APPLICATIONS OF
TELEMEDICINE
IN FAMILY PRACTICE

Breaking Down Telemedicine Barriers: Are Family Physicians Ready?

Telemedicine Update: A Family Physician Approach to Allergy and Care Coordination with the Allergist

ALSO…

- The Opioid Epidemic: Rural Health Challenges
- Family Care Track Capstone Project: Winning Essay
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**Mission Statement**

To support and promote Maryland family physicians in order to improve the health of our State’s patients, families and communities.
You mean it’s NOT just a fun position?”

I laughed aloud when a Family Medicine colleague made that remark regarding the role of MDAFP President. His innocent surprise, in response to my description of a recent chapter-related effort, indulged my sense of humor.

Being President IS a fun role, yet one that I take seriously.

Your President and your Board make certain we bring value to you in exchange for the dues you pay every year. Here I’ll highlight some of many recent Board activities and decisions guided by that principle.

Just a few days ago, your Board voted unanimously to introduce legislation in the 2018 Maryland General Assembly to support Direct Primary Care (DPC)*. This is a watershed moment for our chapter: we have gone from reacting to State policy to helping shape it, and now we are going to drive it. We will tap the experience of our brother and sister AAFP chapters who have introduced similar bills and have achieved success in their respective states.

In a nutshell, the proposed legislation will provide clarity that DPC is not a form of insurance. As you know, DPC is an off-the-grid contract between a physician and a patient to cover a scope of health services in exchange for a monthly fee and applicable charges. DPC is possible in Maryland right now. But this legislation, if passed, will make it easier for physicians to practice DPC by lifting some regulatory burdens.

Your Board recognizes that DPC is not for everyone. But for those who would like to pursue that option, your chapter intends to open that door wider for you.

The MDAFP Board voted unanimously to host a Family Medicine Advocacy Day during the 2018 General Assembly. This will be our fifth such event, which grows in scope and size each year. Members attend for free and CME credits are awarded for participation. Organizing the event requires that we match physician availability with legislator availability – quite the feat! Yet the payback for the effort is that the MDAFP is recognized as its own voice with its own priorities. No one can speak for Maryland family doctors and our patients like we can.

MDAFP leadership continues to support the Maryland Comprehensive Primary Care Model* and will promote awareness and adoption of the model by family physicians. As I write this, the model is progressing through its clearance stage of approval by federal agencies. This summer, multiple meetings will be held to describe the model and how practices can apply. We will do our part to keep you informed of your options in order to start benefitting financially from the program in 2018.

Your MDAFP Board voted unanimously NOT to increase chapter member dues. This will be the fourth year in a row that we have maintained dues at their current level. Your Board wants to continue focusing on fiscal responsibility and driving value to our membership. We will also pursue non-dues revenue to support our efforts.

That’s a sample of what your Board has been doing. These are volunteer leaders who dedicate their time and resources to advocate for you and your patients. Yet that’s rewarding to do because we have champions like our members in the trenches, working hard every day.
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You’re an inspiring group! Note that, this year, we have as of this writing SIX Fellows to honor at our annual meeting: an unprecedented number! These individuals will be recognized and celebrated for their dedication to Family Medicine, which they have demonstrated through leadership, education, advocacy, research, and community service.

Yes, being President is fun. And challenging. And rewarding! ■

Yours in service,

Pat

*For a description of DPC and the Maryland Comprehensive Primary Care Model, see the last issue of Maryland Family Doctor, “President’s Letter.”

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AAFP Annual Conferences

Annual Chapter Leadership Forum (ACLF) and National Conference of Constituency Leaders (NCCL):

2018: April 26-28 (preconference April 25), Kansas City, MO

National Conferences of Family Medicine Residents and Medical Students:

2017: July 27-29, Kansas City, MO
2018: August 2-4, Kansas City, MO
2019: July 25-27, Kansas City, MO

Congress of Delegates (CoD) and Family Medicine Experience (FMX):

2017: Sept. 11-13 (CoD); Sept. 12-16 (FMX), San Antonio, TX
2018: October 8-10 (CoD); October 9-13 (FMX), New Orleans, LA

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Summer and vacations have become synonymous. As this journal arrives many of you are anticipating taking the time to enjoy the beautiful outdoors. As for me, I prefer the comfort of air conditioning. One of my new favorite places is the movie matinee and I do not want to be late for one of my favorite parts – the coming attractions. It allows me to play movie critic and give my thumbs up or thumbs down and determine in advance which movies will excel at the box office or are unfortunately dead on arrival.

Like the movies, as technological advances abound – the field of medicine is full of coming attractions. Medical futurists over a decade ago predicted the development of technologies such as robotic assisted surgery, 3D printing applications, the use of drones and telemedicine. These have all become realities and current efforts and research now work to enhance these and other advances with a goal to improve patient health and health outcomes for society as a whole.

This edition of Maryland Family Doctor will take a look at one of these advances, the field of Telemedicine. Telemedicine has gained traction as a tool to provide care to patients in rural and remote areas where access to care is limited. Indeed numerous current programs in Maryland and elsewhere in the US have shown Telemedicine as a valued asset to provide expert medical care when resources in the region are lacking. However, the future of Telemedicine lies in broadening its use to become more mainstream in medicine and a part of patient care activities of the office based family physician. One can paint a future of the family physician who will have in addition to the office schedule, hours during the week set aside for Telemedicine for a cadre of patients near and far. This coming model could blur the definition of urban- suburban – rural physicians as the potential patients on a doctor’s schedule become increasingly diverse. Stay tuned for this is just a snippet of the “coming attractions” for Family Medicine.

Two articles in this edition will introduce and elaborate on Telemedicine and its potential applications. As you read the articles from Dr. Minoti Parab and Dr. Tania Elliott, I encourage you to consider how you can plug this technology into your current practice. Our Resident Editor, Dr. Christine Jones provides a comprehensive overview on the opioid epidemic in rural America. In this arena, telemedicine is being used nationally to help fight this growing problem. Finally, as always, please enjoy our other features. After reading our journal, please remember to enjoy the varied enjoyable activities that summer has to offer, including a movie matinee and arrive on time for the coming attractions.
This Summer, 2017 edition of The Maryland Family Doctor (vol. 54, No. 1) has been reviewed and is approved for THREE (3) Prescribed Credits by the American Academy of Family Physicians (AAFP). Credit may be claimed for one year from the date of this edition (expiring July 31, 2018).

