teaching adult learners can be challenging, especially in today's world of shortened attention spans. By actively engaging the learner in the education process via simulated cases, the ability to retain key information is enhanced. The learning objectives now become an active experience that is better recalled at a later date. We have used simulated cases to teach not only key clinical management concepts but also communication skills, patient safety, health care systems, evidence-based medicine, and other core competencies required in residencies. At the end of each session, the positive experiences and actions are acknowledged to encourage retainment of key concepts.

Special Interest Discussion Breakfasts

Saturday, November 7

7-8 am

The following presentations/discussions will be offered with the continental breakfast on Saturday morning. Other "common interest" discussion topics may be added at the conference.
Basie Ballroom B-C

B1: Initiating a Program to Assess and Address Improving Low Health Literacy in Residency Clinics
Barbara Leone, MD, University of Minnesota
Health literacy is defined as "the ability to read, understand, and use health information to make appropriate health care decisions and follow instructions for treatment." It is known that approximately 40% to 50% of Americans have some problem with health literacy. Health literacy is a stronger predictor of health status than age, income, employment status, education level, or racial and ethnic group. The discussion will focus on heightening awareness of the problem in our clinics and the assessment and initiation of addressing low health literacy in a respectful and non-shame-based way.

B2: Engaging Practices in Quality Improvement Through Multi-method Assessment Processing Data and Message Framing
Caitlin O'Neill, MS, RD, Tiffany Noelle Brown, PhD, Linda Niebauer, BA, Wilson Pace, MD, University of Colorado Health Science Center
Medical practices have their individual definitions of "quality improvement," which they carry out using their own styles, personalities, and energy. Our team of practice facilitators from NIH- and AHRQ-funded studies have learned important lessons that may help practices successfully adopt quality improvement processes. A Multi-method Assessment Process (MAP) establishes a baseline status including leadership, teamwork, communication, work flow, and culture. Facilitators present qualitative and quantitative data specific to that practice, which frames the discussion and acts as a driver for the quality improvement process. We will review the MAP process and message framing as tools to engage practices in quality improvement processes that can otherwise seem daunting.

B3: [Canceled]

B4: Providing Immunizations in the Patient-centered Medical Home—Implications for Practice
Herbert Young, MD, MA, Bellinda Schoof, BSPH, MHA, CPHQ, American Academy of Family Physicians, Leawood, Kan
A Patient-centered Medical Home (PCMH) is an approach to providing comprehensive primary care for people of all ages and medical conditions. A medical practice that operates as a PCMH consists of the personal physician leading a team of health care professionals who collectively take responsibility for the ongoing care of the patient. The provision of immunizations is a key component in the PCMH. However, barriers such as vaccine shortages, VFC participation, immunization registry use, and catch-up of immunizations continue to be problematic. Discussion will focus on these barriers, possible solutions, and implications for practice.

2009 Exhibitors

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Exhibits & Welcoming Reception
Count Basie Ballroom

Friday, November 6: 7 am-3:15 pm
Continental Breakfast, Lunch, and Refreshment Breaks
Count Basie Ballroom

Booth 1: Time to Talk CARDIO/Porter Novelli
75 Varick Street, 6th Floor
New York, NY Phone: 212-601-8239
Contact: Pamela Counsell
Display: Time to Talk CARDIO is a free, web-based educational program underwritten by Merck/Schering-Plough Pharmaceuticals and developed in partnership with the American Academy of Family Physicians (AAFP) Foundation, Canyon Ranch Institute (CRI) and RIASWorks. Time to Talk CARDIO is dedicated to advancing cardiovascular health by helping to improve the dialogue between patients and health care providers. Experience first-hand how this tool can help you and your patients at www.timetotalkcardio.com.

Booth 2: Merck/Schering Plough Pharmaceuticals
351 N. Sumneytown Pike
North Wales, PA 19454 Phone: 267-305-8151
Contact: Geri Drages
Display: Representatives will be available to provide information on VYTORIN and Zetia.

