NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

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TABLE OF CONTENTS:

ISSUES IN THIS ISSUES

Roger W. Schauer, MD

When I saw my breath this morning it reminded me that autumn is coming, which also means the Fall issue of the FMQ needs to be distributed. This issue includes an article from Dean DeMers which provides characteristics of the Class of 2012, students many of you will be precepting in two-three years.

While reviewing a recent issue of the "Kansas Family Physician" the title "Pissants and Criminals" caught my eye so I had to read the article. The experience cited by Dr. Wenger is also described too frequently by our own students in North Dakota. I know this is "preaching to the choir", but Dr. Wenger gave us permission to reprint his article. You might consider how we, as family physicians and teachers, can address this while mentoring and teaching our students.

In this issue Dr. Glunberg continues the discussion he initiated in the Summer FPQ about the Patient-Centered Medical Home (PC-MH). He introduces us to the "TransforMed" (or TMED MHIQ) practice assessment tool (see website in his article). TMED MHIQ is interesting and informative, whether you are responsible for only your practice or are in a larger system. Dr. Bittner also addresses TMED in her "Congress of Delegates Recap" . Her report also highlights a number of other issues. In her report she challenges us to do TMED IQ test. Although my practice is now limited to my time at the Developmental Center in Grafton, I completed several modules. The score for each module was immediately available, as were suggestions or links to information about options to improve the practice. Some of the options are not without challenges, as much of the PC-MH works more smoothly if the practice has a rather comprehensive electronic medical record (not available at the Grafton Developmental Center).

In his article, "Setting a Policy Course for the Coming Months", Bruce Levi highlights a number of opportunities and challenges that face us in the near future regarding political and medical economic issues. Resolutions adopted by the House of Delegates at the recent NDMA meeting in Grand Forks are noted in his article, including a resolution addressing the concept of a PC-MH, submitted on behalf of the NDAFP and the ND Chapter of the American college of Physicians. A number of the resolutions passed by the delegates during the NDMA meeting address issues that will be, or should be, addressed during the 2009 Legislative Assembly. Regarding that session and your potential, I also refer you to Dr. Kim Krohn's article in the recent Summer issue of the FMQ where she talks about the value of serving as Doctor of the Day during the Assembly.

Two articles address practice improvement, including the "AAFP Practice Enhancement Forum" submitted by Dr. Charles Christianson, and a report on a NORTHSTAR (Northern States Ambulatory Research Network) project that looked at adherence to

-Continued on Page 3

Message from the NDAFP President

Steven Glunberg, MD

I have just returned from San Diego where I served as one of your alternate delegates to the AAFP Congress of Delegates and also attended the AAFP Scientific Assembly. Dr. Ted Epperly, who was the AAFP representative to our NDAFP Annual Meeting this past April, was installed as the new president of the AAFP. It is apparent he is bringing to the office passion and energy to improve the specialty of Family Medicine. A recurrent theme at the Congress of Delegates was to embrace the Patient-Centered Medical Home (PC-MH) concept as the best solution to many of the challenges family physicians face today. The implementation of the PC-MH will require significant changes on all levels of our health care system but the potential benefits will be significant for family physicians. This will include improved patient care as we move from a fragmented specialty oriented system that values treating disease more than maintaining patient's good health. It will transform our payment system so family physicians are fairly compensated for the value they add to a patient's care. Improving compensation for primary care will also serve to boost interest by medical students in family medicine. Dr. Epperly asked that we all collectively step forward now and transform our practices as soon as possible to be designated as PC-MH. He challenged all of us to take the AAFP's TransforMED Medical Home IQ test and begin the transformation to the PC-MH. This test can be found at www.transformed.com/MHIQ/welcome.cfm.

Dr. Epperly called on us to build relationships with people of influence at all levels of business and government to build a broad coalition of people who want a transformed primary care based health care system. We will soon be electing our representatives to the North Dakota legislature that will meet starting in January 2009. Each of us can play a part in our state academy's role as an advocate for our specialty by contacting our state as well as national representatives regarding issues that are important to us. The NDAFP works with the North Dakota Medical Association on legislative issues and I would encourage each of you to be willing to contact your legislators when you receive information from the NDMA during the legislative session about bills that affect us. Please don't underestimate the influence your opinion can have, especially if you know or have an existing relationship with your elected representatives. I don't need to tell you that our health care system currently is not working well for us or our patients. Because of this our health care system is now more moldable and ready for change than it has been in decades. Together we can make change happen.