The American Medical Association (AMA) accepts AAFP Prescribed credit as equivalent to AMA PRA Category 1 Credit for the AMA Physicians Recognition Award (PRA). CME activities approved for AAFP Prescribed credit are recognized by the American Osteopathic Association (AOA) as equivalent to AOA Category 2 credit.

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The process for completion and submission of MAFP Journal CME quizzes is fully automated. Read the CME articles in this edition (listed above) either from your mailed version or the online version. Each “live” version is posted online at the Publications and News tab. Access the quiz by clicking on the CME Quiz tab at www.mdafp.org.

Once on the CME Quiz page (where quizzes for each “live” edition are posted), follow the directions. Upon submitting your completed quiz, you will receive an immediate confirmation that your quiz has been received by MAFP. The confirmation will list the edition and the amount of credits earned. KEEP A COPY OF THIS CONFIRMATION FOR VERIFICATION.

READERS ARE RESPONSIBLE FOR THE REPORTING OF CREDITS DIRECTLY TO AAFP AND/OR OTHER ENTITIES. Quiz answers for each edition are posted at www.mdafp.org; Publications tab. Questions? Contact the MAFP office via email to info@mdafp.org or call 410-747-1980.
Those were the surgeon’s words during a phone call 10 days post-op to my husband, Mike Barr.

What led to our hearing those welcome words? Well, just this past April 6th, on colonoscopy after a GI bleed, a mass was found. You can imagine our shock… and fear. However, later that day, a CT Scan indicated that the tumor was contained and operable. Twelve days later a laparoscopic left hemicolectomy was performed.

I met Mike 50 years ago this August 12, 2017. We celebrated our 47th Anniversary last month.

I’ve always loved the guy (a lot) but thru this whirlwind of an ordeal, I’ve gained for him added admiration and pride. Following his lead several years back, I decided to “take care of myself,” making some overdue lifestyle changes. Now my plan is to draw from his bravery and poise should I ever face a similar circumstance.

Dr. Joyce Evans speaks in her Editorial (p. 10) about the ever-increasing technological advances in medicine. In our case, we were the beneficiaries of state of the art medical care and treatment which included screening techniques (colonoscopy & CT scanning), and surgical procedures (laparoscopy with some kind of “super glue” instead of stitches…) contributing to his short 2-day hospitalization and subsequent comparative speedy recovery.

My point in bringing this personal experience up is to use this space to thank the medical team, without whose quick action and coordination/communication, the outcome, I’m convinced, would have been vastly different. Before diagnosis, wheels were put into place by Mike’s trusted Family Physician who acted swiftly and continued to provide expert, coordinated steerage throughout. A 2nd family doc plays such an important and valuable role in all things Barr family medical… I can’t even begin to tell you…

We are also so grateful (and lucky) to have had the swift, expert and compassionate service of 1) our Gastroenterologist, 2) our (come to find out acclaimed) Colorectal Surgeon, 3) fabulous nursing care. We also value the office staffs of each physician involved. We know that the optimal outcome achieved might not have been, if all aspects were not as well aligned.

My career with MDAFP has been a long one… approaching 35-years. Our family’s experience has taught me many things, not the least of which is a renewal of the pride I take in serving the medical profession… and YOU!
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An established patient calls the office for a same day appointment and is told that there are no openings in any provider’s schedule for the next week. He has not been in the office for over a year. This 57-year-old male presents with intense pain in his right big toe that is 9/10. He has had similar pain previously in the same location approximately twice for which he has never been seen. He was out drinking with friends last night. He denies fever. ROS is otherwise negative.

Past Medical History: HTN
Medications: Lisinopril/Hctz 20/12.5mg 1 po qd
Allergies: No Known Drug Allergies

PE:
Vitals: Temp 97.1
Gen: Appears in distress due to pain
Skin: 1st MTP joint – red, swollen, warm and tender to palpation

What is different about this patient presenting with gout? The difference is this patient was seen via telemedicine instead of in an office or clinic.

Telemedicine provides cost-effective, convenient, and portable healthcare. A rising number of providers are considering adding telemedicine to their practice; however, for many physicians, adapting to this delivery system can seem daunting due to concerns which include: quality assurance, time allocation, training requirements and an online limited physical exam. Furthermore, some providers feel telemedicine will fragment patient rapport and continuity of care, which could further fragment healthcare. Despite multiple published surveys showing patients are ready for telemedicine, these concerns raise the question, “Is Medicine ready for Telemedicine?”

These concerns, while valid, should not deter physicians from embracing innovation as healthcare advances into this new technology-driven frontier. Addressing these concerns can generate a more inviting view of telemedicine. Regarding quality assurance, telemedicine physicians are held to the standards for both brick and mortar and telemedicine practice. On top of this, many telemedicine providers practice in multiple states and are, thus, vetted by multiple state medical boards and payor - contracted credentialing organizations. They must demonstrate knowledge of federal and multiple states’ regulations about practice and prescribing.

Although medicine is essentially the same no matter how it is practiced, via office or telemedicine, specialized telemedicine training is essential. Organizations should make this protected training time to assuage providers’ fears of being overloaded with more work. Training should include basic technology, troubleshooting issues, appropriate online care, and regulations pertinent to telemedicine. Formal training as opposed to trial and error, ensures a smoother transition for patient and physician alike.

Another concern is the physical examination, or lack thereof, via telemedicine. This should be thought of not so much a limitation, but a factor to help determine what is appropriately seen

Instead of thinking telemedicine fragmenting care, we should embrace telemedicine’s ability to strengthen continuity of care and build patient rapport by making health care more accessible and affordable, all the while maintaining quality of care.

by Minoti Parab, M.D.
in a telemedicine setting. Some diagnoses are easily supported in telemedicine using evidence based medicine from the office environment combined with office experience. A standard of care has already begun to take shape as more physicians and organizations have honed their telemedicine practices. Despite the progress, it takes a conscientious team to work through diagnoses and symptoms commonly seen to develop telemedicine standardization that can be disseminated to new providers and organizations.

Instead of thinking telemedicine fragmenting care, we should embrace telemedicine’s ability to strengthen continuity of care and build patient rapport by making health care more accessible and affordable, all the while maintaining quality of care. Often patients cannot be seen by their primary care provider for a variety of reasons, including provider unavailability, self-pay status, high deductibles and copays. Sometimes the patient is in a location that is inaccessible to in-person care, such as those patients traveling or residing in rural locations.

