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Fix It Now!

If We Don't Do It, Who Will?

see page 1

CONTENTS

Front Cover Photo of Dr. Larry Fields by:
Sheri Porter, *AAFP News Now*

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FROM YOUR PRESIDENT

by Samuel Matheny, MD
Lexington, KY

Fix It Now!

There was a new feeling of optimism and energy to organized family medicine at the latest AAFP Congress of Delegates in Washington DC this September. A virtual sea of white-coated family physicians descended on the Capital lawn, led by President Larry Fields. They repeatedly gave back the refrain of "FIX IT NOW!" referring to the woes of the American health care system. The focus was clear: The American health care system is severely broken; adequate primary care physicians are essential in its repair; and Congress needs to perform its responsibility in fixing it.

Congressional health care reform efforts remind me of Lucy with the football in the Peanuts comic strip: every year she holds it for Charlie Brown; every year she jerks it away and he falls flat, and every year he tries again. None of us are naive enough to believe members of Congress were peering out of their windows to listen to the goings-on-- there have been bigger and more vocal groups before. But it did have the effect of energizing the participants and focusing on issues that we think are crucial to our nation's health and survival.

We also may not need yet another report to remind us, but the poor performance of the American health care system was documented once more by the Commonwealth Fund in a recent article in *Health Affairs*. The U.S. scored worst of 23 industrialized nations in infant mortality rates, and tied for last with several other countries on healthy life expectancy at age sixty. That was just for starters. Particular mention was made of the lack of coordination of care: over one-third of Americans have no primary care "medical home". The bottom line: "on multiple indicators, the United States would need to improve its performance by 50% or more to reach benchmark countries…". (1)

The November elections may be imminent or over by the time this issue of the KAFP Journal comes out, but regardless of the outcome, we need to keep up the pressure on our representatives to the 110th Congress in both the House and the Senate. Some of us will have personal connections with them. Others will have opportunities in various venues to press them on their views and let ours be known. They need to know our stands on Medicare reimbursement reform, malpractice reform, and universal health coverage. They also need to understand that a healthy country depends on an adequate supply of primary care physicians, and they need to support and restore funding to the training programs. And it's not too early to start on the candidates running for the Kentucky executive positions and state legislature in 2007 and beyond.

If this isn't the time to act, when will it be? If we don't do it, who will? It's time that the football is held in place and kicked hard.

1. Schoen et. al. U.S. Health System Performance: A National Scorecard. Health Affairs-Web Exclusive. DOI10.1377/jlthaff.25. w457. September, 2006.

FROM THE EDITOR

by William Crump, MD
Madisonville, KY

A MODEST PROPOSAL: SHORTEN MEDICAL SCHOOL AND PRODUCE MORE FAMILY DOCTORS?

One of the roles of a journal editor is to create intellectual curiosity and stimulate reasonable controversy, so here goes. One of the things I do as a "Deanlet" of a medical school is to read the journal of the Association of American Medical Colleges (AAMC) Academic Medicine. The AAMC is considered the authoritative national voice of medical educators, and is generally perceived as fairly conservative. Clearly this organization is entrusted with the legacy of Louisville's Abraham Flexner to seek the highest quality for American medical education.

Recently the AAMC has begun to make strides into what we called in south Georgia "tall grass"- those issues likely to seem quiet from a distance but with lots going on underneath. Several months ago the lead editorial in their newsletter suggested that US medical educators should begin to learn more about offshore medical school training, since so many of our residents in training are their graduates. This is a bit of a departure from the traditional view that it might be best to ignore what are considered inferior institutions.

In the March 2006 Academic Medicine issue, the lead editorial broached another controversial topic, that of shortening medical school training to 3 years (1). This reconsideration of an old idea is based on the startling report that 60% of medical school matriculants come from families in the top 20% of income. There is accumulating evidence that many college students (including those that would fit the profile of students who choose Family Medicine and ultimately practice in underserved areas) give up on the idea of medical school for financial reasons.

In the same issue, an original report summarized the recent changes and 4 methods to address the issue (2). From 1990 to 2003, medical school tuition and fees increased 167%, and in 2003 the average debt for graduating students was $100,000. More recent anecdotal information is that the average now is closer to $120,000. Those of us close to medical students in training have seen another change during this time. Fewer medical students seem willing to delay "living like doctors," buying nice homes and nicer cars during medical school. While this lifestyle clearly doesn't represent those destined to be family doctors, it does add to the reported total indebtedness that may scare off college students from families of modest means.

