Volume 53
Fall 2005

KAFP JOURNAL

The Official Publication of the Kentucky Academy of Family Physicians

Colorectal Cancer Screening

Pay for Performance is Coming!

The State of Oral Health in Our State

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- Letter From The Associate Editor
- Letter from Your Resident Member of the AAFP

KAFP JOURNAL
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FROM THE EDITOR

by Bill Crump, MD

Much is changing with your Journal. I pledge to keep some of the tradition alive while bringing you current events and issues. I am truly pleased to introduce our new Associate Editors, Charles Kodner in Louisville and Steve Wrightson in Lexington. Twice a year, each will take the lead in producing an issue. We hope to include brief clinical studies and timely topic reviews brought to you from a uniquely Family Medicine viewpoint. We also want to share the stories of family doctors throughout the Commonwealth that paint a picture of who we are and what we do.

Borrowing a term from the Future of Family Medicine Report, we believe each Kentuckian deserves a medical home. This home should be tended by that person's family doctor that may not actually provide each and every service needed, but who manages the "basket of services." When a patient needs a service not provided by his doctor, a consultant is chosen carefully based on the unique knowledge of the totality of that patient as an individual. We all have stories of how knowing someone as a person has affected health choices and outcomes. We ask you to share your stories with us, maybe answering the question : "Why in the world would this patient do that?"

I'll start with one of my own. Returning from a week away from practice, a young woman who I had seen for 6-8 visits over about a year appeared on my schedule again. Entering the room, I could see she was distraught. Holding a sheet of paper in her hand, she looked up and said, "I'm so glad you're back!" It took the next ten minutes to recreate the 2 visits to the urgent care center, 1 ED visit, a cardiology consult, and a treadmill test that had transpired as I was at CME. It started with just heart racing and "feeling funny." The nurse practitioner at the urgent care center said the EKG didn't look just right, and suggested a cardiologist visit (worry begins). Then it turned out that the first appointment was 3 weeks away (more worry).

Then a brief episode of chest pain and shortness of breath resulted in another urgent care visit 2 days later, where she was sent straight to the ED. The ED folks seemed to the patient to be really worried, and before she knew it she had an IV in her arm and some bitter NTG spray in her mouth that only gave her a headache. The ED doctor said the EKG looked fine to him, but scheduled a treadmill in the AM (even more worry). The treadmill wiped her out, and the doctor said it was inconclusive and scheduled a cardiac cath. The paper in her hand described the instructions for this test, scheduled for tomorrow. She was now really worried. "What should I do?" she said.

All of this made sense to me. I had seen her twice with fleeting symptoms with normal findings before I asked if she had any insight into why she is so sensitive to such feelings. Through some tears, she explained that her father had been killed in a mining accident when she was in fourth grade, and she had been worried about her own death ever since. Now she was married, had a 7 year-old daughter, and every little health issue loomed like it could be her last. After that, she would come in with a small reactive lymph node convinced she had leukemia or a rash that she thought was spotted fever. Each time I would carefully examine her and order basic lab as indicated. When I went back in the room with the results, ready for a difficult time reassuring her, each time it was easier. We had finally gotten to the point where she would say "All I need to hear is that it's okay- if you say so."

I also knew that her husband left on a week-long business trip about the time her last round of symptoms began. I reviewed her low-risk history, again examined her, and repeated a normal EKG. I was all prepared to talk about predictive value and false positive treadmill tests, when she said:"Just tell me what you would tell your daughter in this situation." I could honestly say that I wouldn't recommend the cath. Hearing that her husband would be back tomorrow, we were both okay with waiting, with a dose of hydroxyzine tonight at bedtime.

Although this visit just got coded as a 91214, it was important. If I had not known her well enough, I could have easily said to proceed with the cath. I could have let my own slight uneasiness show, making hers worse. Instead, I played the role of her doctor, tending her medical home. Since then I have delivered her second child and seen her husband through a couple of minor illnesses (that she thought were life-threatening). Family doctoring is just so much more than CPT codes and making referrals.

I invite you to comment on my story or share your own. Call or Email whichever Associate Editor is closest to you, and he will help you get it ready for publication. The family doctor's story is just too good not to be shared.

Bill Crump, M.D.
Madisonville, KY

KAFP Associate Editor Announcement

Dr. Stevens Wrightson has been named one of the two Associate Editors of the Journal of the Kentucky Academy of Family Physicians. Dr. Wrightson is the Residency Program Director at the University of Kentucky Department of Family and Community Medicine where he has been on faculty since 1999. He has presented locally and nationally on topics ranging from the new competency initiatives mandated by the Accreditation Council for Graduate Medical Education and on Oral Health education of family medicine residents and faculty. Prior to returning to Lexington, Dr. Wrightson practiced in Olive Hill and Morehead in Kentucky.

FROM THE ASSOCIATE EDITOR

by A. Stevens Wrightson, MD

I began my career as a family physician when I was 12 years old. That was when I started working for my father in his drug store in Lyndon, Kentucky, then a small community in Jefferson County. It was during those years that I saw my father teach and care for his patients. Whatever I did, I knew it would involve that type of relationship, one that included a joke, a story about the kids, a hearty handshake, and maybe a hug, when necessary.

Sixteen years after my family medicine residency, I find myself at the University of Kentucky, teaching residents and medical students. I still see patients and the stories we share still make me laugh and, occasionally, cry. But I am also in charge of developing new family physicians who will continue the tradition of the generalist of old, not because they are "generalists", but because they are connected to their patients, their families, and their communities.