Finally, a follow-up plan is essential. Documentation and communication with the primary care physician should be no different than would be expected in the brick and mortar practice. Also, due to unchartered waters for many patients utilizing this delivery system, it is important to take the time to educate and set patient expectations from the beginning.

As mentioned before, telemedicine can address the gaps in healthcare. It can improve patient care through compliance, access, continuity and outcomes, and help capture revenue that would otherwise be lost. In 2014 the telemedicine global market was valued at $14 billion and the projected market for 2020 is $35 billion. North America dominated the market in 2014, but the Asia Pacific is expected to dominate by 2020. According to the Tractica report, telehealth video consultations sessions will increase from 19.7 million in 2014 to 158.4 million by 2020. In fact, the telemedicine provider REACH Health survey done in 2015 said 44% of organizations indicated telemedicine as high priority, and 22% as top priority.

**Looking back at this case, what does telemedicine offer our patient?**

In 2013, less than half of US adults reported being able to secure same- or next-day appointments with their physicians, and less than 40% reported being able to obtain care after hours without going to the emergency department.

Gout is one of the most poorly treated rheumatologic diseases in that a gold standard assessment is available, i.e., MSU crystal positivity. While this gold standard has high specificity, its feasibility and sensitivity may be inadequate. While it is ideal to send each patient for joint aspiration, it is not common practice. Gout is typically diagnosed using clinical criteria. The 2015 ACR/EULAR criteria for the classification of gout, a clinical-only version can be considered for use in settings in which synovial aspiration or tophus aspiration is not feasible. Many patients experience a delay in gout diagnosis due to office availability, but telemedicine offers easy access to healthcare so patients can be seen and diagnosed quickly. Treating gout flares as quickly as possible (<24hrs) is ideal. For most patients, a typical history, classic exam observed by webcam, and use of clinical criteria, can support the diagnosis. Once these patients are seen via video conferencing, counseled and treated, a follow-up plan can help the patient enter the health system, or simply follow-up and continue appropriate long-term management. With time, we will be able to determine if adding this new type of visit will improve patient compliance and outcomes. Once followed up in the office, future acute gout exacerbation managed via telemedicine helps decrease overall patient cost while offices are free to see those medical conditions truly appropriate for an in-person visit. For initial diagnosis, when in doubt, it is important to explain to the patient, why, when and where the patient should be seen in an office setting.

It is obvious that technology has changed people’s lives, and its use within medicine should be no different. By allowing access to care to anyone who has even the simplest technology (PCs, notebooks and mobile devices), telemedicine can improve the quality of life of both physicians and patients. It is important to learn more about this topic, keep an open mind to its value, speak of its concerns, expect high standard of care, and develop standardized guidelines. Ongoing discussion and collaboration will help ensure best care practices in telemedicine and help to alleviate the concerns mentioned above while improving the current health care system.

Dr. Parab is a Board Certified family physician at Humana Utilization Management-Reviewing Medical Director at Humana in Charlotte, NC. She is Chair of the AAFP’s Telehealth Member Interest Group (MIG). The American Academy of Family Physicians (AAFP) Telehealth Member Interest Group (MIG), is a group of physicians who are members of AAFP with shared professional interests in the practice of Telehealth. For more discussion on Telehealth, check out the community online at the AAFP site (www.mdafp.org).

Note: References for this article are posted at www.mdafp.org; Publications tab. CME question for this article are posted at www.mdafp.org; CME Quiz tab, Summer 2017.
Telemedicine Update

A Family Physician Approach to Allergy and Care Coordination with the Allergist

by Tania Elliott, M.D., FAAAAI, FACAAI

Charles Babbage is considered the “father of the computer” as he conceptualized and invented the first mechanical computer in the early 19th century. Intel launched the first microprocessor chip in 1971, and a computer took up an entire room. In 1972, Murphy and Bird conducted 500 patient consultations via interactive television and Bird offered the first formal definition of telemedicine. He refined his definition of telehealth to include, “the practice of medicine via interactive audio-video communication system” in 1975. Fast-forward to 2017 where three billion people carry smartphones in their pockets, each more powerful than that room-sized computer.

Telemedicine and telehealth are also more clearly defined. According to AAFP, telemedicine is the practice of medicine using technology to deliver care at a distance, over a telecommunications infrastructure, between a patient at an originating (spoke) site and a physician, or other practitioner licensed to practice medicine, at a distant (hub) site. Telehealth refers to a broad collection of electronic and telecommunications technologies and services that support at-a-distance healthcare delivery and services. Telehealth technologies and tactics support virtual medical, health and education services. On the other hand, mhealth is known as mobile health and is a form of telemedicine using wireless devices and cell phone technologies.

Why is there such a need to change how we practice medicine? According to projections by the Association of American Medical Colleges, the nation will be short more than 90,000 total physicians by 2020, and 130,000 physicians by 2025. The Annals of Family Medicine projects that the United States will need 52,000 more primary care physicians by 2025. Access to specialist care can also prove challenging, as it is often limited to academic centers. Telemedicine can be leveraged to improve access to not only family physicians, but specialties, in particular, Allergists. Access to Allergists is particularly limited, with as few as 3000 practicing specialists nationwide. Telemedicine offers increased access to the specialty. Care coordination is already an integral component of family physician visits, and soon to become more valuable as we see a change in payment models. Telemedicine affords the opportunity to consult with the specialist to determine whether an in-person consultation is necessary.

Today, 75 percent of health plans offer telemedicine service reimbursement, and according to the American Telemedicine Association, more than 15 million Americans received some form of medical care remotely in the last year. However, telemedicine is not as simple as “skyping” with a patient. “Webside” manner, physical examination, clinical decision making, documentation and care coordination need to be adapted for a video platform, in addition to supporting a HIPPA-compliant technology platform.

The top 5 urgent care conditions currently treated through telemedicine services include allergies, cough, upper respiratory infections, sinusitis, and rashes. The prevention, diagnosis, and treatment of allergic and immunologic conditions are everyday occurrences for the practicing family physician, whether it be the management of more benign conditions (e.g., allergic rhinitis) or severe and potentially life-threatening conditions (e.g., anaphylaxis, status asthmaticus). Let’s discuss how telemedicine can be used to diagnose allergic rhinitis and improve care coordination with Allergists.