The 4 methods reviewed by the article and the median net savings to the individual student shown in parentheses included: reducing tuition ($30,000), decreasing duration of medical school to 3 years ($200,000), increasing residency compensation ($80,000), and decreasing residency duration for medical subspecialists ($170,000). The actual median values will likely be lower for primary care physicians because the model factors in first-year practice income, but the comparisons are still relatively valid.

So, what if? The ABFM model from many years ago combined medical school and FM residency into a 6 year program at selected sites, including UK in Lexington and Marshall in West Virginia. The perception of outsiders was that this was a very successful program, generating a not-so-small amount of jealousy in residency directors competing with these sites that seemed to have an "inside track" to some of the best students.

This 3+3 pilot program was allowed only for FM and Internal Medicine, and was ended in 2004 by the ACGME by a narrow interpretation of the requirement that residents must have *graduated* from medical school. There were many who believed that this was accomplished by specialties and

sites excluded from the pilot program. The AAFP felt so strongly that this option should continue that last year, the Commission on Education sent a letter to the ACGME outlining the specific wording in Section VIII of the ACGME program requirements that should allow for continued approval of these innovative programs. Some believe that the timing is right for this change now.

If we re-created that system and all the assumptions held, it could: 1)attract more college students of modest means into medical school and ultimately into Family Medicine residencies in our Commonwealth, 2)guarantee our residencies a regular flow of American graduates where each student is a "known quantity" and 3)create innovative opportunities for programs that train medical students in regional community sites to collaborate with residencies in their region to ensure a seamless transition.

For instance, current M-4 requirements for Neurology or Anesthesia could be interwoven into some M-3 and some PG-1 experiences, to be sure the objectives were met. Some PG-1s in this new system would require more educational support (similar to that many programs are reporting with current offshore grads), a need that could be met best by medical school educators. In fact, rather than "retrofitting" once a PG-1 is determined to have special needs, it would be logical to address this during the M-3 year of a student in the 6-year Pathway. This has to be better than the current situation where our best residencies are scrambling to meet the unpredictable needs of offshore grads during the high pressure PG-1 year.

So what are the potential negatives of this new system? Certainly it would place even more pressure on young folks to make lifelong decisions at younger ages. No later than beginning of the M-3 year, these students would have to be in this special track. What if they decide they want to change specialties to one not offering the 6-year option? Will they feel trapped by their financial commitments? What if family obligations limit their geographical choices for residency? One of my reasons for writing this editorial is to try to get feedback from M-1s and M-2s (and maybe even some pre-meds) who read our journal on how important these concerns are to them. We all have known students who at age 21 are ready to make such choices, as well as some who struggle at age 26.

I also want to hear from practicing docs and our academic leaders. Is this an innovative idea whose time is now or is this just crazy? Please write or Email me. I hope to get some responses that we can publish in future issues of our journal.

Bill Crump, M.D.
Madisonville, KY

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1. Whitcomb ME. Who will study medicine in the future? Acad Med 2006;81:205.

2. Dorsey ER, Ninic D, Schwartz JS. An evaluation of four proposals to reduce the financial burden of medical education. Acad Med 2006;81:245-251.

FROM THE ASSOCIATE EDITOR

by A. Stevens Wrightson, MD
Lexington, KY

Our ability to communicate is intimately connected to our ability to listen. I was taught over and over again that if you listen to your patients, ultimately they will tell you what is wrong with them. Perhaps there have been a few times that both the patient and I were surprised by what we discovered, but I think, in general, the patient's exchange of information with me usually led me to the appropriate conclusions. As one of the six general competency areas emphasized by the Accreditation Council for Graduate Medical Education (ACGME), none are more closely linked to primary care, and in particular, Family Medicine, than Interpersonal and Communication Skills.