Congress of Delegates Recap

Heidi Bittner, M.D. NDAFP Delegate

"It was the best of times; it was the worst of times." Our new vice speaker John Meigs started his candidate speech with these famous words, feeling that they are not only the start of a great classic novel, but also appropriate to the current status of family medicine in this country. Our recent congress dealt with many issues suggesting this is so.

Our "Bold Champions" campaign was felt to be "absolutely" successful by all the president-elect candidates. It was targeted not only to the membership and the country, but primarily to political targets, which enabled us to be seated at the tables where important issues re: the future of health care in this country were being discussed and decided. This publicity, along with our growing FamMedPAC, was very effective at allowing us to be right where we needed to be to press on for family medicine.

FamMedPAC: $750,000 has been donated this election cycle. This has allowed us to make significant changes for family medicine—which impact our daily practice. Personally, I am a member of the "George Club"—a dollar a day--because protecting and enhancing our practice is worth it. Our state is at a DISMAL 3.96% of members contributing; let's rectify that!

Our Finance and Insurance Commission (including our own remarkable Dale Klein) made huge changes this year to enable us to have a balanced operating budget. This meant cutting and/or combining programs, decreasing the number of face-to-face meetings to reduce travel costs, and restructuring and streamlining staff including the reduction of over 50 staff positions. These were incredibly difficult decisions, but will allow us to avoid using our reserve funds for operating expenses even with the decrease in pharmaceutical funds and variability in investment returns.

Discussion re: the Patient-Centered Medical Home was pervasive throughout the meeting: how to define it, get paid for it, transform our practices into it, etc. We know that patients with family doctors have better outcomes and comprehensive preventative care at lower costs—finally the rest of the country is realizing that our medical system needs to be reformed with primary care as its base. The Patient-Centered Medical Home is coming—long past due!

The "Pipeline" of family doctors to provide this care was also a major focus. How do we recruit students into fam-

ily med? This is an ongoing issue for North Dakota. We need to identify students early on, ensure their admission to our medical school, encourage involvement in programs such as Mission Physician, FMIG, Don Breen externship, family medicine clerkships, ROME, filling student and resident positions on our own NDAFP board, loan deferment/forgiveness/repayment programs, etc.

The Academy continues to push for health care for everyone in the face of the tragedy of 47 million uninsured in our country. Payment reform remains a top priority. Involvement in the development of primary-care based health system, Pay For Performance discussions, patient advocacy, student/resident advocacy all remain on the list of important topics.

We had fewer resolutions to consider on the congress floor this year. The most lively debate was sparked re: whether or not to consider tobacco monies as a source of funding for the Tar Wars program. After extensive and rather heated debate, we elected to avoid any type of connection with the tobacco companies. The hope is that other funding will be available and a challenge was made for each of us to donate to Tar Wars.

Lori Heim was elected as our new president-elect. She is an incredible and capable woman, and the trio of Jim King, Ted Epperly and Lori will be a powerhouse for family medicine. Our three new board members are Jeff Cain (CO), Tom Felger (GA), and George Shannon (GA). Leah Raye Mabry (TX) and John Meigs (AL) were elected as speaker and vice speaker respectively. We continue to gently nudge our own Dale Klein towards a run for the board; stay tuned. I have offered to act as campaign manager, but after my "Disco Dale" ideas—Brandy may veto my involvement.

So what can YOU do?

1- Take the TransforMed online IQ test and start making changes toward becoming a Patient-Centered Medical Home.

2- Support our FamMedPAC by becoming a Club George member.

3- Remind your patients to stop tobacco use, and donate to Tar Wars through the AAFP Foundation.

4- Make sure you know who your legislators and government officials are (local, state and national) so that you can quickly contact them if and when needed.

5- Continue your involvement with the NDAFP. Continue or consider being a Don Breen preceptor. Encourage students at all levels to consider family medicine.

Dale, Steve, Rich and I represented North Dakota at the congress, and will be happy to answer any other questions. We were fortunate to have dinner with Dr. Bill Buckingham while in San Diego. We did not have anyone walk from the airport with their wheel-less luggage this year, but Deb Klein did enjoy an unexpected trip to Mexico (thank goodness she had her passport along!). Fashion review confirms that family physicians may be the next group featured on What Not To Wear, though our ND crew looked dapper at all times and Brandy frequently sported a trendy poncho.