Allergic rhinitis is the fifth most common chronic disease in the United States, and affects about one in six Americans. It accounts for as much as $2 to $4 billion in lost productivity annually, and an estimated 800,000 to 2 million lost school days.
Although few studies exist on how to differentiate among types of rhinitis upon history alone, a thorough and comprehensive history is suggestive of the correct diagnosis. A focused physical examination should follow the history. Infectious rhinitis, the most common cause of rhinitis, can be excluded with the presence of generalized symptoms, fever, and lymphadenopathy.

Family physicians should send patients for an in-person office visit, or refer patients to an Allergist when Immunoglobulin E–specific skin or blood testing is recommended when first line treatment (e.g., environmental controls, allergen avoidance, medication) has been ineffective, a diagnosis of allergic rhinitis is uncertain, identification of a certain allergen could affect therapy, or to aid in titration of therapy.

Other reasons to refer to an Allergist include evaluation of primary immunodeficiency, and interpretation of Immunocap (formally RAST testing) results, as well as, difficult to treat asthmatics, initial workup for food allergy, management of urticaria and angioedema, and evaluation and management of atopic and contact dermatitis. Allergist referrals typically and historically take place in an office setting; however, average wait time to see an Allergist in the office is approximately three weeks. Allergists as well can utilize telemedicine for some appropriate visits. Not only does telemedicine promote longitudinal care coordination, but new technology such as three-way video conferencing, improves collaborative care allowing the patient visit to occur with the family physician and the specialist at the same time.

Aside from allergic rhinitis, telemedicine for chronic disease management of other allergic diseases are promising. Allergic asthma or extrinsic asthma is the most common form of asthma and it is defined as asthma caused by an allergic trigger. A recent Cochrane review concluded that current randomized evidence does not demonstrate important differences between face-to-face and remote asthma check-ups in terms of exacerbations, asthma control, or quality of life. A follow-up randomized controlled trial demonstrated that telemedicine was as effective as in person care for children with asthma.

Additional telemedicine applications for patients with asthma include real time advice in a setting of perceived asthma exacerbation, proper inhaler technique, home environmental trigger assessment, medication management, and real-time video guidance with school nurses and teachers. Remote video visits will continue to expand in scope of practice as more store and forward technologies come on the horizon, from stethoscopes to interactive asthma pump device counters. Improved molecular diagnostics and interactive patient engagement apps will give physicians the additional tools they need to catch disease early and keep patients motivated and engaged in their healthcare.

Telemedicine can improve patient outcomes, not only through initiating timely medical visits for minor urgent care complaints, but also by monitoring chronic conditions more closely, and allowing greater time for counseling. Telemedicine does not only improve patient access to care with family physicians, but it also improves access to specialists and help with care coordination. The time for virtual visits is no longer the future of medicine; it is now.

Dr. Elliott is Associate Attending, Department of Medicine, New York University Langone School of Medicine and Bellevue Hospital Center, NY NY. She served as Medical Director for the telemedicine company, Doctor on Demand, and is currently Chief Medical Officer of the corporate health and wellbeing company, EHE International.

Dr. Parab’s bio appears on page 15.

Note: References for this article are posted at www.mdafp.org; Publications tab. CME question for this article are posted at www.mdafp.org; CME Quiz tab, Summer 2017.
The growing opioid epidemic in the United States has been at the forefront of recent debate and research for good reason. The first question one must ask is why so many opioid prescriptions are being written. Starting in the mid-1990s a trend towards treating pain as the fifth vital sign emerged within the medical community, ultimately leading to pain management as a key component of comprehensive disease management and patient satisfaction. Opioids are currently being used to manage acute pain and chronic pain, both appropriately and inappropriately. The National Health Interview Study conducted in 2012 showed that a significant portion of adults, up to 11.2% report having chronic pain. The question then becomes what is the appropriate way to manage this chronic pain. Increasing opioid prescriptions increases the risk of patients developing opioid use disorder and may ultimately lead to death, which highlights the need for physicians to engage in safer prescribing practices. In 2011, the Drug Abuse Warning Network estimated that greater than 420,000 emergency department visits were related to misuse or abuse of opioid medications.

In 2012 alone, 259 million prescriptions for opioids were written, which equates to enough prescriptions for each adult in the United States to have a bottle of opioids at his or her dispense. As the medical community at-large started prescribing more opioids, access to these medications increased for both medical and non-medical reasons. The drastic increase in the availability of prescription opioids was reflected by increased substance abuse treatment admissions related to prescriptions opioids and overdose death rates. Since the 1990s, unintentional overdose from opioids has sharply increased and by 2007 the number of unintentional deaths resulting from opioid overdoses had surpassed the combined number of deaths due to heroin and cocaine. While the opioid epidemic represents a national problem, certain areas of the country appear at higher risk for individuals developing a problem with opioid use, specifically as it relates to rural versus urban populations.

A striking gap exists between rural and urban Americans in relationship to health care that has put rural Americans at increased risk of early mortality. The rural American population consists of approximately 46 millions Americans comprising 15% of the national population, making up a substantial proportion of the population. Americans living in rural regions are at increased risk of dying from five leading causes compared to those living in urban areas. The five leading causes include heart disease, cancer, unintentional injuries which includes motor vehicle accidents and opioid overdoses, chronic lower respiratory disease and stroke. In the last decade, opioid related deaths increased while the death rates for heart disease and cancer declined. In addition, in rural areas the percentage of deaths that were considered preventable were higher in comparison to urban areas. Unintentional injury deaths were approximately 50% higher in rural regions compared to urban areas. Misuse of medical opioids is a leading cause of unintentional injuries and deaths in these areas.

Misuse of prescription opioids represents an expanding problem in the all areas of United States. Some of the most impacted areas are in rural Kentucky, West Virginia, Oklahoma, and Alaska. Rural populations also have a higher ratio of non-medical opioid users to medical users in comparison to urban populations. Per capita data has shown a general trend of states with larger rural populations having among the highest opioid prescribing rates. The increased prescription rates in these rural areas may contribute to the root cause of increased misuse. This increase in opioid usage has affected populations of all ages including adolescents. Data has shown that adolescents are more likely to use opioid prescriptions

Rural populations are at increased vulnerability to the opioid epidemic and it is imperative that the medical community at large find ways to combat the epidemic by considering the driving forces behind it.
limited to acute needs, but is also a problem
overdoses. The lack of access to care is not
and emergencies for example acute opioid
treatment for a host of diseases
reflected in increased distance to hospitals
communities. Concretely this limitation is
populations that live in suburban or urban
have health insurance, another barrier exists
results from rural Americans having higher
cultural norms also represents a major influencing factor highlighted by
qualitative research in rural areas such as
prescriptions are a part of the accepted
culture as it maintains the labor force for
physically demanding occupations.