I spend much of my day gathering "data" from patients. I translate that data into a biomedical language that makes sense to me. My patient will tell me his mother died of heart disease. In order to counsel that patient appropriately, I need to find out if he means Coronary Artery Disease, Hypertensive Cardiomyopathy, Valvular Heart Disease, or some other heart related ailment. My questions need to be asked in a way that is culturally sensitive and understandable by my patient, that is, appropriate for a university professor, a teenager working at Walmart, a young Hispanic father new to this country, a 40 year old business executive. And I have, at tops, 15 minutes for the interview. Once deciphered, I must develop an action plan and provide the appropriate education for my patient. My message, then, must be effective, efficient and patient-centered. I would like to help the teenager quit smoking. I would like to delay or prevent the onset of Diabetes in the young Hispanic man. I want the executive to see he really can add exercise into his daily routine without negatively impacting the bottom line. And the University Professor, well maybe he can teach me a thing or two about nutrition, if I would only listen.

Listening is the cornerstone of good communication. When I am stumped, I try asking the questions again, maybe in a different way. Listening includes those nonverbal cues, the uncomfortable shift in the chair when my question hits a nerve, or the leaning in of the patient when I finally "get it." I try to resist that impulse to throw in a closed-ended question when the patient is telling me their story. Oh, I find myself directing the interview often enough, especially if patients are lining up in other rooms. I might even begrudgingly admit to myself I would rather not take that line of questioning because of the "can of worms" it might open. But then I do, and the patient thanks me in the end, that day, or a few days later, or next year, for listening to her.

I never know when I will need to take a detour with my patients. That is what makes our job so challenging and, I believe, satisfying. In Lexington, actually in all of central Kentucky, we have experienced a tragedy. The crash of 5191 in August touched many of us. One day during the week or two after the accident, while I was at work, one of my patients, in for a "quick" follow-up from an asthma exacerbation, told me how sad she was about the crash. I asked her if she knew anyone on the plane. She said no, but that she was sad all the same for the families. We spent a few minutes talking about that. She needed some time to publicly express her grief, her anger, her fears, and she felt safe doing so with her family physician. Sometimes patients talk to me about tragedy. Sometimes, it's about my son's swimming or my daughter's band. Sometimes it's about work, or a change, or a move. And in some way, it is often about our patient's view of health and wellness. It is all part of that therapeutic relationship we, as family physicians, develop with our patients. We usually know when we need to spend that extra 5 minutes just listening. And as Family Physicians, the communication goes both ways. It is truly an exchange of information and more; of expectations, of regrets, of hopes and dreams. We are better at what we do because we allow communication to occur.

KENTUCKY ACADEMY OF FAMILY PHYSICIANS Oct 31, 2006

e-News from KAFP is a monthly newsletter for Kentucky Academy of Family Physicians (KAFP) members. Please contact Gerry Stover (gerry.stover@kafp.org) if you have any comments or suggestions or you want to receive this fax by email.

Dr. Rick Kellerman, AAFP President, needs your help!

Dr. Kellerman asks, "Will you be able to care for your Medicare patients next year while sustaining a ***5.1 percent decrease*** in reimbursement? If you find this a real threat -- and I'm sure you do -- please join me and the AAFP Board of Directors in a broad, sustained grassroots effort to convince elected officials that they must prevent this Medicare cut from taking effect Jan. 1." To learn more how you can HELP go to -- http://www.aafp.org/online/en/home/publications/news/news-now/opinion/20061011presmessage.mem.html -- you will need your membership number to get access to this 'action' item.

KAFP Advocacy Committee Evaluates PCJ

KAFP Advocacy Committee, under the leadership of Drs. Swikert and Wright, at it last meeting heard a presentation on the Partnership for Commonsense Justice (PCJ). The mission of the PCJ is to '… recognize the need for fairness and excellence in the Kentucky legal system." Dr. Wright pointed out that one of the main values that PCJ offered was another partner in the 'fight' to get meaningful tort reform in Kentucky. Dr. Swikert was encouraged about the additional resources that physicians could use to 'educate' their patient on the issue. The KAFP Advocacy Committee encourages members to go to the Partnership for Common Sense Justice web site at http://www.kycommonsense.com/ to review the information to understand the position of judicial candidates in the upcoming November 7th election.

Francis Halcomb, MD receives AAFP President's Award

One of Dr. Larry S. Fields last action as AAFP President was to acknowledge the mentorship and many years of 'service before self' actions displayed by KAFP member Dr. Halcomb. Due to the recent death of his wife, Dr. Halcomb could not attend the award ceremony but Dr. Max Crocker accepted the award in his behalf.