-Continued from Page 1

guidelines regarding management of patients with diabetes (submitted by Jessica Behm). The latter reminded me of process and outcome audits imposed by the JCAH (now JCAHO) in the early and mid-1980s, but now with a positive spin. Results of NORTHSTAR studies can compare outcome between institutions or practices, which then provide opportunities to look at how practice patterns influence outcomes.

The article from "The Teaching Physician" is included to alert you to further potential changes in how medical education is delivered, to both students you are precepting and to physicians in practice. In the FMQ we frequently reference available technology, but hosting medical students for clerkships can be another excellent resource for practicing physicians to become aware of available technology. Most of our students today can teach all of us how to access the most current information.

If any of the FMQ articles raise thoughts or questions, please get back to us.

Setting a Policy Course for the Coming Months

Bruce Levi, JD
Executive Director, ND Medical Association

The tradition of the NDMA annual meeting just concluded in Grand Forks, with meetings held in conjunction with the ND Psychiatric Society, ND Chapter of the American Academy of Pediatrics, the ND Society of Eye Physicians and Surgeons, ND Medical Group Management Association, and the Medical Center Advisory Council. Your NDMA leadership includes Kim Krohn who chairs the NDMA Board, Rob Beattie who serves on the NDMA delegation to the AMA, Dale Klein who chairs the NDMA Commission on Legislation, and Roger Schauer who chairs the Commission on Medical Education.

Our annual meetings are more than tradition. Getting together "face-to-face" as individuals and as a profession allows us all to think more broadly about ways we can foster professionalism, improve the quality of medical care, and develop strong physician leadership.

We all recognize, whether it be NDMA or NDAFP, that it's getting more difficult each year to bring you together. We all communicate more electronically, our younger members and perhaps many of our not-so-younger members don't care to go to meetings. It's all about each of us balancing our personal and professional lives. In fact, as we continue to focus on our physician workforce challenges, the generational differences among our physicians cannot be ignored. And so we know at least intuitively that the workplace, and our professional organizations, must recognize that physician well being and balance in life is a valid and important concern and is not contrary to our notions of professionalism. The profession has a right to expect excellence and total commitment to medicine but should also allow for structures that encourage balance in life, and an environment that fosters the joy of being a physician.

And so, perhaps, our notion of an annual meeting needs to change to be consistent with the thinking among our younger physicians. Our ability to bring you together to talk about the issues is critical to "doing the right thing." And the coming months will be critical to our future.

We are at the table participating at the request of Senator Kent Conrad on a Medicare Payment Task Force to craft a North Dakota solution to the disparity in physician and hospital Medicare payments, and to work with similarly-situated states to implement that solution.

A preliminary agenda has been prepared by your Commission on Legislation for the 2009 North Dakota Legislative Assembly which convenes January 6.

We are working separately on recommendations for addressing our state's physician workforce needs.

Our efforts last legislative session have now resulted in a consultant's study showing you receive 51 cents for each dollar of care you provide your Medicaid patients. This will provide the data and groundwork we need to argue for rebasing Medicaid payments. An additional $20 million in state general funds is needed to bring your Medicaid payments to actual cost of providing those services. An additional $10 million in state funds is needed to bring hospital Medicaid payments to cost.

Our physician leadership is meeting with representatives of the WSI Board of Directors, to make changes that can restore both physician and public confidence in our workers compensation system.

Your leadership is involved in the controversy between BCBSND and the Insurance Commissioner on health insurance premium rates which will play out through the end of this year.

Clearly, the capacity and effectiveness of our physician leadership will be critical, as well as challenged, in these coming months.

Specifically, as we prepare for the 2009 ND Legislative Assembly, the NDMA House of Delegates adopted the following broad policy concepts as part of its preliminary legislative agenda:

- Support efforts to enhance North Dakota's workforce climate for physicians and other health professionals
- Support additional state medical liability reforms – protect existing reforms
- Support the independent medical judgment of physicians in medical practice
- Support Medicaid payment increases for physicians and hospitals
- Support Medicaid program and management reforms
- Support public health initiatives
- Support ways to enhance patient decision making
- Support funding increases in the UNDSMHS budget
- Support efforts to encourage strategies and plans for health information technology
- Support expanded coverage for uninsured and underinsured people, including children

- Support physician scope of practice and oppose inappropriate challenges to that scope of practice

More specifically, the House of Delegates also adopted the following legislative initiatives for 2009:

- Support Medicaid Physician Payment Rebase to Actual Cost
- Support Trauma System Reform Priorities
- Support Initiatives to Address Physician Workforce Issues
- Support Revisions to the Medical Practice Act to Address Scope of Practice by Mid-Levels
- Support Changes to the Good Samaritan Law
- Support Changes to the Medical Liability Certificate of Merit
- Support Re-Introduction of Informed Consent for Minors' Pregnancy-Related Care
- Support Changes to Statutes Relating to the UNDSMHS Purpose, Advisory Council and Student Loan Fund
- Support Fair Commercial Insurer Contracting Standards

The House of Delegates also considered several resolutions introduced by NDMA commissions, specialty societies and district medical societies.

A resolution was adopted supporting the medical home concept. Introduced by Dale Klein and James Brosseau on behalf of ND Academy of Family Physicians and ND Chapter of the American College of Physicians, the resolution urges NDMA to support the concept of a patient-centered medical home as a means to improve the quality of care and reduce health care costs; and to continue to study the various medical home proposals and take appropriate advocacy action that best serves the interests of North Dakota physicians and patients.

Another resolution introduced by the Ninth District Medical Society (Dickinson area) directs that NDMA investigate methods to retain and improve satisfaction among physicians working in rural settings, and to seek assistance as necessary from the UND Center for Rural Health and other organizations.

Other adopted resolutions include support for Medicare payment reforms; support for efforts to correct deficiencies in the Medicare physician practice expense GPCI; support for rebasing of Medicaid physician payments to actual cost; support for continued study and development of a report on North Dakota's physician workforce for completion by the end of 2008; encouragement for improvement in WSI physician reimbursement system and the WSI relationship with physicians; and urging commercial health insurers and the North Dakota Commissioner of Insurance, in review of premium rates for health insurance policies, to more formally consider appropriate statewide standards for physician and hospital payments consistent with regional commercial market.

The House also accepted the Council's action in endorsing Measure #3, to establish a CDC-based tobacco control program in our state.

Your attention to policy will be critical in the coming months. Talk to your legislators now, particularly about our Medicaid concerns. Our Commission on Legislation will be meeting between now and January, refining our agenda and formulating responses to legislation coming at us. You'll be kept in the loop!

AAFP Practice Enhancement Forum

Charlie Christianson

The American Academy of Family Physicians is partnering with the Institute for Healthcare Improvement in a grass-roots effort to help family physicians implement the Chronic Care Model and quality improvement processes into their practices. Practices will send teams of three (physician, nursing staff and office staff) to a regional two day Practice Enhancement Forum to learn hands-on approaches to practice improvement. The teams will receive materials before the Forum with background information and a practice assessment instrument. At the Forum the team will plan a QI intervention for their practice, which they will implement over the next 3-6 months with the help of a mentor. Kim Krohn and I recently attended the training for QI mentors and found it very useful and informative. The method emphasizes experimenting with many small changes and keeping those that help while discarding those that do not; stay away from big high-stakes system-wide changes until you are sure they will work. Hopefully many of us will be interested in participating in the PEF. The North Dakota/Minnesota Forum will be October 22-3, 2010, so there is plenty of time to prepare. For further information you can go to the AAFP website: www.aafp.org/pef.

Characteristics of the Class of 2012

Judy L. DeMers, Associate Dean for Students

The Class of 2012 (entering on August 4, 2008) is composed of 62* individuals. The following provides statistics in relation to class members.

Sex: Male = 26 (41.9%) Female = 36 (58.1%)

Age: ---at date of matriculation (8-6-07)

Range = 21-37 yrs	21 yo = 1	28 yo = 2
Mean = 24.2 yrs	22 yo = 20	29 yo = 1
Median = 23 yrs	23 yo = 15	33 yo = 1
Mode = 22 yrs	24 yo = 7	35 yo = 1
	25 yo = 8	36 yo = 2
	26 yo = 1	37 yo = 2
	27 yo = 1	

State of Residence (9 states)

ND = 46	AR = 1 (INMED))
MN = 4	AZ = 1 (INMED)
MT = 5 (All WICHE)	CO = 1 (INMED)
OK = 2 (Both INMED)	TN = 1 (INMED)
	WI = 1 (INMED)

Ethnic Background: Twelve (19.4%) of the students self report an ethnic minority background. Seven are American Indian, four are Asian/Eastern Pacific, and one is Hispanic..