It is important to not only consider
factors related to the patient that can lead
to increased opioid abuse, but also factors
related to the prescriber. Primary care
clinicians have reported increased stress
in-relationship to managing chronic pain
and have voiced concerns regarding patient
addiction. Primary care physicians have also
reported inadequate training in prescribing
opioids. This is further exacerbated in rural
areas by a lack of physicians, specifically
those trained in medication-assistance
treatment and other resources such as
physical therapists who can appropriately
manage chronic pain aside from prescribing
opioid on a long-term basis. It is imperative
that health care providers consider the vast
range of therapeutic options when managing
chronic pain.

To address the growing opioid epidemic,
the CDC in March 2016 released new
guidelines regarding prescribing opioids.
These guidelines highlight that assessment
and treatment of chronic pain present
a significant challenge for physicians. In
addition, physicians have concerns regarding
opioid over-prescription and addiction
development. Healthcare providers should
find the appropriate balance in which they
recognize and treat pain appropriately
without over-treating pain with opioids. The
CDC guidelines attempt to address these
concerns by providing information to improve
clinical knowledge and prescribing practices
of primary care clinicians in the outpatient
setting. This will in turn ultimately benefit
the patient population at large. Aside from
appropriate training in prescribing opioids,
physicians can expand access for patients via
telemedicine to help reach populations that
may have limited access otherwise.

It is clear that the opioid epidemic is one
that must be addressed on a national scale;
however, when attempting to address the
epidemic it is also important to take in to
account regional and local factors that may
be at play. Rural populations are at increased
vulnerability to the opioid epidemic and it
is imperative that the medical community
at large find ways to combat the epidemic
by considering the driving forces behind it.
Appropriate prescribing, increasing access,
and increasing treatment options are all
viable options to help to address this issue.

Resident Editor, Dr. Jones, now in her 3rd
year of training at the University of Maryland
Family Medicine Residency. Continuing in
her 2nd year on the MDAFP Editorial Board,
she writes this, her 2nd feature article for
the publication and contributes to Residency
Corner on p. 28.

Note: CME question for this article are
posted at www.mdafp.org; CME Quiz tab,
Summer 2017.
Primary Care Track Capstone Project: Winning Essay

Dylan Peterson

Introduction: The University of Maryland School of Medicine celebrated the graduation of its 2nd class of students who enrolled in a five year Health Resources Services Administration grant creating a Primary Care Track (PCT). Forty four students completed the PCT, with 62 % choosing to pursue a primary care residency. The first place awardee for the best reflective essay describing his experience with the PCT was Dylan Peterson. Mr. Peterson matched at the Family Medicine Residency Training program at the Brown University Memorial Hospital of Rhode Island in Pawtucket, Rhode Island. His winning essay follows.

Richard Colgan, M.D.
Professor
Vice Chair for Medical Student Education and Clinical Operations
Department of Family and Community Medicine
University of Maryland School of Medicine
Baltimore, Maryland

When I trace the seeds that make me passionate about primary care I think of the early influences from my mother, a home health and hospice nurse. From her I learned several things that are foundational in my love of medicine, including a desire for longitudinal relationships with patients, a commitment to social justice and health care equity, and the importance of treating the entire person and not the disease. In addition to this, I grew up in a rural part of the world where primary care was valued and where I had several generalist mentors to look up to. For these reasons, my earliest imaginings of myself as a doctor were as a primary care physician. Primary care always seemed like an obvious choice to me.

When I was admitted to medical school, I was surprised to find that the attitudes around primary care in my class differed from what I encountered growing up. On the one hand, some classmates would offer admiration after learning I was interested in family medicine; “How great! The world really needs more primary care providers.” On the other end of the spectrum were students who felt that it is a waste to go into the field. Like many of my classmates interested in primary care, I had the experience, early in medical school, of being asked “why do you study so hard if you are just going into primary care?” It was rarer to meet someone that viewed entering primary care as something people might choose because they liked it. I had difficulty finding people that were excited about primary care in the way that I was, and I wondered if I had been naive about what it meant to be a doctor before coming to medical school.

This is where the Primary Care Track was enormously affirming for me. I remember listening to several primary care physicians (many of whom would later become important mentors for me) speak passionately about their field at the first event. Throughout the years they shared their personal stories about the choices they made to get where they are and gave me ideas for how I could frame my career. Perhaps more importantly I was surrounded by other students who were interested in primary care through the lectures, grand rounds, and social events associated with the Primary Care Track. These events became an opportunity to catch up with these classmates and geek-out about all things primary care. I would walk out of these sessions feeling re-energized and excited about medicine. When they finished, I would immediately start looking forward to the next one.

It turned out I would need this network of support and mentorship many times during medical school. There was one time in particular that the relationships I formed in the Primary Care Track helped to sustain me. As I started my third year clerkships, a family member passed away from complications of heroin addiction. I found myself wanting to be there for my family at this difficult time, and my inability to take time from school added to the stress of trying to understand my new role as a third year medical student on the wards. In addition, I had trouble interacting with many of the patients in the hospital with addiction issues. I frequently saw my family member in these patients and my interactions carried an emotional component because of this. As a coping mechanism I started to buy into the cynicism that can be pervasive in the hospital. I realized I really didn’t like the strategies I was developing to handle this stress, and I was afraid of losing my capacity for humanism and compassion. In this time it was relationships with friends I met through the Primary Care Track that grounded me and reminded me of what I valued. Just as I had been re-energized at events during my first
Like many of my classmates interested in primary care, I had the experience, early in medical school, of being asked “why do you study so hard if you are just going into primary care?”

two years, lunch breaks, coffee visits, and late night talks over wine with friends from the Primary Care Track re-energized me during my third year. I was able to borrow from their passion to help remind me of my own.

