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Do you know that the U.S. health care system ranks 37th in the world yet is number 1 in health care costs? We also rank 36th in life expectancy and 39th in infant mortality. Recently, I attended a grand rounds at Baptist Medical Center in Montgomery given by Richard Streiffer, MD, professor of family medicine and dean of the College of Community Health Sciences at the University of Alabama. He recently traveled to Cuba and studied its health care system. He noted Cuba’s health care system ranked 39th, just two places behind the United States, with the same life expectancy and lower infant mortality rates at 10 percent of our costs. Cuba’s focus is population health management. It emphasizes overall outcomes of the population through a focused and intense management of each person’s primary care needs. Primary care physicians make up over 50 percent of the physician workforce, compared to a meager 18 percent in the United States. Even worse, those 18 percent aren’t all practicing office-based primary care.

The U.S. health care system is, for the most part, a fee-for-service system. It should really be termed a fee-for-being-seen system with little accountability placed on outcomes or achievement of proven measures. The only way to get paid is to see the patient. The more patients I see and the more procedures I do, the more I get paid. It would be naively heart-warming to think that money doesn’t matter, but we all know that just isn’t true. Medicine is operated as a business in the United States, and businesses exist to make money. Therefore, we are going to chase and compete for the dollar, see the patient and do a procedure. Hospitals, rehab centers, outpatient surgery centers, urgent-care clinics, radiology clinics, durable medical suppliers, nursing homes and pharmacies are all fee-for-service businesses. Most of these have been created not to improve the health care of populations but to provide care for a patient for the sake of making a dollar. Don’t misunderstand me — they provide a service, desire good outcomes and genuinely care for the patient, but their focus is not population health.

Population health aims at improving health outcomes of groups of individuals and is not focused on profits. Our current system provides fragmented care that mostly happens when the patient shows up in our facilities and presents a complaint. We rarely, if ever, think about the patient if he or she is not sitting in our office. We are managing individuals, not populations, and we aren’t even doing that very well. As family physicians in office-based practices, we like to think that we are doing a good job at focusing on our patients’ health. However, only 59 percent of our patients are getting recommended cancer screening, 68 percent of our children get their vaccines, 48 percent of patients with hypertension are controlled, and 20 percent of diabetics have HbA1cS over 9. Population health extensively manages primary and secondary prevention. Extensively manages means takes a proactive, focused approach on getting patients linked with a primary care team that works to promote health, decrease risk factors and manage chronic diseases. There is plenty of data that shows that this approach decreases morbidity and saves money. So why are we not doing this? Simply, we aren’t paid to do this.

How does population health save money? The two most expensive cost centers in our fee-for-service approach are hospitals and pharmacies. Nursing-home care must be added when applying this to Medicaid. The least expensive location is the primary care office. The primary care office reduces disease burden and promotes health better than any other single entity. If we are the least expensive venue and have the greatest potential to impact population health, why is this not our national focus? There is a lot of talk in CMS surrounding primary care improving our health care system. The problem is that shifting to this model of health care delivery causes great pushback from everyone profiting or at least sustaining his or her entity in the current model. Changing our delivery system where primary care is the base of our pyramid would mean that we don’t need as many hospitals, specialists and pharmacies. Someone is suddenly out of business or suffers a decrease in his or her income. This creates that pushback.

Population health aims at improving health outcomes of groups of individuals and is not focused on profits. Our current system provides fragmented care that mostly happens when the patient shows up in our facilities and presents a complaint.

If you want to make money in our current system, you need to see a lot of patients, do procedures and admit them to hospitals. Providing primary care where one doctor sees one patient and provides preventive medicine and treatment of his or her chronic disease takes a lot of time and generates about the same reimbursement as seeing a patient for a sore throat. We get paid about the same for the five seconds that it takes to freeze an actinic keratosis as we do for that 20-minute preventive visit. This explains why our family medicine graduates are choosing urgent care, hospitalist or emergency medicine over office-based primary care and why our medical school graduates choose specialty care over primary care. I was shocked to recently discover that the family physicians in our community who work in urgent-care centers earn twice as much as our physicians providing office-based primary care and, in some cases, triple the amount. Just to be clear, urgent care is not primary care.
If we want our patients to have the best outcomes and lower our costs, we must change our approach to providing health care. Every person should have a primary care physician managing his or her overall care. We must have a team approach to manage patient populations. That team must be led by the physician and include nurse practitioners, social workers, dietitians, psychologists and pharmacists. We must value this physician by paying him/her at least 75 percent of what a specialist earns, not 50 percent or less. We must accept that many hospitals, urgent-care facilities, pharmacies and rehab centers will close if we provide the patient with a team to manage his or her care. This approach shifts money from expensive cost centers and will actually save money while improving outcomes.