* Four previously admitted students are joining the class of 2012 in August, bringing the total to 66. In addition, two of the entering INMED students who are now part of the class will transfer to the University of South Dakota at the completion of Year 02.

Majors**: Bachelor's Degree -

Biology/Biological Sciences = 34
Interdisciplinary Studies = 2
Chemistry = 6
Microbiology = 2
Psychology = 3
Zoology = 2
Biochemistry = 3
Honors = 3
Nutrition & Dietetics/Nutritional Science = 3

One major each: (N=10)

Anthropology	Nursing
Behavioral Neuroscience	Spanish
Biomedical Engineering	Political Science
Clinical Laboratory Science	Exercise Science
Psychological & Brain Sciences	
Occupational Safety & Environmental Health	

**Total exceeds 62 due to students having more than one major or more than one Bachelor's degree.

College/University Attended for Bachelor Degree Study (N=29)
University of North Dakota = 20
Minot State University = 2
North Dakota State University = 6
Moorhead State University = 2
University of Minnesota – Twin Cities = 4
University of Mary = 2
Concordia College = 3
University of ST. Thomas = 2

One student each: (N=21)
Alverno College (Milwaukee, WI)
Northeastern University
Byranjce Jeejeebhoy Medical College (India)
Northern Arizona University
Carroll College (Helena, MT)
Oklahoma State University
Cornell University
University of Allahbad (India)
Dartmouth College
University of Colorado – Boulder
Dickinson State University
University of Colorado – Colorado Springs
East Carolina University
University of Kansas
Kansas State University
University of North Carolina
Mankato State University
University of Pennsylvania
Medical University of South Carolina
University of Wisconsin
Montana State University

Graduate/Advanced Degrees (8 Institutions) with Majors:
East Carolina University (MS) - Nutrition
JN University (India) (MS) – Life Sciences
North Dakota State University (PhD) - CerealScience
Oregon Health Sciences University (MS) – Nursing
Southern Methodist University (JD) – Law
University of Mysore (India) (MS) – Food Technology
University of North Dakota (PhD) – Anatomy and Cell Biology
Washington University, St. Louis (MS) – Social Work

Pissants and Criminals

Gregg Wenger, M.D.—Kansas AFP

"...either brace yourself for elimination Or else your hearts must have the courage for the changing of the guards." – Bob Dylan

My son Alex recently told me about a guy he works with in New York. This guy wanted to ventilate about some medical misadventure his brother's wife and newborn had recently endured in one of those Spartan-existence New England states. Anyway, as he told it, things went from bad to worse—ruptures for both the mother and infant-- and they had to be transferred somewhere more civilized for a higher level of care. And then he fumed that he had told his brother and told his brother that he should have moved to the City, where there were real doctors, because "you know the only ones up there in places like that are pissants and criminals. Why else would they be there?"

I've been asked to precept for a pre-med student, a young man who needs to be able to say he shadowed a doctor when he fills in his application. A rite of passage 35 years ago, it apparently still is an opportunity for applicants to show they know (a little bit) what being a doctor is about and they still want to do it. I'm willing to let this kid tag along, see what I see, and check that off his to-do list. We've all done that much.

But we can do better than this passive participation. I believe we have to see this as one more opportunity to grab these kids early, show them what we do, see our brand of magic at work. When we do this right, we can imprint these kids just like that psychologist did with his ducklings. We can turn new generations of medical students on to primary care in general, and Family Medicine specifically. But we have to sell it every chance we get. We have to be generous with our time, and we have to be enthusiastic and passionate. We have to show we practice real medicine, challenging medicine, medicine that matters.

When my younger partner Kerry eventually opted for a Family Medicine residency, she asked a to-be-unnamed Internal Medicine department head at KUMC to write her a letter of recommendation, hoping his name might lend weight to her application. But once he had seen her transcript, he advised that her grades were really too good to settle for Family Medicine (pissants and criminals?) and that she would do better to consider Medicine, or at least a Med/Peds program. I am grateful she had the wisdom to know how selfish and prejudiced and flat-out wrong he was. And I recognize this blatant level of political incorrectness probably isn't the norm at the KU, but I suspect the sentiment isn't buried too deeply. I know our Family Medicine Departments fights the good fight; I just can't help thinking it's an uphill battle most days. (To review our early labor pains, read John McPhee's "Heirs of General Practice" in his book Table of Contents, originally published as an essay in New Yorker in 1983.)