The program not only helped nurture my interest in primary care during medical school, but taught me how to grow it in the future as well. I was placed at a Baltimore area clinic for my summer AHEC (Area Health Education Center) rotation between 1st and 2nd year. My preceptor was a National Health Service Corp (NHSC) scholar (a program I would later join) and was finishing his four year service commitment. He was planning on exiting primary care however, and had matched into a fellowship. He shared how he felt that he had been placed into an environment without the support to accomplish what he hoped, and felt burned out because of this. While this is not the experience most hope for in their Primary Care Track placement, it turned out to be very informative for me. I decided that I wanted to apply in the same scholarship program as my mentor from that summer, and from his experience I learned what to look for when evaluating residencies and work sites in the future. Specifically, I learned that I do best when I am in a community of people who are also passionate about working with vulnerable communities and challenging health care inequity. I used this experience to find residencies where I felt the entire team is passionate about the mission of the program and is excited to come to work. I plan to use this same knowledge when I eventually look for my own NHSC placement so that I can find a work community that kindles my passion for primary care the same way the Primary Care Track has.

I came into medical school passionate about primary care, but the Primary Care Track was essential to sustaining and growing this interest. The friends I made through the program reached out to remind me of my excitement for primary care at moments that I was most at risk of losing it. The mentors I met taught me how to keep this passion alive as I go forward in my career. From their example, I know that in the future I want to teach so that I can introduce students to primary care and inspire others the way that the Primary Care Track inspired me.

Like many of my classmates interested in primary care, I had the experience, early in medical school, of being asked “why do you study so hard if you are just going into primary care?”
2017 AAFP Annual Leadership Conference
ACLF and NCCL Maryland Chapter Delegates Reporting In

The 2017 AAFP Annual Leadership Conference (ALC) took place in Kansas City, MO April 27-29, 2017. The Conference theme was “The Leader Within Me Is…” There are two concurrent and overlapping tracks to the ALC: The Annual Leadership Forum targeting Chapter Leaders and Staff, and the National Conference of Constituency Leaders representing the following member segments: Women, Minority, New, IMG and GLBT.

We hope you will enjoy reading the following perspectives from each of the MDAFP member delegation of 8 who traveled to Kansas City to represent the Maryland Chapter.

Members are encouraged to contact any from the 2017 Delegation through the MDAFP office (info@mdafp.org or 410-747-1980). We will channel your questions/comments and you will receive responses. If you are interested in becoming involved with MDAFP, perhaps attending ALC in the future, let us know that, as well.

ACLF – President-Elect
Ramona Seidel, M.D.

This was the second ACLF I have attended, and as after my initial experience, I came home rejuvenated and educated.

Here are some take-aways:

1. As relates to board planning /succession going forward:
   - Lessons from larger chapters include-
     - how to keep past board members engaged might include: developing/maintain the “archives” of MDAFP,
     - encouraging ongoing committee work and/or foundation work,
     - involvement in training/mentoring new leaders and/or developing robust board orientation materials
   - We interviewed AMC’s (Association Management Companies) and left with a favorable impression of using such a company as viable option going forward.

2. As relates to Productivity Styles: a nice tool was presented that helps determine personal style and how to work with team members who have different styles.

3. As relates to overall AAFP goals, our Maryland members need to know that the national organization has focused goals which include:
   - Working with new administration (i.e., under the new POTUS) on simplifying administrative burden for practicing family physicians in their day to day work.
   - A new Center for Health Equity has been created.
   - Helping members through MACRA and avoiding burnout are ongoing priorities.

NCCL – New Physicians 1
Kate Jacobson, M.D.

There is a lot of excitement and energy in the New Physician Caucus. Resolutions were put forward ranging from payment for telemedicine services to investigation of support for physician wellness activities. There was near unanimous support for a resolution to eliminate the recertification board exam (in favor of only the initial exam followed by other recertification activities, and not the exam itself)

It was also a tremendous opportunity for connecting and aligning priorities with other members of the academy. I had conversations with multiple AAFP board members about reconciliation of the AAFP parental leave policy with the ABFM requirements which are currently at odds.

Dr. Kate Jacobson with Baby Hannah.
One of the most beneficial sessions for many of us revolved around identification of our personal productivity styles so we can learn to use the inner workings of our brains to lead, plan, and relate with our professional peers. (A few of us found it could be applied to our relationship with our spouses as well). A similar workshop I believe would also be very beneficial on the state level as I am confident that I am not alone in wanting to maximize my productivity.

A final highlight was recognition of the Maryland Academy for our full delegation present at NCCL. Overall it was a phenomenal experience and I hope I will have the privilege to participate again in the future. In fact, I’ve already started brainstorming resolutions.

**NCCL – New Physicians 2**
Joseph S. Nichols, M.D.

**Major take aways:**
The AAFP remains committed to supporting diversity in its leadership, as evidenced by the high quality of the NCCL Conference. The pre-conference and breakout sessions were worthwhile. I participated in both sessions on Media Training and found these engaging and helpful. This was an excellent experience, and I thank the Board for supporting my participation.

**Major recommendations:**
Continue to send a full delegation. Having an alternate delegate is helpful, as travel plans may change and we benefit from full participation. A pre-conference meeting, or at least conference call, would be helpful to plan for resolutions and individuals intending to run for office. These topics are covered on site; however they are covered in a rush and not well. In addition, it takes some time and advanced preparation to contemplate taking on a national leadership position, and therefore one would in most cases need to plan for this in advance. Assistance from MDAFP staff would be welcome in knowing what positions are realistic, for those interested in running. Also, might help to make dinner reservation 1 week or more in advance.

**NCCL – IMG Physicians**
Daniel Gold, M.D.

This year’s NCCL was a great experience. As this is my second year attending, I could take the time to enjoy the process and enjoy the ability to network with individuals I met last year, and meet many new members. It was also a great opportunity to spend time with members from the Maryland chapter.

As the IMG delegate, I had the opportunity to raise issues specific to family physicians that graduated abroad. As a small group at the conference, and a signification number of family docs, it’s nice to have a voice. Overall I was excited to vent/collaborate about the struggles of practice management, electronic records, difficult patients, burnout, insurance issues, loan repayment, and credentialing.

**NCCL – GLBT Physicians**
Kisha Davis, M.D.

This was my 9th year attending the AAFP Leadership conference. The conference this year, like many years before, is the spark that rejuvenates and encourages me to keep pressing on to promote family medicine and work on behalf of our patients to create a better future for their health. Dr. Camara Phyllis Jones, past president of the American Public Health Association, led the opening plenary reminding us to recognize the injustices that exist in society and how that plays out in healthcare. I find this conference to be like a Homecoming, a time to meet old family medicine friends and to make new ones. I encourage anyone who wants to get more involved in family medicine or wants to learn how to be an advocate for our patients and our profession to attend.