As an associate editor of the KAFP journal, I want to let you, the family physicians of the state, know about what is new in residency and medical school education. I assure you, we have not forgotten the "Art of Medicine." On the contrary, we continue to provide innovative material for and ways of training residents, with the emphasis being that our graduates are the care providers of individuals and communities. In this issue, Dr. Baretta Casey and I write about new initiatives in improving the oral health of Kentuckians. With all the improvement from fluoridated water, Kentucky still ranks poorly in the oral health of its citizens, especially those who are poor and rurally situated. Educationally, these projects show how we can link a health need to an instructional method that benefits family medicine residents as well as community-based faculty and physicians. In addition, these projects put into practice what they teach, that is a full service dental clinic in a rural family medicine clinic in Hazard.

I hope to share with you other changes in medical education. I invite you to write to me about the teaching and caring you provide in your offices. Those are the experiences that help all of us become better educators of the next generation of family doctors. As each of us has pledged in taking the Hippocratic Oath, "I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow."

A COMMUNITY-BASED COLORECTA

William J Crump, M.D.**

**Professor, UL Family Medicine and Associate Dean, UL Trover Campus

INTRODUCTION

Screening asymptomatic individuals for any disease is controversial. To meet generally accepted criteria for screening, the disease must have a significant burden of suffering, early detection must make a real difference in outcome, and a reasonably easy and inexpensive screening test must be available. Colorectal cancer is the second most common cancer, and accounts for about 10% of all cancer deaths (1). While there is little agreement on screening for many cancers, there is consensus on colorectal cancer (2). Table one shows the American Cancer Society recommendations(1).

The primary obstacle in colorectal cancer screening is patient acceptability (2). All methods but fecal occult blood test (FOBT) are invasive and uncomfortable and require a significant amount of the patient's time. Even FOBT requires avoiding red meat and nonsteroidal anti-inflammatory agents (NSAIDs) for several days and is considered unpleasant by many patients. Inadequate payment for preventive counseling and difficulty working preventive issues into daily practice have also been identified as obstacles(3). For a community effort, FOBT is the only reasonable alternative.

Previous large population studies have shown that from 1 to 9 % of those screened will have at least one positive FOBT card. Patient cooperation with subsequent diagnostic testing has ranged from 42% to nearly 95% (4,5,6,7).

We report a community screening project conducted by a collaboration of a regional cancer center, the American Cancer Society regional office, and the Kentucky Cancer Program. Previous studies have shown that only about 20% of Kentuckians are receiving appropriate colorectal cancer screening, despite adequate physician capacity (8). The purpose of this effort was to use relatively inexpensive methods to raise awareness and increase the number of those screened.

METHODS

Two 2-hour sessions at the regional cancer center were advertised in the local newspaper and flyers were posted at a local senior center. At each session the patient completed some identification information including the name of their primary care physician and then received individual health advice from a trained patient educator. Written materials were supplied to each patient and posters were displayed in the waiting area that gave details of further diagnostic testing and other screening methods. As the patient left the teaching area, an evaluation form was completed.

Each patient was given a 3-card FOBT kit with written instructions that were reviewed at the education session. The kit had a self-addressed envelope for return, and the cards were processed on return without rehydration.

RESULTS

The effort was well-received, with patients expressing appreciation for both the education and the kit. 188 patients were seen, and 106 returned the kits (see figure). Twelve patients had at least one positive result (11.3%), and were sent a registered letter. The letter informed them that there are many possible causes for the abnormal test, and that it is important that they see their doctor soon.

Six and 15 months after the letter was sent, charts were reviewed at the only site in the county where colonoscopy is performed and both large clinics in the county. Telephone calls were then made to those individuals who received further testing outside of the county. Ten of the patients had colonoscopy, with the results shown in Table Two.

One patient with a positive FOBT, an 88 year-old man, declined the colonoscopy recommended by his personal physician. About 8 months after the screening, he presented with a bowel obstruction and was found to have an "apple-core" lesion in the mid-transverse colon, subsequently proven to be colon cancer. One 87 year-old woman chose not to have any further testing, and was without gastrointestinal disease at 15 month follow-up.

The costs of the screening project are shown in Table three.

AL CANCER SCREENING INITIATIVE:

and Allison M Crump***

*** Trover Campus summer research assistant, undergraduate student, Murray State University

DISCUSSION

This colorectal cancer screening effort is an example of a small-scale community project that is within the scope of the primary care physician. The Kentucky Cancer Program is undertaking a statewide effort to reach more of the population at risk, and family physicians are ideally placed to make this effort more successful.

This study does show some of the problems of community-based screening. First, only the patients most motivated and with reliable transportation could come to the sessions. True community-based efforts will include taking the screening to places more convenient for the population. Even in this motivated population who received good education, only 83% followed through with the recommended evaluation. While this doesn't negate the positive impact on the majority, it is a reminder that a minority of the screened population will require multiple follow-up efforts.

ACKNOWLEDGEMENT

This effort would not have been successful without the support of the Trover Foundation and its Merle Mahr Cancer Center staff. The regional office of the American Cancer Society and the Kentucky Cancer Program were key partners in what has now developed into an annual screening program. The University of Louisville Trover Campus supported chart review and data analysis.