Kerry and I met during her first year of medical school when she pitched up on our doorstep for her Rural Practice Weekend. She returned for a two-month summer stint, and again for a month during her fourth year. I can't say this early exposure caused her to choose Family Medicine and a rural lifestyle, but I have to think it helped. Obviously, we cannot take students in expecting this kind of return every time. Most of my students choose some other specialty—some of them certainly should— but at least they go away with an idea of what we do and that most days we do it well and with a sense of commitment.

I don't intend to sound immoderately paranoid, or as selfish and single purposed as that misguided internist. But I know we aren't pissants and criminals, and you know that and so do your patients. But too many still think real medicine is only practiced in a referral center, or at least a big city. Too many, including that Ivory Tower dweller, think maybe we do family medicine because we couldn't swing a real specialty. I think our too-well-kept secret is that we choose Family Medicine because we need diversity and challenge; we want to care for the whole patient and not just his renal function or her rotten hip.

I'm not suggesting we're facing Dylan's elimination, but if we have the courage of our convictions, and the necessary sense of commitment and purpose, we can change the guard. We can continue to build our reputation and our relevance one newly-minted medical student at a time.

Gregg Wenger, M.D., serves as the KAFP Communications Chair. He is a K-State alumnus, graduating from KUMC in 1978,completing his residency in family medicine in Phoenix, Ariz., at Good Samaritan Medical Center. He has practiced in Sabetha since 1981.

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Information Technology and Teaching in the Office

Options and Considerations for Online Meetings Among Preceptors, Students, and Faculty

By Thomas Agresta, MD, University of Connecticut

We are increasingly becoming a society of high speed Internet connections and wireless access. This permits a revolution in the way in which we communicate with, learn from, and educate our community faculty preceptors and students. With careful planning we can leverage the newer Internet communication options as we collectively train medical students in our communities.

Have you ever wondered any of the following?
• How could I best train my preceptors on that new form we developed for evaluation and get feedback from them?
• How can I as a community faculty member connect with and get advice from others who take students in their office in an efficient manner?
• What are best practices for involving students in office-based quality improvement initiatives?
• What is the best way to give advice to a new faculty member on efficient, effective precepting? Can I observe this encounter directly?
• How can we support the student and preceptor handhelds from a distance most effectively?

Increasingly, the answers to these questions can be found in the use of online collaboration and meeting software that allows both the sharing of data and audio-video feeds between participants with networked computers.

Most of our students and academic faculty are by now familiar with, and use, Learning Management Systems (LMS) to host and archive the various lectures, presentations, and other resources used in medical education. (Blackboard,© WebCT,© Sakai,© etc.) These tools help organize course and learning materials for storage and delivery and also provide a cadre of other options for communicating among the participants within those courses. Yet for many of the functions outlined above, these LMS are complex and costly to use.

There are a growing number of inexpensive, simple to use and navigate commercial and Shareware software tools. Used correctly these products can greatly enrich the connections we have between the community physician, students, and academic faculty. It is now feasible to incorporate the cost of use into departmental budgets with good justification. The costs range from free to about $1,000 per year and depend on the features, overall ease of use, brand name, and need for user IT support. They can enhance the overall human connections with our learners and preceptors while decreasing the costly and time-consuming travel to office sites for an often brief, one on one meeting with preceptors.

How do the Web conferencing programs work? Well, in general they rely on standard Internet protocols and either require a small client program to be temporarily or permanently installed on each of the computers that will be connected. These programs perform secure connections between computers, such that there is easy broadcasting of the presenter's desktop, data, and audio/ visual feeds to all other computers as desired.

Features vary based on product but in general allow between two and 15 simultaneous users to be connected to the "host" or originator of the Web event. The host needs to invite the others to participate and then sends a secure login via e-mail. This invitation can be either done in advance or on the spur of the moment if desired. Once the participants click on this link, the client program is launched, and they can sign into the Web conference. Then the desktop of the presenter is seen by the meeting attendees, along with whatever program is being run at the time (Word, PowerPoint, Web Browser, Movie, etc). The presenter can also be talking directly with the audience, either in a separate telephone teleconference or directly through the Web conferencing program with Voice over IP (VoIP) on the Internet. There may also be a video feed from the presenter and/or the other participants' desktop, depending on product and hosts preferences. Some programs allow all participants to share a video or picture of themselves while the conference is progressing. Most allow the host to turn over control of their desktop to another user to "drive" and make changes to the software being displayed. Several allow users to take online surveys and live polls of the attendees while in the Web meeting.