At Baptist Health in Montgomery, we have shown this model works through a program called CareAdvisor. About six years ago, Baptist Medical Center-South identified about 500 uninsured patients who had used the Emergency Department or had been admitted eight times within the previous year. These patients had a chronic problem that, if properly managed, would decrease their utilization of the hospital and thus decrease the cost burden to the hospital. We were able to find about 300 of these patients and offer them a medical home within the residency program, a social worker, a nurse and a pharmacy. In turn, each patient had to agree to come to all of his or her appointments, take his or her medications and not use illicit drugs. The social workers provided for the patients’ transportation and their communication needs (they were given a free cell phone if needed) and tried to help with other social barriers. In between physician visits, the nurses followed up on their medications, their symptoms, weight changes, diet, smoking and other medical needs in order to avert urgent situations. The pharmacist managed the cost of the patients’ medications by offering alternatives and by watching for drug interactions and duplications. The hospital provided labs and radiology services. All of this was at no cost to the patient. All he or she had to do was comply. If the patient failed to show for his or her physician appointment, the social worker would call or visit to find out why. While this seems very expensive, costs to the hospital were cut by 60 percent, hospital admissions decreased 80 percent and the patients became healthier. Many of those patients have since been able to obtain gainful employment or qualify for disability benefits. Some patients were removed from the program due to continued drug abuse and noncompliance, and others were added, keeping the overall number of patients around 250 to 300. This small model of population health management has been successful in decreasing costs and improving health. It also proves that one doctor and one patient is not the most successful model of health care and that a team approach is necessary to manage populations, improve health and decrease costs. We need to develop a global payment system that allows health care teams to be built with the purpose of managing a population of patients while holding them accountable for achieving evidence-based outcomes, decreasing ED visits and hospital admissions, and controlling overutilization of testing and specialist referral. As Alabama Medicaid develops regional care organizations, it appears that this is possible if we remain altruistic to patient care and not slip into the battle of monetarily trying to maintain the status quo.
The Medical Society of Montgomery County Outstanding Resident Award is given to a third-year resident from the UAB Health Center Montgomery Internal Medicine Residency Program and the Montgomery Family Practice Residency Program.

Our family practice residency program’s Outstanding Resident is **Gaurav Parmar, MD.**

Dr. Parmar received his MD from Government Medical College, Bhavnagar, India, in 2005. Dr. Parmar went on to receive his master’s degree in public health from the University of Alabama at Birmingham in 2008.

During his public health internship at the Alabama Department of Public Health, he interviewed and surveyed American Indian tribal members regarding their health care needs, preparing a 62-page report, which is the first to document the health status of Alabama Indians.

Dr. Parmar has exemplified a family medicine resident during his entire three years in Montgomery, pushing the program to become academically better and taking an active role in teaching and leading medical students and residents. He is focused on quality and safety of patient care at the medical school, and in the community, he actively volunteers for sports physicals for the colleges and high schools and works with the underserved.

He is an avid reader of nonfiction science books, and he enjoys learning astrophysics, playing tennis, chess and swimming.

With his graduation from residency training in June, Dr. Parmar is now providing patient care as a hospitalist at RMC in Anniston, Alabama.

The Medical Society and the Montgomery Family Medicine Residency Program are pleased to present Dr. Gaurav Parmar with the Outstanding Resident Award.

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2014 Alabama Tar Wars® State Winner: Ava Duke

Ava is a fifth-grader at Collins Intermediate School in Scottsboro, Alabama. She will travel to Washington, D.C., July 21-22, 2014, to compete at the Tar Wars® National Conference.
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Legislature Allocates $685 Million from General Fund to Medicaid

A General Fund appropriation of $685 million will make it possible for the Alabama Medicaid Agency to continue its current operations into fiscal year 2015, according to State Health Officer Dr. Don Williamson, who is overseeing the agency’s transition efforts. The 2015 Fiscal Year begins in October 2014.