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TABLE ONE *

1)Fecal occult blood test (FOBT) annually, or

2)Flexible sigmoidoscopy every 5 years, or

3)Annual FOBT and flexible sigmoidoscopy every 5 years, or

4)Double contrast barium enema (DCBE) every 5 years, or

5)Colonoscopy every 10 years

* all beginning at age 50 for low risk patients

Figure One

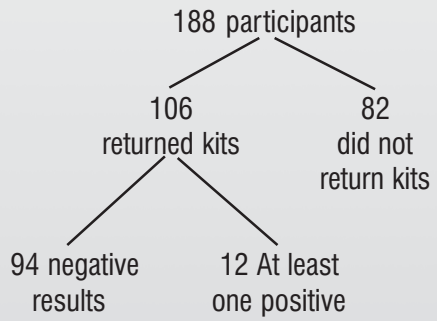

TABLE TWO

Colonoscopy Results (n=10)

Hemorrhoids only	3
Hyperplastic polyp	2
Tubular adenoma	2
Normal exam	3

TABLE THREE

Cost of screening project (n=188)

Materials	$300
Postage	$ 75
Publicity	$ 80
Staff*	$205
Total	$705

* If volunteers had been paid

PAY FOR PERFORMANCE IS COMING!

By

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INTRODUCTION AND BACKGROUND

Pay for performance (P4P) is coming! P4P is a priority for Medicare, health plans, and other healthcare organizations. This term is generally used to describe payment incentives for physicians and other providers based on their past performance on quality measures. Non-financial incentives, such as public recognition and commendations, are also powerful motivators in P4P, but they will not be addressed in this article.

P4P is already used to pay hospitals and nursing homes. Physicians are next. P4P confronts concerns about patient safety, quality of care, escalating costs of healthcare, and problems with Medicare payments to physicians. A P4P system requires consensus on quality measures and the use of electronic health records (EHR) for reporting and tracking performance. This article is intended as an introduction to basic P4P issues.

IMPROVING PATIENT SAFETY AND QUALITY OF CARE

The Institute of Medicine (IOM) report To Err is Human: Building a Safer Health System (2000) delivered a "wake-up call" about patient safety.[1] Hospital-based medical errors were cited as the eighth leading cause of death in the US, estimated at 98,000 annually. Healthcare professionals have long been concerned about patient safety, but widespread media publicity of the IOM report dramatically elevated the concern to public levels. The IOM stressed that system problems were behind most safety and quality problems, not the performance of individual doctors and other providers.

The 2001 IOM report Crossing the Quality Chasm[2] focused on redesigning healthcare to improve quality, including a call to action for payment policies that reward performance. Again the IOM raised long standing quality concerns to the public level. In a 2005 telephone survey of 2,012 adults, nearly half said they were concerned about the safety of medical care they and their families received.[3] Fifty five percent said they were dissatisfied with the quality of healthcare – up from 44% in a similar survey in 2000. Apparently the public heard the calls, but progress toward improving safety and quality has been insufficient to change public perceptions.

RISING HEALTHCARE COSTS

The United States has the most expensive healthcare system in the world, using one seventh of the economy ($1.7 trillion in 2003) for healthcare.[4] Total national health expenditures increased by 7.7% from 2002 to 2003, four times the rate of inflation. Nonetheless, the US ranks in the bottom half of industrialized countries for life expectancy and infant mortality, with relative rankings worsening.[5] Increasing hospital costs, especially outpatient hospital costs, account for almost half of the annual increase. Advances in technology, including new drugs, devices, and therapies are significant cost drivers.

Americans say quality is a more important concern than costs, benefits, and choice of physician.[6] Yet, their physicians follow evidence-based guidelines only about 50% of the time.[7] Traditionally, clinicians have not been paid for quality of care. They are paid to see more patients, perform more tests, or do more procedures – without regard to quality of care or outcome. This model not only fails to provide incentives for patient safety, but it can reward unsafe care. Is it fair to pay providers the same amount, regardless of the quality of care, and in some cases for care that's not needed or that results from medical errors? P4P may be a solution to this dilemma.

THE NEED FOR MEDICARE PAYMENT REFORM

Medicare payment has not kept up with inflation. Medicare paid approximately 83% of typical commercial payers in 2001, and these percentages declined to 75% – 78% over the next two years.[8] If the Medicare physician reimbursement formula remains unchanged, payments will decline 17% from 2002 to 2005.[9] Another 4.3% cut is scheduled to become effective on January 1, 2006, and further reductions scheduled over the next six years add a decline of 26%.

Cuts in Medicare reimbursement may impact patients' access to care and the quality of their care.[10] The percentage of physicians categorically accepting new Medicare patients dropped from 72% in 1997 to 68% in 2001.[11] When asked what practice changes they would make if Medicare payments were cut 5% in 2006, 38% of responding physicians to an AMA member survey reported that they would decrease acceptance of new Medicare patients.

Medicare cuts may also be accompanied by decreased physician investments in office technologies. If Medicare payments were cut by 5% percent in 2006, 61% of physicians responded that they would defer purchase of new medical equipment, and 54% that they would defer purchase of information technology. The latter issue is critical to P4P, since EHR infrastructure and information exchange networks are essential for effective P4P programs.

HOW DOES PAY FOR PERFORMANCE WORK?