**NCCL – Women Physicians**
Tobie-Lynn Smith, M.D.

**Major Take Aways**
As usual, many of the resolutions put forth by NCCL focused on social determinants of health and health equity.

Some of these resolutions that were passed included:
- “A social justice framework for health policy”
- “Supporting Family Physicians in Social Determinants of Health Screening, Data Collection and Payment”
- “Develop Residency Curriculum for Social Determinants of Health”

The AAFP has recently developed a Center for Diversity and Health Equity in order to take a leadership role in addressing social determinants of health, nurturing diversity and promoting health equity through collaboration, policy development, advocacy and education.

I coauthored a resolution that was passed “Health in All Policies to Achieve Health Equity” which asks for the Center to specially utilize the terminology “Health in All Policies” in its stated objectives as well as advocate for a Health in All Policies framework to be adopted by local and state governments.
Recommendations: A resolution was passed for the AAFP to adopt a “Social Justice Framework for Health Policy.” The California AFP has adopted this framework and put out a general statement on health policy. MAFP may consider adopting a similar policy, to use as guide when deciding whether and which health policies are consistent with the mission of MAFP and whether we want to support or actively advocate for certain policies.

CAFP General Statement on Health Policy:
- Health care is a human right
- We believe in evidence-based medicine and public health policy
- Mental health services are a fundamental part of health care
- Women’s health must be protected
- People deserve health care regardless of immigration status
- The neglect and mistreatment of marginalized communities affects health and must be opposed
- All people, regardless of their gender identity or sexual orientation, must be treated with dignity and respect

NCCL – Minority Physicians
Vivienne Rose, M.D.
AAFP NCCL meeting was quite an enlightening experience. It was well organized, relevant, and timely. As a member of the Maryland delegation it was an honor to represent the MD Chapter, and also provide perspective on minority issues. As a first time attendee I was somewhat uncertain as to what to expect and how best to participate, but the First time Attendee orientation was informative and very helpful.

The Plenary sessions were excellent in their own right. Both speakers provided inspiration to address both personal and societal problems with hope and energy.

The Town Hall meeting and session on MACRA & Quality Payment Programs was quite informative. AAFP Academy activity and updates were also very enlightening.

Breakout sessions provided good topics which addressed various issues of political, professional, and clinical concern.

The most rewarding and instructive part of the program for me was actually participating in writing and speaking on behalf of or about proposed resolutions, as well as voting for NCCL leaders. Overall, being with colleagues – both from Maryland and from other states was empowering.

Take Aways - The academy as a body can do much for our profession, the health care system and for society – especially the underserved and marginalized.

Getting involved and organized amplifies our voice.

Recommendations: New physicians should be exposed to the “big picture” and the process early in their careers. Try to generate more interest at the resident level. Pre-Conference Meeting/Communication of MD delegation would be helpful. Continue to promote/highlight this aspect of the AAFP at our local meetings to encourage more of us “in the trenches” to get involved.
Greetings from the Maryland Academy of Family Physicians. As a Past-President, and also a Past Director of Dr. Reichel’s Franklin Square Program, I feel very qualified to comment on the effects of Dr. Reichel’s work on the discipline of Family Medicine, The citizens of Maryland and indeed much of the United States, and our Academy.

Dr. Reichel began the Franklin Square Family Practice Residency in the early days of residency development. He was truly one of the pioneer visionaries who saw the need to re-focus medical education on the patient and the community, as opposed to primarily on the disease. His program was a perfect blend of clinical competence and care for the patient.

Program quality is reflected in its graduates, and Dr. Reichel’s excelled. His graduates have served as solo and group practitioners, HMO medical directors, Hospital Clinical Directors and Department Chairs, in community roles such as County Medical Examiner, and indeed virtually every professional opportunity available to Family Physicians. Three have served as President of the Maryland Academy of Family Physicians. This excellence continues in the program today, due in large part to his ability to unite other disciplines in resident education.

When I became Director in 1989, I heard of his gentle manner and exceptional diagnostic skills. Both were immediately evident when I met him. His work, both in clinical care and program development, has improved the lives of innumerable Marylanders.

So, Dr. Reichel, I join with the Academy and also personally wish you Happy Birthday, and hope that you have many more years to celebrate. Thank you, personally and from the Maryland Academy of Family Physicians, for making such a positive difference in Medicine and in your community.

William D. Hakkarinen, MD
President, Maryland Academy of Family Physicians, 2000-2001
Chairman and Residency Director in Family Practice, Franklin Square Hospital, 1989-2001

Dr. Reichel

Dr. Hakkarinen

News For and About MAFP Members

The following was sent in response to requests from friends and colleagues to congratulate Dr. William Reichel on the occasion of his 80th Birthday this past May 20th. Dr. Reichel stands out as a true pioneer in the development of the specialty of Family Medicine. We thank MAFP Past President Dr. William Hakkarinen for drafting the message. We thank MAFP member Dr. J. Michael Niehoff for presenting the greeting at Dr. Reichel’s party.

Happy Birthday, Dr. Reichel!

Congratulations to MAFP Members for Special Achievements!

Nancy Beth Barr, M.D. of Fulton, Medical Director of the Family Health Center at the MedStar Franklin Square Medical Center in Baltimore, was awarded the Faculty Affiliate Award faculty member at the Georgetown University School of Medicine 39th Annual Golden Apple Awards. The award is presented to a physician outside of Georgetown who has made a significant contribution to clinical medical education and provided mentorship to medical students during their rotations.


Dr. Davis also participated in an event in Washington, D.C. on April 7, 2017 entitled “Coverage in an Evolving Market – The Future of Health Care.” She represented her employer, Casey Health Institute, in the discussion segment, “On the Ground Considerations and Implications” which explored important factors and trends about the future that policymakers should consider when making health care policy decisions this year. The Event was co-sponsored by Health is Primary where Dr. Davis serves as consultant to CFAR/Family Medicine for America’s Health.

G. Panisri Rao, M.D. of Owings Mills authored “Milia are white bumps, but they’re not acne” which appeared in the “Ask the Doctor” segment of Health & Style section of the May 4, 2017 edition of The Baltimore Sun.