The Alabama Legislature adjourned its 2014 session after approving a $1.8 billion General Fund budget, which included funding for the Medicaid agency. The budget reflected the recommendation made earlier in the year by Gov. Robert Bentley to increase Medicaid funding by $70 million over the previous year’s appropriation of $615 million. Gov. Bentley signed the funding bill into law on April 4.

“The Legislature had the very difficult job this year of balancing the needs of all the agencies which depend on the General Fund,” Dr. Williamson said. “We appreciate the support provided by the governor and the Legislature to Medicaid as we continue our efforts to implement key payment- and delivery-system reforms.”

RCO Legislation Revises 2013 Law as Agency Moves Forward on Reform

A new law signed April 4 by Gov. Robert Bentley now sets the stage for publication of rules and other activities to transform the agency’s fee-for-service system to a capitated, coordinated care model.

Senate Bill 459 was introduced on March 11 to amend the Regional Care Organization (RCO) law passed during the 2013 legislative session, according to Dr. Donald Williamson, state health officer and chair of the Medicaid Transition Task Force.

“The new law is based on considerable input and discussion by physicians, hospitals and other health care providers and is designed to support and strengthen regional care organizations as they prepare for this transition,” he said.

The legislation amends current law to revise the membership of and eligibility requirements for an RCO’s governing board, to allow the appointment of an executive committee, to require the creation of a provider standards committee by each RCO and for the state Medicaid agency to establish minimum reimbursement rates and to review all RCO contracts and agreements, among other stipulations.

“My expectation is that we will probably see more rapid engagement in collaboration as a result of this,” said Dr. Williamson, noting that collaborative activities are an important aspect of the reform process.

“When you are collaborating, you are not acting as an agent for your organization but as an agent for the state,” he said. “We are creating a market where we hope to have better care at a lower cost in a market created by the various providers working to develop and implement the RCO.”
Moving Alabama Medicaid from a fee-for-service system that is based on visits and volume to one that focuses on value, quality and outcomes will require new ways of evaluating health care services offered by Regional Care Organizations, according to Dr. Robert Moon, Medicaid medical director and deputy commissioner, health systems.

To facilitate that change, a Quality Assurance Committee comprised of 23 physicians, pharmacists and other health care professionals has been meeting since October 2013 to determine the metrics by which the new RCO organizations will be measured. The QA committee was created under a 2013 law establishing regional care organizations and is comprised of health care professionals, of which 60 percent or more must be physicians.

On April 17, the committee voted on a set of nationally recognized metrics. The committee recommended that five to 10 of these metrics be used in an incentive program for the RCOs but that the other metrics in the set be used for monitoring RCO performance. At the committee meeting, other metrics were considered for monitoring.

“The amount of engagement and dedication to the work of the committee by its members has been impressive,” Dr. Moon said. “While we were unsure of the participation we would receive when the process began, we have averaged over 90 percent attendance at all of the meetings and have seen members put in considerable work and study between meetings.”

The QA Committee will meet again in May and June to finalize and adopt the initial set of measures for RCOs. The agency will provide initial baseline analysis and technical assistance to the RCOs as they begin to develop their data collection and reporting systems. The goal is to have all measures in place when RCOs begin October 1, 2016.

Are You an RCO Collaborator?

by Richard D. Sanders, Esq., The Sanders Law Firm, P.C.

Academy members are trying to determine what Regional Care Organizations (RCOs) mean for them in managing their Medicaid patients, and the Academy leadership has been working hard to preserve a role for family physicians in the governance of these RCOs. Now that the rules have been revised and finalized this past April, potential RCOs are required to notify Alabama Medicaid of their intent to apply by October 1. This starts the clock ticking on what kind of arrangements RCOs and family physicians can develop to increase quality and improve clinical outcomes for Medicaid enrollees under this new capitated system.