P4P introduces market forces to motivate improvements in healthcare quality, safety, and reducing costs. P4P is meant to reward practitioners for using "best practices," by monitoring and reporting on treatment processes and/or outcomes. For example, a P4P program of Bridges to Excellence (BTE), a nonprofit coalition of large employers, providers, and health plans, pays physicians achieving certification in the Diabetes Care Link program annual incentive payments ranging from $50 to $100 a year for each covered employee or family member.

Developing P4P typically involves a phased approach. Steps typically include:

1. Selecting quality indicators and measures
2. Profiling practitioners and providers
3. Public reporting of performance data
4. Paying incentives – or P4P
5. Program evaluation

The Centers for Medicare and Medicaid Services (CMS), the BTE program, and other health plan P4P programs have used this approach.

THE IMPORTANCE OF ELECTRONIC HEALTH RECORDS

P4P as proposed by CMS and most health plans depends on consistent electronic reporting of data by

physicians. The architecture of the requisite health information infrastructure is as yet ill-defined. The system envisioned by CMS involves secure reporting via the Internet to a "data warehouse." A data warehouse for voluntarily reporting of quality measures is currently in place for hospitals; almost all U.S. hospitals report their data. According to a large survey by the Healthcare Information and Management Systems Society,[12] approximately 20% of respondents indicated that a health information exchange network will be in place within five years, while another 40% indicate that P4P models will become the norm in five to ten years.

Physician practices will need EHRs to track and report their data. The term "electronic health records" has different meanings for different people and purposes. Optimal and necessary characteristics of EHRs for physician offices for quality reporting are not yet standardized, although EHR is one component of the New Model of Family Medicine that can facilitate the "new basket of services".[13] The AAFP's Center for Health Information Technology (CHiT) is one resource for learning about EHR. Another is the Doctors' Office Quality - Information Technology (DOQ-IT) project provided by the Medicare Quality Improvement Organization (QIO) in each state. Both CHiT and DOQ-IT provide unbiased evaluations of available EHR products to assist physicians in their acquisition decisions.

LEGISLATIVE INITIATIVES ADDRESSING PAY FOR PERFORMANCE

In August 2005, Representative Nancy Johnson introduced a new bill - HR 3617: Medicare Value-Based Purchasing for Physicians' Services Act of 2005. This bill would repeal Medicare's physician reimbursement formula and replace it with one based upon the Medicare Economic Index. It creates payment incentives for physicians to practice quality improvement. Voluntary electronic reporting of quality measures would begin in 2007 and 2008, and P4P would be implemented in 2009. The AMA, AAFP, and other medical groups laud this bill for meeting many principles for fair and ethical P4P programs.

Other bills have been introduced that support P4P. The Grassley-Baucus Senate bill authorizes CMS to put all of the nation's hospitals, doctors, home-health agencies, and nursing homes on P4P plans.[14] Companion bills by Senators Kennedy and Enzi propose cash incentives to healthcare providers to increase use of information technologies. Senators Clinton and Frist have a bill to develop uniform standards for EHRs. President Bush signed the Patient Safety legislation into law in July 2005, supporting voluntary, confidential reporting and analysis of healthcare errors, with protections that limit use of information for litigation.

CAN P4P CONTAIN RISING HEALTHCARE COSTS?

One question about P4P is whether it can stem the tide of rising healthcare costs. The Bridges to Excellence (BTE) program is designed to help employees and family members choose physicians providing high quality care for selected chronic illnesses and/or those that have invested in EHRs. Programs associated with the National Committee for Quality Assurance are used for certification in chronic disease care, including Diabetes Care Link and Cardiac Care Link, and the Physician Office Link reward program. Certified physicians are eligible for annual incentive payments for each covered person.

The initial evaluations of the BTE program are being analyzed in Louisville, Kentucky. Average annualized costs of care for diabetic patients by BTE endocrinologists were $370 less than for non-BTE specialists ($770 vs. $1140). Most of their cost savings were associated with decreased hospital costs. However, certified primary care physicians did not realize similar cost savings.

P4P IS STILL IN THE EARLY STAGE OF DEVELOPMENT

P4P raises many unanswered questions related to healthcare quality. Demonstrations show improvement in target conditions, but P4P incentives may possibly encourage de-selection of patients in poor health to increase financial rewards. This process is akin to "cherry picking" of patients with minimal health risks. Are patients that do not have targeted conditions at risk for lower quality care, given the lack of P4P incentives? Will patients with time-intensive psychosocial conditions or requiring complex diagnostic workups for non-targeted conditions receive less care? Given the high cost of implementing EHRs and redesigning office practices, will physicians simply ignore P4P and maintain current practices? Are incentives too low to outweigh the office-based costs associated with P4P, especially for physicians close to retirement? Larger studies are needed to answer questions of unintended negative consequences.

P4P profiling of individual physicians presents some problematic statistical

issues. Even common diagnoses become unique cases when multiple co-morbid conditions, interacting medications, and psychosocial situations influence compliance, disease progress, and health status. Both the AMA[15] and Medical Group Management Association (MGMA)[16] recommend use of confidence intervals in public reporting to express the variability of the data.[17] Statistical methods used in profiling affect the results. [18] Covariates representing co-morbid conditions, severity ratings, measures of functional status, and medication use must be the same in all profiles for valid comparisons. Fairly allocated incentives require valid results using the same statistical methods.

Profiling individual physicians may be unreliable.[19] For example, in profiles of primary care physicians for diabetes hospitalization, encounters, laboratory utilization, and glycemic control, 4% or less of the overall variance was attributable to differences in physician practice.[20] Unless panel sizes of patients are large, profiling may lack statistical reliability. Incentives for group or facility performance, rather than individual practitioners, may be a preferable approach to overcome this potential problem.