This wide range of options opens the door for many potential uses for medical education.
• Continuing Medical Education: Web conferences can be a wonderfully interactive and effective method of CME delivery. Small learning groups can be formed either in advance or spontaneously by who signs up for the CME event. Polling can be used to see participants' prior knowledge and future plans for changing practice behavior.

• Computer training for software or hardware: I am aware of preceptors being trained with Web conferences on how to use evidence-based medicine software in groups with this process. I have also participated in vendor-run Web conferences for training on new versions of an electronic health record.
• Distance support of hardware and or software: We will be using Web conferencing to do one-on-one support for our preceptors for their newly supplied handheld computers. When there has been an issue in the past, we have talked through the problem and at times have had to do site visits to explore these issues. With the ability to directly manipulate their computer remotely, we believe most problem solving can be done quicker and more efficiently.
• Building a Virtual Preceptor Network: Often in my years as predoctoral director, I heard the desire to find out from the other community preceptors how they deal with different student related issues. In-person retreats are difficult to arrange, but a quarterly Web conference that takes place just before office hours might be an excellent alternative. In addition, the preceptors themselves could "link up" in virtual networks of their choosing, giving peer support to one another.
• Midpoint feedback: How about that difficulty giving feedback that the preceptor would like help giving to the student? A Web meeting could place all of them in the same virtual room, allowing the academic faculty to facilitate a discussion about student needs and future expectations.
• Observation and feedback of preceptor/student encounter: Taking this one step further, for the inexperienced preceptor a direct observation of teaching style can be helpful in anchoring good habits and techniques early on. This could be done by directly observing a preceptor student encounter from a distance and giving immediate feedback. This could also be used as a means for quality control for educational excellence.
• Simultaneous student projects: Let's say for example you want students to work on a collaborative project while at distant sites. The secure connections that Web conferencing offers can facilitate this process. See Table 1 for some example programs. Most can be tried for a limited time for free.

Personally, one of the most interesting opportunities I had to use Web conferencing was in working with two students who were on international electives in Honduras. I was able to keep tabs on how they were doing and remain available to them via the use of the free program Skype. I was also able to talk with their preceptors prior to their arrival to set expectations and do follow-up conversations after they had returned to the United States. In the future I anticipate doing additional training and collaborative work with these techniques when students travel far from home.

Enjoy and experiment with these options, but remember that educational techniques should be used only if they fit the circumstances. There can be a temptation to use technology because you can. It is wise to consider the options available and plan out well how you will use the tools (purpose, process, and training of end users). Remember that it can take a moderate amount of time to learn how to use the software, although these are becoming much more intuitive to use. End users still might need a moderate amount of support in setting up and getting onto the Web conference. It is still often a wise idea to have a support person available to answer questions and help people who are facing challenges in getting connected until users get comfortable with these tools.

Reference material:
1. Kropf R. How shall we meet online? Choosing between video conferencing and online meeting. J Healthc Inf Manag 2002;16(4):68-72.
2. Anonymous. University of British Columbia CPD-KT improves medical education with WebEx. www.webex.com/pdf/cs_UBC.pdf. Accessed July 7, 2008

Table 1—Example Programs

Sample Programs	**Web URL**	**Comments**
WebEx	http://webex.com	Most used Software—can install for one time events.
GoToMeeting	www.gotomeeting.com	Well supported—also has software for GoToPC that allow remote access to desktop from Internet.
EPOP	Www.wiredred.com	Newer Program—easy to install in large institutions.
Tandberg	Www.tandberg.com	Offers high end options as well as Video Telephones; Webex is conference software
Skype with addition of Talk and Write	Www.skype.com Www.talkandwrite.com	Free calling/video with Skype; Talk and Write allows sharing documents/desktop.

Dilated Retinal Exams in Clinical Care (DREC): A NORTHSTAR Project

Jessica Behm

The Northern States Ambulatory Research Network (NORTHSTAR), the first practice-based research network in the state of North Dakota, focuses on quality improvement in practice, conducting best practices research, and identifying and testing new methods of health care delivery in rural settings. NORTHSTAR has now enrolled over 25 primary care providers from around the state and adjacent areas. For the last year NORTHSTAR has addressed diabetes care.