As the Academy reported in the 2013 third-quarter edition of The Scope of Family Medicine, Alabama Medicaid finalized new rules in October to establish RCO collaborators (The Scope of Family Medicine, October 2013, page 10). This sounds like the villain in a James Bond movie, but it is actually an important role under the new rules because family physicians can be RCO collaborators. RCOs will contract with Alabama Medicaid to operate the new Medicaid system on a regional basis. RCO collaborators, on the other hand, include family physicians “who are expecting to collectively cooperate, negotiate, or contract” with another collaborator or RCOs (AL Medicaid Rule No. 560-X-62-01(1)). By filing an application with Alabama Medicaid, a family physician notifies the state that he or she is interested in collaborating with others and potentially negotiating with other providers in establishing arrangements with the new RCOs. By issuing these rules, Alabama Medicaid provides a way for family physicians to work together in a manner that complies with federal antitrust guidelines.

At our 2014 Annual Meeting, the Academy discussed the latest developments in RCOs and explored the best ways to educate family physicians on these issues and help them operate in this new Medicaid environment.
The University of Alabama College of Community Health Sciences provides psychiatric care and diabetes education through telemedicine, and its programs are continuing to expand.

A key part of the College of Community Health Sciences’ mission statement is to improve the health of individuals and communities in rural Alabama. Often, these rural areas aren’t able to attract the needed physicians and specialists to their communities — plus limited resources can make it challenging for residents to travel to the nearest physician available.

So the college, through the use of telemedicine, provides telepsychiatry and diabetes education services to a number of rural communities across the state, with plans to expand to even more.

The college’s telemedicine efforts began in 2007, when it partnered with the Alabama Department of Mental Health, the West Alabama Mental Health Center in Demopolis and others on a $1.2 million grant awarded by the Bristol-Meyers Squibb Foundation with the goal of improving mental health care in the state’s rural and impoverished Black Belt region.

With the grant, the College provides telepsychiatry in five rural West Alabama counties: Choctaw, Green, Hale, Marengo and Sumter.

Then the college’s Institute for Rural Health Research was awarded a nearly $100,000 grant in 2009 from the U.S. Department of Agriculture’s Distance Learning and Telemedicine Grant Program. The funding allowed the college to purchase video conferencing equipment, including cameras and monitors, for the rural Alabama clinics with which the institute had partnered on the grant.

And in 2012, a nearly $20,000 gift from the Verizon Foundation enabled the College to expand its already established program in Tuscaloosa that teaches diabetic patients how to better manage their disease.

The College’s Diabetes Self-Management Education Program is now offered via telemedicine at the Sumter County Health Center in York, Pickens County Medical Center in Carrollton and Family Medical Center in Thomasville, and efforts are underway to expand the program to Lamar and Walker counties. Efforts are also underway to provide asthma education through the College’s telemedicine program.

A Life Changed by Education

When Barbara Fulghum was diagnosed with Type 2 diabetes in 2011, she was devastated. After taking care of her mother and her grandmother, who also had the disease, she feared the complications she saw them experience.

"It’s really a healthy lifestyle," she says. "And I can adapt."

When first diagnosed, Fulghum says she received a prescription after an emergency room visit, but she didn’t know how to manage her diabetes.

"I knew I needed education," she says.

So she reached out to her doctor’s office and was eventually referred to a class offered in her rural hometown of York, Alabama. Fulghum, along with 24 other patients, make up the Diabetes Self-Management Education Program at the Sumter County Health Center, which had its first class in January 2013.

But now she says both her outlook and her lifestyle have changed thanks to the Diabetes Self-Management Education Program offered by the college in her area through telemedicine.

It was the location where the college first started offering diabetes education services through telemedicine after receiving a gift from the Verizon Foundation that enabled the expansion of its Tuscaloosa program. Classes began at Pickens County Medical Center in Carrollton, Alabama, in August.
Diabetes is the sixth-leading cause of death for Alabamians, according to the American Diabetes Association. Diabetes-related deaths in rural Alabama are as much as 18 percent higher than in the state’s urban areas and are as much as 44 percent higher than diabetes-related deaths in the United States, according to the ADA.

Since Fulghum has been attending the classes, she says she has lost 25 pounds with the knowledge she has gained and healthy eating tips she has learned. She says she hopes more people who are able to participate in the program decide to join.