There is controversy about using process vs. outcomes measures for quality indicators. The American Quality Association (AQA) Starter Set of quality indicators for primary care set contains both process and outcomes measures.[21] Medical care involves interaction between clinicians and patients in which clinicians counsel patients and prescribe treatment, but have little control over patient compliance. More than half of patients failing to achieve blood pressure goals display suboptimal compliance with medications.[22] P4P incentives based upon patient outcomes must attend to this inherent inequity. In short, outcome measures may not be a fair measure for P4P incentives for physicians. Using process measures to determine P4P incentives would help address this inequity. Employers and health plans may offer patient-centered incentive programs to complement P4P for physicians.

CONCLUSIONS

An appealing premise of P4P is that doctors that provide better care can earn more money. P4P has the potential to re-align the incentives of all the major stakeholders in the healthcare marketplace. Potential beneficiaries from P4P strategies include patients, organizational providers, individual practitioners, payers, and purchasers. Measuring quality and rewarding indicators of best performance may be one component of a long-term national approach for addressing health quality and safety issues.

The focus of P4P strategies on improving quality of care through incentives is better aligned with the moral and ethical basis of medical practice than the restrictive business practices found in managed care or the laissez faire business approaches in fee-for-service models. Enhancing patient outcomes through quality process review is consistent with altruist priorities of compassionate physicians, and providing incentives for quality care is consistent with the business needs of physicians in private practice. P4P seems to address both major issues in a seemingly reasonable manner.

However, evidence to support the effectiveness of P4P is still limited and conflicting. Demonstration projects show improved quality and cost savings for target conditions, but long-term follow-up evaluations to detect unintended adverse consequences are lacking. In other words, the safety and effectiveness of P4P in the context of all patients - those with and without target conditions - has not yet been demonstrated. It is also possible that there may be an exodus of physicians from participation in Medicare or other P4P programs, given the high costs for implementing the required EHR, especially when linked with declining reimbursement rates. The incentive bonuses of P4P may simply be too little, too late in the eyes of many practicing physicians.

Initiatives from major payers and legislative proposals herald the arrival of P4P as a social experiment that will change the payment system for medical care. Paying physicians for reporting quality data will likely precede the onset of actual pay for performance incentives. P4P may be viewed as an acceptable and timely solution for Medicare's broken payment system.

There is currently a broad base of support for P4P. AAFP policies support healthcare quality improvement endeavors, including the use of performance measures, provided they do not interfere with the doctor-patient relationship.[23] CMS and AAFP support the use of EHR in physicians' offices as a necessary infrastructure component to support P4P. The AMA[24] and MGMA[16] suggest a more cautious approach to P4P, including voluntary participation.

In summary, Congress, CMS and other national organizations seem intent upon bringing P4P into the mainstream of reimbursement, focusing first on quality issues in conditions that generate high costs.[25] Additional quality indicators that focus on improving quality of life in the community may follow by targeting highly prevalent conditions that are associated with large burdens of suffering. Although the evidence to

support the effectiveness of P4P is not conclusive, there are tremendous political and economic surges to implement such programs. Physicians may well consider preparing themselves and their practices for these coming changes.

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KAFP 55th Annual Scientific Assembly
May 12-14, 2006
Louisville Marriott East, Louisville, KY

National Conference of Family Medicine Residents and Medical Students
August 2-5, 2006
Bartle Convention Center/KC Marriot, Kansas City

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A Letter from Your Resident Member of the AAFP Board of Directors

by Michael King, MD

Colleagues,

Throughout the end of medical school and during my residency training I have had the great fortune of being involved in the American Academy of Family Physicians. Over the years I have served as a Family Medicine Interest Group (FMIG) Regional Coordinator, on numerous academy commissions, as the National Resident Delegate to the Congress of Delegates and this past year as the Resident Member of the AAFP Board of Directors. I mention all of these service opportunities because each is unique and provides different experiences within our professional organization, the AAFP. Anyone who has a desire to be involved can likely find a place to learn and grow within the AAFP.

Serving in the Academy early in my training allowed me to see Family Medicine from a national perspective, to appreciate not only the diversity of Family Medicine across the country but also the common bond that Family Physicians share with each other regarding the health of their patients and their communities. This experience helped solidify my choice of Family Medicine as a specialty. Over the years one of the most rewarding aspects of being involved professionally in the AAFP has been the students, the residents, and the family physicians I have met and served with. I have never seen such dedicated people who really want to be agents of change within medicine. The commitment of these individuals helped empower me to always improve and get involved, so I, too, could make a difference.

My experience this year on the Board of Directors was truly a remarkable one. I gained a heightened respect for the AAFP and its commitment to transforming healthcare so that it is equitable for all individuals and successful at achieving optimal health for all people, families and communities. Most of the business of the Board of Directors centers on achieving this vision and serving the needs of the Academy membership. The framework of these actions is the Academy's strategic objectives of advocacy in healthcare, practice enhancement, education, health of the public, the communication of family medicine, an effective workforce and outreach at all levels, local to international. All of these objectives align towards achieving the vision of the Future of Family Medicine.

As many of you know, this has been a very active year within the Academy and with the Board of Directors. Along with the actions of the Congress of Delegates and the work of Commissions and Committees there have been some major initiatives undertaken that will have a tremendous impact on students, residents, and family physicians as they look toward the future of the specialty.