In November of 2007 we developed our first research project "Dilated Retinal Exams in Clinical Care" (DREC). As many primary care practitioners know, a common issue in rural North Dakota is the lack of access to an appropriately trained professional for dilated retinal examinations for individuals with diabetes. The objective of the DREC project was to further investigate this issue. The first phase of the project was completed in March. With the assistance of the two family medicine residency clinics in Minot and Bismarck, we randomly selected 100 diabetic patient charts and collected data concerning their compliance with yearly retinal exams as well as other recommended diabetes monitoring tests. The data exhibited surprising results. Only 16% of Minot patients and only 32% of Bismarck patients had a documented retinal exam. This was considerably less than the other diabetes monitoring tests: Microalbumin, A1C, and Lipids (See Table 1). The dramatic differences between the results brought about several other questions. Were these numbers accurate or were there patients who had a dilated retinal exam but their results were just not documented in their chart? If this was the case, how many of the patients actually had exams? We addressed these questions with a second phase of the project.

	Retinal Exam	Microalbumin	A1C	Lipids
Minot	16%	80%	86%	85.7%
Bismarck	32%	54%	68%	62%

In phase two of the DREC project, we decided to contact the patients directly via telephone to collect information concerning their retinal exams. The phone calls were conducted by two residents from the Minot family medicine clinic. Each resident was provided with a script which outlined the three questions to be asked. The initial question was "Did you have a diabetic eye exam at an eye doctor's office during 2006 or 2007?" If the patients answered yes, they were asked two follow up questions: "Which eye doctor did you see?" and "Could you give me an approximate date of the exam?" The results of this phase of the project were equally surprising as the first. Of the 50 randomly selected patient charts, 42 (84%) of them did not have a documented retinal eye exam. The residents were able to make contact with 21 of these patients. Their conversations revealed that 11 (52%) patients actually had a yearly retinal exam but the information was not recorded in their chart. Important information concerning the non-compliance to yearly retinal exams was also gained from conversations with the 10 other patients. Some expressed that the eye exam was not considered a priority compared to other healthcare requirements. Others indicated that financial concerns were the reason why they chose not to have the exam. We found that a majority of the patients did not know dilated retinal exams were covered by Blue Cross Blue Shield; however, once they were informed of this, many indicated they would make an appointment.

We are currently broadening the scope of our study of diabetes care. For this next phase, we chose a "best practices" approach to research, which involves selecting exemplars in the field of diabetes care and learning about some of the practices they employ to retain such a high level success. In June, Blue Cross Blue Shield of North Dakota released the list of their 2007 Diabetes Care Provider Achievement Award Winners, composed of providers and clinics that were selected based on their performance on five criteria outlined by the American Diabetes Association Standards. We have interviewed six physicians from this list and asked them to discuss the practices they used their clinics for care of diabetic patients beyond standard care. We are already seeing similarities between the physicians' practices. Some of the beneficial methods mentioned were the assistance of a diabetes educator/nurse, electronic diabetes registries, clinic guidelines outlining specific diabetes goals, and the performance feed back provided by the BCBSND Diabetes Care Provider Reports. Our future plan for the project involves identifying a final list of practice interventions, then asking a broader group of network physicians to indicate which interventions they use in their practices, and correlating the answers with their diabetes care outcomes. In this way we can identify which of these interventions are actually associated with better care.

As you can see, the first year of the NORTHSTAR project has been a busy but successful venture. However,

this success would have never been possible without the assistance of our participating physicians and clinics. Drs. Kimberly Krohn, Suima Aryal, and Nabeel Nasir of the Minot Family Medicine Residency Clinic; Drs. Jeff Hostetter, Karin Willis, and Kelly Longie from the Bismarck Family Medicine Residency Clinic; Dr Eric Johnson from the Altru Health System in Grand Forks; Dr. Robert Kemp from the Craven Hagen Clinic in Williston; Drs. Ronald Wiisanen and Mary Jo Lewis from the Meritcare Health System in Fargo/Moorhead; and Dr. Susan Betting from the Q & R Clinic in Mandan.

If you are interested in participating in NORTHSTAR or have any more questions concerning the project, please feel free to contact:

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www.med.und.nodak.edu/northstar

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November 1, 2009
NDAFP Fall CME **Grand Forks, ND**

January 19 - 23, 2009
32nd Annual Family Medicine Update
Big Sky, MT

June 17-19, 2009
NDAFP Annual Meeting & Scientific Assembly **Bismarck, ND**

January 18-22, 2010
33rd Annual Family Medicine Update
Big Sky, MT

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