Booth 3: Biomet Orthopedics
56 E Bell Drive
Warsaw, IN 46581 Phone: 574-372-1726
Contact: Lorrie Stout
Display: We will be exhibiting patient education materials designed to assist the physician in educating her/his patients. These materials include brochures, bone models, anatomical notepads, and flip charts.

Booth 4: AAFP Americans in Motion
11400 Tomahawk Creek Parkway
Leawood, KS 66211 Phone: 913-906-6000
Contact: Janet Ann McAndrews
Display: Get the highly acclaimed AAFP Americans In Motion-Healthy Interventions (AIM-HI) educational resources including the new DVD and children's book to enhance your practice with healthy lifestyle coaching methods for your patients. Also, pick up many other new physician free resources at the AIM exhibit! Find out why AIM-HI works!

Booth 5: AAFP Scientific Activities Division
11400 Tomahawk Creek Parkway
Leawood, KS 66211 Phone: 913-906-6000
Contact: Joyce Haas or Pam Rodriguez
Have you participated in Tar Wars? What is Ask and Act? Are there new tobacco cessation resources available to help patients quit smoking? Stop by our booth to get answers to these questions, and pick up free materials (new Tar Wars wall posters and tobacco cessation resources). www.tarwars.org and www.askandact.org.

Booth 10: AAFP Foundation
11400 Tomahawk Creek Parkway, Suite 440
Leawood, KS 66211 Phone: 913-906-6224
Contact: Phyllis Naragon
Display: The AAFP Foundation is working to improve the health of all people through scientific, educational and humanitarian efforts. Discover the products, programs, and grants that have been developed for family physicians and other health care professionals from the support provided by physician members and corporate partners.

(Exhibitor list continues on next page…)

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Count Basie Ballroom

Booth 16: Quest Diagnostics, Inc.
10101 Renner Blvd.
Lenexa, KS 66219 Phone: 913-577-1395
Contact: Susan Blair
Display: Clinical laboratory services.

Booth 18: CHPA Educational Foundation
900 19th Street, NW, Suite 700
Washington, DC 20006 Phone: 202-429-3518
Contact: Mimi Pappas
Display: The CHPA Educational Foundation housed at otcsafety.org, is the nonprofit organization devoted to providing consumers information about the safe use of OTC medicines. Otcsafety.org provides resources for consumers on how to appropriately use, administer, and store OTC medicines. Materials are free of charge and many are available in Spanish.

Booth 19: Salem Health
P.O. Box 14001
Salem, OR 97309 Phone: 503-561-5358
Contact: Patrick Devlin
Display: Recruitment – new Patient-centered Medical Home clinic in Salem, Oregon. Excellent salary and benefits in a community offering an excellent lifestyle.