Practice Resource Center

Since the release of the Future of Family Medicine Report, the Academy and the other Family Medicine organizations have been working hard to implement its recommendations. This roadmap to our future described a New Model of Care that many have questioned whether it is viable and valid in the real world. At the beginning of this year the AAFP Board of Directors approved nearly $8 million for the creation of a new model practice resource center. Since then a Board of Directors for the resource center as well as the CEO has been selected to begin its work. The initial focus of the practice resource center will be to validate the new model of care through a 2 year national demonstration project that will transform 20 family medicine practices to the new model, beginning in 2005. In 2006, the resource center will begin to expand to provide products and services to family medicine practices to help implement the new model of care.

FamMed PAC

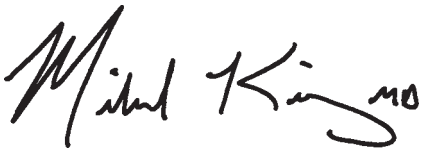
At the 2004 AAFP Congress of Delegates, the congress approved a resolution to establish a Family Medicine political action committee. Under this direction the Board of Directors created the FamMed PAC,

selecting its Board of Directors and appointing a PAC manager, Mark Cribben for the venture. In June operations began and its first contributions were accepted for its activities. The purpose of the FamMed PAC is to bring family physicians' voices directly to the nation's political table. The activities of the FamMed PAC will include direct contributions to candidates for the U.S. House of Representatives and the U.S. Senate, based on criteria that include membership on important legislative committees and/or previous voting records and positions as they relate to the priorities of family physicians and their patients. The decisions for contributions will be bipartisan. Contributions will be to both Democrats and Republicans. FamMed PAC will also be committed to regularly informing contributors about FamMedPAC activities and an "insider" view of the national political scene and how it stands to impact the priorities of family physicians. This PAC will allow the AAFP more influence and access to key legislatures regarding important healthcare legislative issues. Title VII funding, Medicare reimbursement, potential implementation of pay-for-performance and quality measures have all been prominent issues this past year. These priorities as well as efforts to improve patient safety and address universal health care coverage and liability insurance reform will be strengthened through the creation of the FamMed PAC.

Governance

Along with these important decisions the AAFP Board of Directors also worked towards and approved a new governance system to help carryout the work of the Academy which will become effective in 2006. This new system was developed after a year of review and study by the Subcommittee on Governance, appointed by the Board in 2004. The new structure was designed to more closely align the Academy's work within the context of the needs and strategic priorities of the organization in order to achieve the goals set forth by the Future of Family Medicine Report. The new structure will improve the overall efficiency of the Academy's work as well as give it more flexibility to effectively deal with current and future strategic priorities. This new governance structure has nine commissions and eight Board-mandated subcommittees. This redesign along with the establishment of the Practice Resource Center and the FamMed PAC has put the Academy on a solid foundation for future growth and success.

Throughout the year my work and participation as the Resident member of the Board of Director, I have traveled to nearly all of the major functions of the Academy across the country. It has been an extremely large commitment of time but well worth it. This position has given me the unique and incredible opportunity to work with the Academy, its outstanding staff, and with all of the amazing and dedicated family physicians serving as officers and directors on the Board. The experience I have gained both in terms of personal and professional growth and in my understanding of Family Medicine and healthcare has been immeasurable. One reason I have and will continue to be active in such a great organization is that it allows students and residents, our specialty's future, an equal seat at that table to influence that future. I would like to say thank you to the AAFP and to those who elected me, for allowing me this great opportunity to serve as the Resident Member of the Board of Directors this past year. I am honored and blessed to have had this opportunity for it has undoubtedly changed my life and career in Family Medicine.



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The State of Oral Health in

By A. Stevens Wrightson, M.

Here are some staggering statistics: 46% of children in Kentucky under age 5 have had one or more dental caries.[1] Nationally, 51 million school hours are missed due to dental problems.[2] Kentucky usually ranks number one or two in the number of residents who are toothless.[3] Kentucky has one of the highest rates of oral cancer mortality.[4] As a whole, Kentucky fares poorly in the oral health of its citizens. The causes are many. Many Kentuckians lack dental insurance. Dental care often is perceived to be less important than medical care, and in families with limited resources, it is certainly less important than food, clothing and housing. Even though Medicaid covers dental visits, the reimbursement rates discourage dentists from accepting Medicaid patients. In a recent survey, only 20% of Medicaid-covered children received a dental visit in the past year.[5] Families that expect their members to begin to lose their teeth prematurely in childhood may see nothing wrong with becoming completely toothless by the time they are 65, which occurs in 42% of Kentuckians. Why don't teenagers feel the same way about losing teeth as they do about losing a finger, given that both are important body parts?

There are social implications as well. What is the cost in lost educational opportunities? Both the student and the school suffer when a child misses school due to a tooth ache. Beyond that, there exists significant disparities in the distribution of oral health services. Those with lower incomes are disproportionately affected by oral disease. Poor children have twice the incidence with twice the severity of oral disease but are less likely to be seen for this problem than children from higher socioeconomic backgrounds.[6]

Further, there exists a connection between oral health and other illnesses, such as myocardial infarction and cerebrovascular disease.[7] Periodontal disease is chronic inflammation of the gums that may add to the inflammatory cascade that causes heart attacks, strokes, even premature labor and birth.[8] Poor dentition may affect eating habits, and in those more at risk for malnutrition, such as the frail elderly, this may have serious consequences. Improving the oral health of Kentuckians has far greater implications than simply preserving teeth, which led to its inclusion as a key health indicator by the state's Cabinet for Health and Family Services' *Healthy Kentuckians 2010* project.[9] This article explores initiatives, both educational and clinical, that have occurred in our state to address oral health needs.