“A lot of people in our community suffer from diabetes,” she says. “I think not only can they benefit from this class but also people who are their caregivers.”

She also says she does not worry the way she used to about suffering from complica-
tions she saw her mother and grandmother face. “I feel like I now know enough to avoid them,” she says. “My whole lifestyle has changed.”

**Changes for the Better in Mental Health**

Three and a half years ago, two residents of DeKalb county in Alabama saw a dire need in their community.

Angela Wilson, a local mental health care activist, and Thomas Whitten, MSW, a licensed clinical social worker and director of DeKalb County Youth Services, found that children and adolescents in their community, particularly youth offenders, needed a psychiatrist who could provide assessments, recommend prescriptions, if necessary, and follow up consistently.

The closest psychiatrist in the area was in Fort Payne and was often booked months in advance. The best answer for them was telemedicine.

So Wilson reached out to the college and connected with Thad Ulzen, MD, chair of the Department of Psychiatry and Behavioral Medicine at the college and associate dean for academic affairs. He recognized Wilson’s goal and connected her with Amelia de los Reyes, RN, the telemedicine coordinator for the college.

Now, twice a month, young patients are assessed through telepsychiatry by Loyda Williamson, MD, child and adolescent psychiatrist and associate professor in the college’s Department of Psychiatry and Behavioral Medicine. Patients communicate with Williamson from the DeKalb County Technical Center through teleconferencing equipment after Wilson. Ulzen also assesses patients twice a month, and Marisa Giggie, MD, an assistant professor in the department who specializes in forensic psychiatry, has assessed patients, too.

Three years after its implementation, more than 200 evaluations have been provided, according to a recent report from Whitten to the Appalachian Regional Commission, which provided grant money to expand services. All cases have been linked with a community provider for follow-up treatment, the report said. Whitten’s report attributes the success to a few factors: the donation of telemedicine equipment by the college; the approval of grant funding through the Appalachian Regional Commission; the frequent communication between the college and the site; and quality improvement efforts, including satisfaction surveys of parents.

“The overall project has been successful from the provider aspect, the community aspect and, most importantly, the patient aspect,” Whitten said in the report. “These are children and youth who would not have been served otherwise.”

In addition to DeKalb County, telepsychiatry services are provided through the West Alabama Mental Health Center with sites in Marengo, Choctaw, Greene, Sumter and Hale counties. In 2013, about 240 patients were seen at these sites (between January and October). This is an increase from about 160 patients in 2012. Faculty members from the college’s Department of Psychiatry and Behavioral Medicine also provided, using telemedicine equipment, training for the West Alabama Mental Health Center’s social workers, psychologists and mental health workers at all of its sites.

**Telemedicine 2013**

The College of Community Health Sciences provides telepsychiatry and diabetes education services to a number of rural areas across the state.

**Diabetes Self-Management Education Program**

- Sumter County Health Center (York): 24 patients
- Pickens County Medical Center (Carrollton): 10 patients
- Family Medical Center (Thomasville): 11 patients

TOTAL: 45 patients

Efforts are underway to expand the program to: Lamar and Walker counties.

**Telepsychiatry**

- DeKalb County Youth Services (Rainsville): 200-plus patients
- West Alabama Mental Health Care Center with sites in Marengo, Choctaw, Greene, Hale and Sumter counties: 240 patients
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The model is called a patient-centered medical home (PCMH). The name can be confusing because in this case, a medical home is not necessarily a place but rather a philosophy of providing care that is readily accessible, coordinated, centered around the patient and with an emphasis on prevention, education and managing long-term chronic conditions.

The College of Community Health Sciences at The University of Alabama will host a conference in July that focuses on the PCMH model and ways that physicians and other health care providers can incorporate this model into their medical practices.

The conference, “Building the Patient-Centered Medical Home: Inspiration and Tools to Help Transform Your Practice,” will be held July 25-26 from 8 a.m. to 4:30 p.m. at Hotel Capstone on The University of Alabama campus. CME will be provided, as well as CEUs for nursing and social work.

Among the keynote speakers is Paul Grundy, MD, director of IBM Global Healthcare Transformation and founding president of the Patient Centered Primary Care Collaborative.