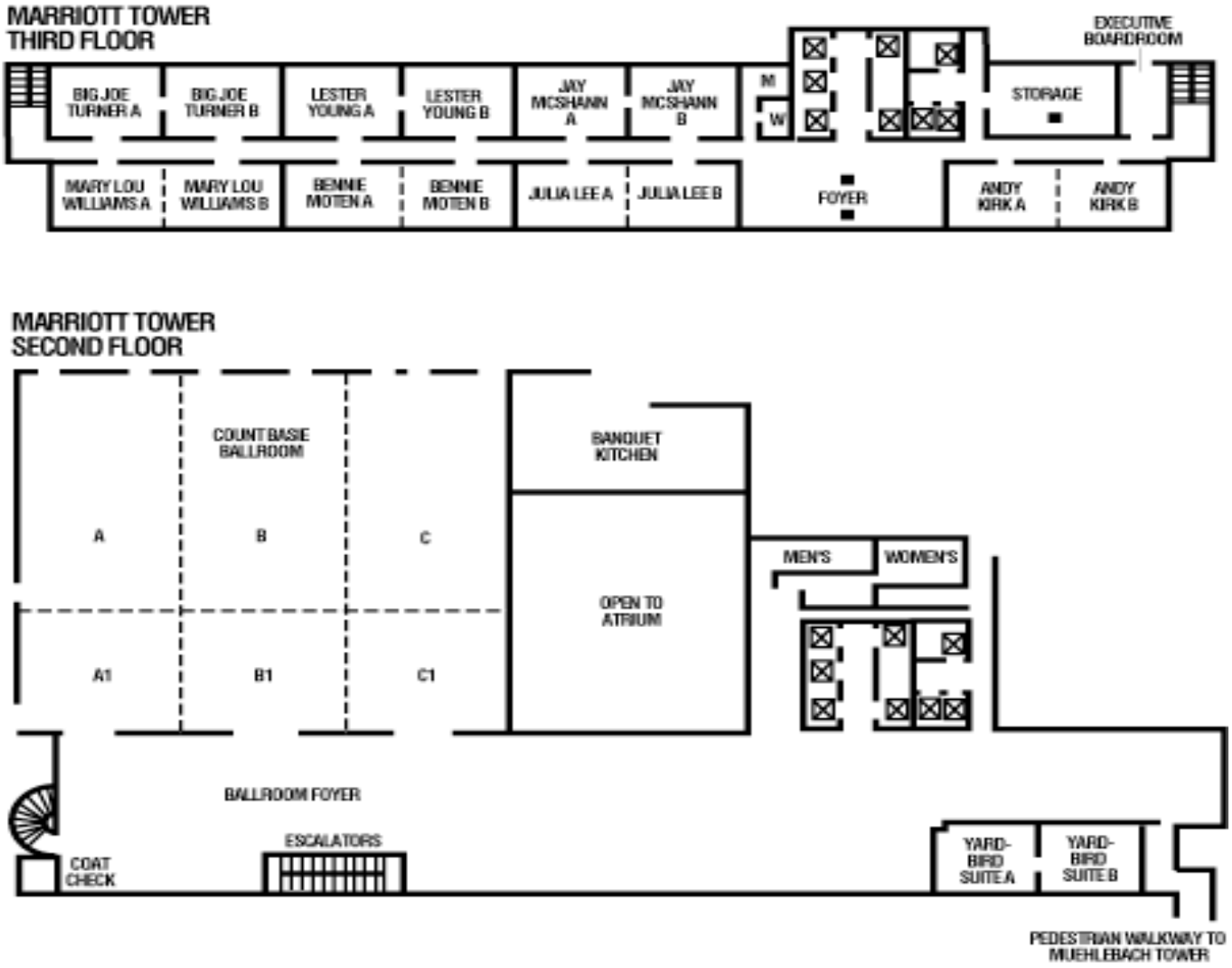
Booth 20: Solveras Payment Solutions
800 Crescent Centre Drive, Suite 400
Franklin, TN 37067 Phone: 615-550-9315
Contact: Russ Evers
Display: Solveras is your electronic payments expert, with complete credit and debit card, E-Check/ACH and virtual terminal solutions for individual and multi-physician practices. Our consultative approach, competitive rates and real customer service are the reasons we are the AAFP' Advantage partner for payment processing.

Booth 21: Instant Medical History
4840 Forest Drive, Suite G-B, #349
Columbia, SC 29206 Phone: 803-796-7980
Contact: Matthew Ferrante
Display: Instant Medical History saves physician time by enabling patients to organize subjective history prior to the encounter, facilitating data entry into the EMR or eVisit. Branching logic enables patients to progress quickly through 6,000 adjustable questionnaires from an extensive medical knowledge base, with output automatically transferred into over forty EMRs.

Booth 22: CINA
12221 Merit Drive, Suite 975
Dallas, TX 75251 Phone: 214-550-6480
Contact: James Mays, Jr.
Display: CINA provides services to support point of care decision support, registries, benchmarking, patient centered medical home, practice improvement, and reporting to PQRI, P4P and others. CINA provides the technical foundation for the DARTNET Research Project.

Notes…

Marriott Meeting "Map"



SAVE THE DATE…
2010 Conference on Practice Improvement

December 2-5, 2010
San Antonio Grand Hyatt Hotel
San Antonio, TX

The 2010 conference ***Call for Papers*** will be available at www.stfm.org in late-December.