In 2001, researchers from the University of Kentucky College of Dentistry met with faculty from the University of Kentucky Department of Family and Community Medicine to discuss the development of a project aimed at improving oral health education of family medicine residents. This project was supported by the Health Resource and Services Administration (HRSA), a federal agency that helps fund primary care training as well as Area Health Education Centers (AHEC) that support medical education in underserved locations. As part of the Surgeon General report in 2000 that stated, "Oral health is essential to the general health and well-being of all,"[6] HRSA allocated funds to support research and training in oral health education of primary care physicians and dentists. Nationally, five programs received funding for this endeavor, and the University of Kentucky became one of those sites. The project was lead by Dr. Gerald Ferretti of the Department of Pediatric Dentistry. The project's name was POHEK, Physician's Oral Health Education in Kentucky.

The concept was straight-forward. Even though there were American Dental Association guidelines in place that recommended all children should see their dentist by age 1 (the American Academy of Pediatrics or AAP recommends the first visit at age 3 unless high risk for oral disease exists, then at age 1), many children did not or could not have an

initial exam at that age. Further, many children, once they saw a dentist, already had caries. Therefore, screening, counseling, and preventive strategies should be in place prior to this first visit, probably prior to the child's birth. Who better to provide this role than family physicians? We see children well before their first birthday and, in many cases, see their mothers before the child is born. Out of this realization grew an expansive curriculum that included medical knowledge about normal and abnormal tooth development, the infectious nature of dental caries (in fact, the leading infectious disease of childhood), and preventive techniques such as fluoridated water and fluoride varnishes (now Medicaid reimbursed in several states, though only by dentists in Kentucky). Patient care issues, including how to examine a child's teeth, were stressed. Residents in family medicine improved their counseling skills in oral health. Education of families, a concept family physicians readily embrace, was addressed in this project. Perhaps the most important concept, how to partner with dental colleagues, was crucial in training about dental urgencies and emergencies.

This curriculum has been taught in Lexington, Morehead, Hazard and Pikeville to faculty and residents alike. The concepts developed have been shared nationally at the Society of Teachers of Family Medicine (STFM) conferences in Toronto and New Orleans. A national committee on oral health has been developed which includes representatives from Kentucky, Texas, Connecticut, South Carolina, and Washington, all of whom had HRSA funded projects on oral health education. This has grown into a collaboration recognized as necessary by physician educators across the country. This group has developed a national curriculum by sharing and combining their individual projects that is now available to use for instruction of family medicine residents and students through STFM. This national curriculum will be presented in 2006 in several cities from Charleston, South Carolina to San Francisco, California. Locally, the University of Kentucky Family Medicine Review has included oral health lectures to its series, including common oral lesions and pediatric oral health. Oral health should remain a part of residency training and continuing education of family physicians.

Clinically, to improve oral health in Kentucky, the collaboration between the medical and dental colleges continued in 2004 with the development of the University of Kentucky Family Dental Clinic-Hazard. This dental clinic is a full service clinic staffed with a dentist, dental hygienist, and a dental assistant. As part of the UK Family Medicine Clinic-Hazard, the dental clinic furthers the mission of caring for the whole patient. The UK Family Medicine and Dental Clinics are designated as both a Primary Care Site and a Rural Health Clinic by federal and state governments. Therefore, patients may obtain services in either clinic regardless of their ability to pay with these services being offered on a sliding fee scale. The dental clinic opened and saw its first patient on August 1, 2004.

The new dental clinic in Hazard opened up additional opportunities to improve oral health. The UK College of Dentistry received two grants from HRSA to extend training in dentistry to the Hazard site. Residents for both general and pediatric dentistry now obtain a portion of their training at Hazard with the UK Family Dental Clinic. They gain first hand experience treating patients in an area with the greatest dental and oral health needs. The residents work under the supervision of a licensed and experienced dentist. The first dental residents began their rotations at Hazard on September 7th, 2004.

Due to the overwhelming need for improved pediatric dental care in Eastern Kentucky, the Colleges of

Medicine and Dentistry at the university sought the aid of the Ronald McDonald Global Charities and Ronald McDonald Charities of the Bluegrass. This collaboration resulted in the gifting of a Ronald McDonald Care Mobile van which will be used as an outreach project for the school systems within the medical and dental service area. The van arrived in Hazard with a rollout ceremony on May 25th, 2005. Dental services on the van will be offered to all children at each target school. The Care Mobile will serve children up to age 20 in schools, daycare centers, Head Start programs, health fairs, and during other community events. This unique clinic will provide education and preventative services, oral hygiene instruction, exams, x-rays, cleanings, fluoride varnishes and sealants, filling and extractions.

The UK College of Medicine and College of Dentistry collaborative is addressing both the dental needs of the Hazard patient population and educating future dentists for Eastern Kentucky. The outcome of these innovative programs will be a healthier population with a healthier smile. Further, these initiatives are in keeping with the Future of Family Medicine[10] goals of providing integrative care that is patient-centered. Particularly in communities in need, oral health must be included in the "basket of services" provided by family medicine physicians.