In his role at IBM, Grundy (known as the “godfather” of the PCMH) develops and executes strategies to shift health care delivery toward consumer-focused, primary-care-based systems through the adoption of new philosophies, primary-care pilot programs, new incentive systems and the information technology required to implement such changes. He is a member of the Institute of Medicine and recipient of the 2012 National Committee for Quality Assurance Quality Award.

The Patient-Centered Primary Care Collaborative, founded in 2006, is dedicated to advancing an effective and efficient health system built on a foundation of primary care and the PCMH.

Other confirmed conference speakers include:
• Beverly H. Johnson, president and CEO of the Institute for Patient and Family-Centered Care and the recipient of the 2011 Dorland Health People Award for leadership in the area of patient- and family-centered care. Johnson has published widely on patient- and family-centered issues and strategies; has more than 25 years of experience in or-

A patient-care team at University Medical Center, from left: dietitian Margaret Garner, RD; nurse Tracy Hallman, RN; Chelley Alexander, MD, a family physician; and Thad Ulzen, MD, a psychiatrist
A patient-centered medical home provides a team-based approach to comprehensive patient care. Led by a physician and including such health professionals as nurses, social workers, psychologists and psychiatrists, nutritionists, pharmacists, and health educators, the PCMH is a way of organizing primary care to emphasize holistic care by a team of professionals who coordinate care and teach self-care skills. The goal is to provide a higher quality of care at a lower cost and to improve the care experience for patients and providers alike.

Second, regular medical management meetings are held by care teams that provide physicians with data on their population of patients showing, for example, the percentage of patients who have had flu shots.

“Providers are thrilled to finally have data on their patients,” Alexander says. “When the group identifies an area that needs improvement, such as the number of inappropriate ER visits, the group brainstorms and then implements changes to ensure improvement. They feel empowered to make a difference.”

She says providers also receive updates about medical problems that have clear, quality guidelines, such as asthma or congestive heart failure, which are common reasons for preventable hospitalizations in west Alabama.

“The MedNet West pilot has proven that changing our model of care, even slightly, can improve the quality of care and reduce cost,” Alexander says.

According to preliminary data, the UMC pilot has resulted in a reduced cost of 5.8 percent compared to nonpilot areas in Alabama, saving the state’s Medicaid program $3.5 million in 2012 and 2013, or approximately $331 per enrollee per year. Much of the savings is due to improved access to a health-care team for patients with chronic conditions, preventing unnecessary emergency room visits and hospitalizations.

In February 2014, the start of a PCMH was implemented within UMC’s Family Medicine Clinic. Among the changes: physicians were provided with report cards showing their performance on prevention (scheduling mammograms) and chronic disease management (getting diabetic patients on lipid-lowering therapy). Teams of providers also evaluate, for example, group visits and additional self-care training for patients.

“All the attention to patients is not an extravagance. Heading off problems in the doctor’s office often keeps patients out of the emergency room or from being readmitted to the hospital, both of which are costly forms of health care. The PCMH has also been shown to help patients manage their own chronic health conditions, which account for an estimated 75 percent of all U.S. health care spending.”

The PCMH model is also becoming part of the college’s curriculum. “We want to teach our medical students and residents how to study their care of populations of patients—to look at their panel of patients and identify strong and weak areas and, by identifying best practices, help each other put processes in place to make quality improvement continuous,” Alexander says.

She says the next steps are to fully implement the PCMH model in all UMC clinics — pediatrics, internal medicine, OB/GYN, psychiatry, sports medicine and the Faculty-Staff Clinic.

Previously published in the Spring 2014 edition of On Rounds magazine
Recognizing the importance of promoting early childhood literacy and language development, the American Academy of Family Physicians has entered into an agreement with the Reach Out and Read National Center (www.reachoutandread.org). The agreement names the Academy as a literacy partner of Reach Out and Read.

“We know that reading aloud to children from an early age is important in their development of language skills, future literacy and, ultimately, school success,” said Jennifer Frost, MD, medical director for the AAFP Health of the Public and Science Division. “Yet, for a variety of reasons, many parents and caregivers don’t read to their children regularly. Through the Reach Out and Read program, physicians provide developmentally appropriate books during the well-child visit and use this opportunity to discuss with the caregivers the many benefits of reading to their children.