Yvette L. Rooks, M.D. of Ellicott City was a speaker “Medical Career Pathways,” a conference sponsored by the Baltimore City Medical Society, held recently at MedChi. The conference targeted high school, college, and graduate students; nurse practitioners; public health administrators; physician assistants; academic advisors and more. Dr. Rooks’ presentation was entitled “Primary Care for Non-Primary Care Physicians.” A follow up article about Dr. Rooks’ presentation, written by conference participant Lisa Clay, appeared in the April/May edition of BCMS Messenger.

Sara Vazer, M.D. of Rockville was appointed in March, 2017, by Maryland Department of Health and Mental Hygiene Secretary Dennis R. Schrader, to the DHMH Statewide Advisory Commission on Immunizations. Dr. Vazer represents MAFP on the Commission.
The MDAFP Editorial Board welcomes Dr. Khan to its ranks. In the next year you will be reading her contributions to Residency Corner, as well as featured CME articles. We thank prior Resident Editor from the PG Program, Dr. Aysha Khan (no relation) for her two years of excellent writing. We congratulate her on her graduation and are happy to announce that, practicing in Maryland, she will continue on as a MFD Editor.

This is an exciting time for our residents, faculty, hospital and community! By the end of this summer, Prince George’s Hospital Center will be a part of the University of Maryland Medical System. This is a major change, and as expected, will bring about new implementations and reassessment of current policies and structures in hopes of providing the best possible patient care. In the residency program, the diligent hard work and persistence helped to exponentially increase the patient volume at the Family Health and Wellness Center by four fold since last year. We are very proud and feel accomplished to reach this level of growth for our practice.

Our community efforts helped to nurture our growth. In the beginning of April, the residents and the majority of our faculty members visited the Salvation Army shelter in Hyattsville, MD as an effort to recruit patients and reach out to the community. The Salvation Army residents were very appreciative of the time, commitment and energy we put into holding small group sessions on nutrition, exercise, doctor visits and managing diabetes. These outreach opportunities serve to improve the well-being of our community. It encourages self reflection which guides us to become well-rounded physicians and individuals.

As July is upon us, we welcome our new interns: Katrina Castillo, MD (University of California, Irvine, School of Medicine), Payal Daya, MD (Ross University School of Medicine), Amrit Parhar, MD (Ross University School of Medicine), and Rohini Manda, MD (Deccan College of Medical Sciences, India). We are excited to have the new interns immerse themselves in our community and in our dynamic program. As the new class enters, our seniors have graduated from our program. This is a bittersweet time, but we wish the graduates all the best and are confident that they will be an asset and important part of the medical community they serve. We would like to extend a farewell to our four seniors who are graduating from residency: Aysha Khan, MD, Sarah Kin, MD, Charles Olaleye, MD and Christopher Riley, MD. With our dedicated faculty members, residents and hospital administrators and staff we will continue to expand and broaden our horizons.

Happenings at the Family Medicine Residency Programs

Prince George’s Hospital Center
by Sidrah Khan, M.D., R-3

While the spring of residency serves as a time of change every year, this year the University of Maryland experienced significant changes and growth on an expanded scale. Long time and beloved program director Dr. Yvette Rooks retired from her position this spring. Her successor will be Dr. Jason Ramirez, who previously served as the director of inpatient medicine for the University of Maryland Family Medicine Program. Dr. Yvette Rooks will take her talents to New Jersey where she will serve as the Chief Medical Officer of Sports Medicine at the Robert Wood Johnson (RWJ)/Barnabas Healthcare System. She has also been named the Head Team Physician for Rutgers Athletics and will serve as Volunteer Associate Professor in the Department of Family Medicine RWJ. The residents wish her nothing but the best and look forward to working with Dr. Ramirez over the next year to make the University of Maryland Family Medicine stronger together.

Our third year residents reached the end of their training with the University of Maryland and look forward to a wide array of future opportunities following graduation. They will be entering the workforce in a variety of settings this summer and fall including community family medicine practices, urgent care centers and fellowships. A majority of the graduating residents will remain in the Baltimore area further strengthening the family medicine network of practitioners and continuing to serve our community. As the third year residents exit the program, the University of Maryland looks forward to welcoming its newest class of diverse residents from all over the country who will further enhance our team.

While the University of Maryland prides itself on serving the community of West Baltimore, we are always looking to expand our areas of service. Third year resident, Dr. Amna Choudry took the opportunity during her elective rotation in March 2017 to...
complete an away rotation in Paris where she worked with the Cochran Center. She performed clinical work with refugees to ensure that they had basic healthcare services, with visits ranging from acute care to preventive health screenings. Her work highlighted the importance of comprehensive family medicine treatment in that her work also included assessing mental health issues specific to refugee populations. While Dr. Choudry traveled internationally to gain new skills working with international populations, several of our residents took opportunities this spring to travel domestically for various educational and research opportunities.

Second year resident, Dr. Greg Jaffe traveled to Boston, Massachusetts in May 2017 for the American Society for Men’s Health (ASMH) national conference. He learned about the multidisciplinary approach that must be taken while treating issues unique to male patients. Third year resident, Dr. Britanne Doss traveled to San Diego, California to both attend and present at the Society of Teachers of Family Medicine (STFM) Conference in May 2017. Her research poster was titled “Healthy Steps Intervention: A Comparison of Emergency Room Visits and Patient Satisfaction Between Two Family Medicine Practices.” Her research aimed to evaluate if participation in the Healthy Steps Program at the University of Maryland Family Medicine program had any correlation with decreased emergency room usage and if participants had increased patient satisfaction with their primary care physicians. Second year resident, Christine Jones also traveled to San Diego for the American Medical Society for Sports Medicine (AMSSM) conference in May 2017. She presented a case presentation poster titled “A College Soccer Player Presenting with Acute Vision Loss.” Her case focused on a soccer player who suffered a traumatic blow to his eye resulting in a hyphema. While some of our residents have spent time traveling, others have spent time earning various well-deserved awards.

Graduating Chief Resident, Dr. Catherine Chamberlain was awarded the Outstanding Resident Teacher Award this spring, recognizing her excellence in teaching medical students throughout the past academic year. Interns Dr. Marie Pereira, Dr. Alexandra Printz and Dr. Marissa Moultrie were awarded a 2017 Family Medicine Cares Resident Service Award by the American Academy of Family Physicians for a service project titled “Partners in Parenting.” The residents’ project aims to identify children in our community at risk for maltreatment and provide information and resources to the parents of at-risk children. Their ultimate goal is to help families lead healthier, happier lives with decreased instances of maltreatment.
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