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Dear practicing Family Physician:
As part of his visits to each FM residency and FM interest group, Dr. Crump has sought the students' and residents' opinions on these questions. Your opinion will allow us to compare how those in practice see the importance of these same issues. Please just respond to this survey once.

Please circle one on each line and answer the question on line 3.

1) Male Female

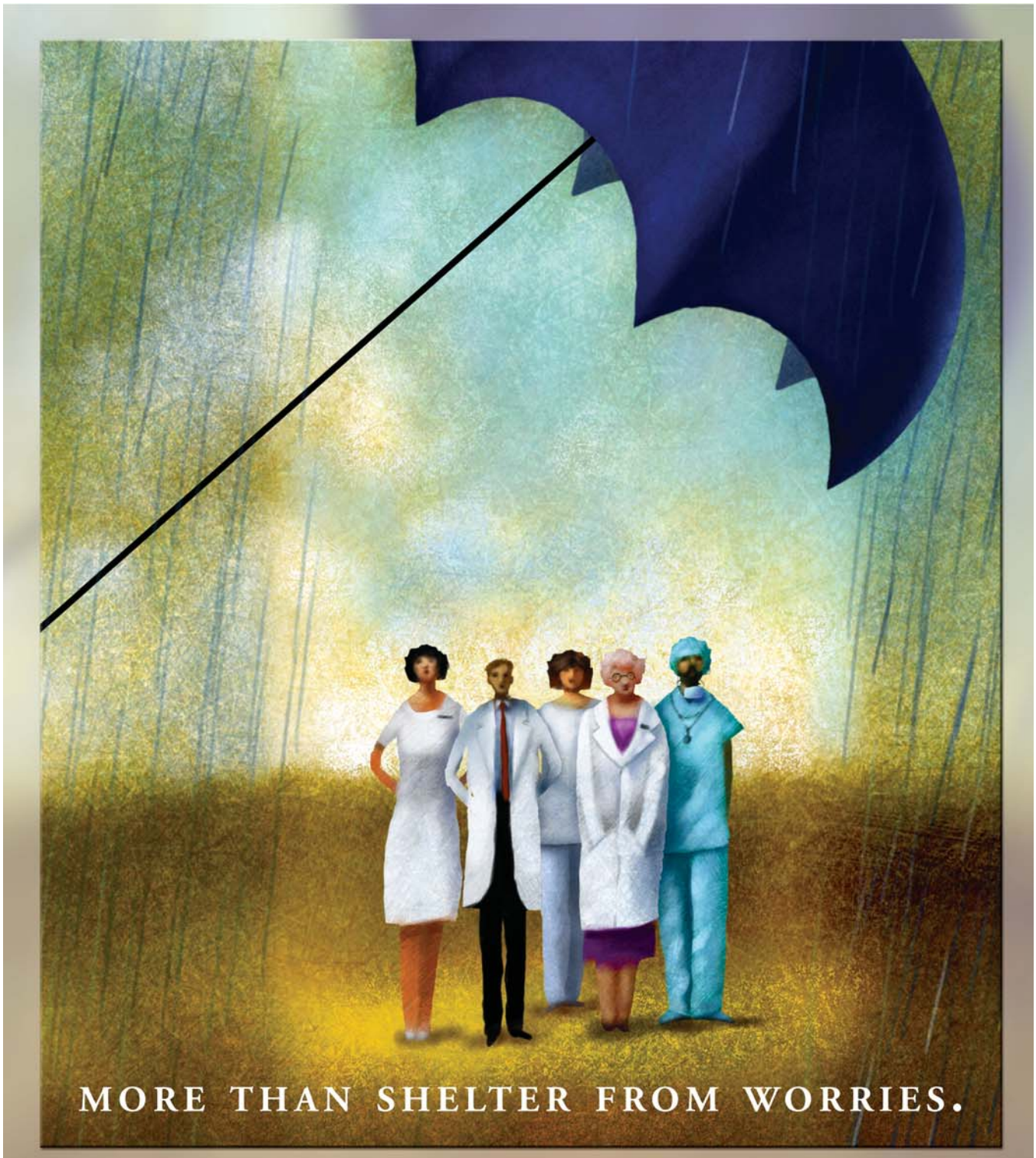
2) From small town From larger city

3) Number of years in practice _____

Indicate your opinion concerning the importance of understanding the following items in choosing the best treatment option for your patient.

		Least important		Somewhat important		Most important
	Circle one number for each	**1**	**2**	**3**	**4**	**5**
1	Understanding the biochemical abnormality involved	1	2	3	4	5
2	Understanding the anatomy involved	1	2	3	4	5
3	Understanding the role of spirituality in the patient's life	1	2	3	4	5
4	Understanding the laboratory abnormalities involved	1	2	3	4	5
5	Understanding the imaging (x-ray, ultrasound, etc) abnormalities	1	2	3	4	5
6	Understanding the health benefits held by the patient	1	2	3	4	5
7	Understanding the mechanism of the medications used	1	2	3	4	5
8	Understanding the role of prayer in the patient's life	1	2	3	4	5
9	Understanding published expert guidelines for the patient's problems	1	2	3	4	5
10	Understanding the ethnic background of the patient's family	1	2	3	4	5

Please fax to Dr. Bill Crump at 270-824-3560 or 270-824-3446. Thank you.



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