“The American Academy of Family Physicians is excited about partnering with Reach Out and Read to promote this important message.”

Boston-based Reach Out and Read is a national nonprofit organization that trains and supports medical professionals who — during well-child visits — give new books to children and advice to their parents about the importance of reading aloud. The program serves 4 million children, ages 6 months to 5 years, throughout the country each year, focusing on those in low-income families.

FPs as Reading Champions

“Reach Out and Read is thrilled to establish an official alliance with the AAFP,” said Brian Gallagher, the program’s acting executive director. “Reach Out and Read’s goal is to reach as many children as possible nationwide with this, our evidence-based early literacy intervention. Working through family physicians, we can reach even more children, especially those in rural areas.”

Often the only primary care physicians practicing in many areas of the country, family physicians can leverage the relationships they have with entire families to encourage early literacy, Gallagher added. “Reach Out and Read already works with many family physicians, and this new alliance offers us a stronger connection to build on our relationship with individual physicians and with family medicine,” said Perri Klass, MD, national medical director for Reach Out and Read. “As medical director, I have learned a great deal from our family medicine champions and look forward to strengthening these ties and reaching even more children and families through primary care health professionals whose perspective includes the health and well-being of children and their parents.”
Reach Out and Read also has alliances with the American Academy of Pediatrics and the National Association of Pediatric Nurse Practitioners.

Making a Personal Connection

Frost was an active Reach Out and Read participant in her previous position as associate program director and director of women’s services at Research Family Medicine Residency in Kansas City, Missouri. For nine years, she taught residents about Reach Out and Read and also implemented the program with her own patients, who she said tended to be from high-risk populations.

“It was certainly a great way to talk to patients about the importance of reading early to improve literacy,” Frost recalled. She said she used the program’s books in the clinic to evaluate whether a child was meeting his or her literacy milestones, such as turning a book’s pages or focusing on pictures. It also helped her gauge how interested parents were in books. “If I have a mom who has no interest, throws the book in her bag, then I’m going to talk to that mom more about reading,” Frost explained. Perhaps there are barriers to reading, or perhaps mom just doesn’t understand how important reading is, she added. Identifying and overcoming such barriers can help build positive relationships with patients.

She recounted a story about a child she had delivered and then saw in her clinic for many years. “We gave him books and talked to his mom about reading at every visit through age 5,” Frost said, but she wasn’t sure if her message was being received by the child. When the child returned for his 6-year-old visit, he was disappointed to find he had aged out of the program. “He asked, ‘Where’s my book?’ He was so excited for his book,” Frost said. Seeing that enthusiasm for reading blossom is what makes Reach Out and Read so rewarding, she noted.

Family physicians interested in starting a Reach Out and Read program at their practices can identify their state or regional coalition’s contact and fill out an online application on the Reach Out and Read website (www.reachoutandread.org).

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$1,000 Stan Brasfield, MD, Scholarship for Alabama AFP Residents Is Available

All resident-members of the Alabama Academy of Family Physicians are eligible to apply for the annual Stan Brasfield Memorial Scholarship. The family of the late Dr. Brasfield created the scholarship fund to honor his memory; it is to be given annually to a first- or second-year resident who meets certain criteria.

Dr. Brasfield, a Montgomery native, earned his medical degree in Alabama. He died at the untimely age of 33 while practicing in Florida. The scholarship is in the amount of $1,000. The criteria are as follows:

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AAFP Contract Review Program for Residents

The Academy is pleased to announce that it has negotiated an arrangement with the Sanders Law Firm, P.C. in Birmingham that will benefit residents and fellow members of the Academy. Specifically, the Sanders Law Firm will review a draft employment agreement for any Academy member, discuss the draft employment agreement with the member and recommend changes where necessary for a flat fee of $500. Rich Sanders, the firm’s president, has spoken at the Summer and Mid-Winter meetings of AAFP since the late 1990s, and he has previously assisted Academy members with HIPAA and corporate compliance programs. If you have any questions about this contract review program, please call Rich Sanders at 205-930-4289, or email him at rsanders@southernhealthlawyers.com.
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