Baretta Casey, MD Receives UK SOM's Alumni Award

Dr. Casey, vice-chair of UK's Family Medicine East Kentucky Campus and Director of UK Center of Excellence for Rural Health in Hazard received the 2006 Alumni Service Award at the UK College of medicine's Alumni Association Reunion on Oct 6. This honor recognizes her for the positive impact she has made for the College and its alumni through her volunteer work in recruitment, fundraising, and service.

Forrest Calico, MD Receives UK SOM's Distinguished Alumni Award

Dr. Calico, senior advisor on quality for the National Rural Health Association, was the recipient of the 2006 Distinguished Alumni Award for his military service and in establishing the St. Elizabeth's Medical Center Northern Kentucky family medicine residency program. Dr. Calico, as a Lieutenant Colonel in the USAF, was the recipient of the Bronze Star and Meritorious Service Medal. In addition he has been recognized as an Alpha Omega Alpha and a Fellow in the AAFP.

John Darnell, MD appointed AAFP's Chair of Finance and Insurance

The function of the Finance and Insurance Commission is to investigate, develop and maintain programs of insurance and investments for the well being of the membership, supervise the keeping of the AAFP's accounts, and oversight of the $71 million dollar budget.

Nancy Swikert, MD appointed KAFP's CHAMPION for the AAFP PAC

Dr. Swikert urges members to go to the AAFP web site and become a member of the PAC. KAFP has had 14 contributors representing 1.13% of our membership. Tennessee is leading with 3.02% of their membership contributing to the PAC. At the Capitol Hill Rally Dr. Fields shared with attendees the value that the PAC has already made by aiding the AAFP leaders to get your issues in front of key congressional leaders. For more information visit the below link -- http://www.aafp.org/online/en/home/policy/fammedpac.html?FeaturePage=/content/en/home/aboutus/theaafp/officersetc/board-directory&FeatureLocation=FeatureAds1

One Extra Chocolate Blizzard

I was introduced to hospice as a third year medical student at a nursing home. On my first day, I was greeted by the hospice nurse who briefed me on Edgar's condition. She commented, "You sure picked a good day to come; he's having a good day." What does that mean? I wondered. How does someone with dementia in a nursing home have a good day? I must have hesitated a bit too long as the nurse called out, "Just go in and start talking, and by the way, he loves Dairy Queen Blizzards." As I walked in and introduced myself I really had no idea what to expect. At first, I tried to make some small talk, which didn't go anywhere. With him lying there staring at me and me wondering what I should do next, I just uttered the next thing that came to mind, "I hear you're quite the fan of Blizzards."

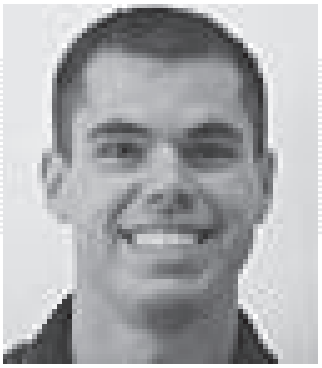
It was as if something just went off inside him. He suddenly sat up on the edge of the bed and with a big smile on his face, proceeded to tell me all about "Blizzards" and how the "Extra Chocolate" one was his favorite. From there the conversation turned to his childhood in Alabama and his days at Birmingham Southern College. He told me about his family and his career. I was completely taken aback. I began wondering if everything I had been told about this man was true.

At this point Peggy showed up at the nursing home. She is one of those people you instantly adore. She was thrilled to see Edgar having such a great day and took yet another chance to remind him that later in the week was their 50th wedding anniversary. They had a little "party" planned. Though she knew he wouldn't remember their anniversary, she was just pleased that today, he remembered they were married.

As I interviewed Peggy later that day she was very anxious to tell me everything. We spent the better part of an afternoon reviewing the steps that brought her husband to this point and place in time. He was a successful businessman looking forward to a restful retirement when a freak bike accident changed everything. He sustained a closed head injury that required surgery. She talked about the surgeons' impression that their interventions had been successful. Next was the year long rehab, which held promise for Edgar's full recovery. Finally, he experienced unpredicted and subtle changes in his personality that heralded the onset of progressive post-traumatic dementia.

She talked of the challenges working with health care professionals. She spoke quietly of the family's heart wrenching decision to move Edgar to this nursing home. It had been a long and sometimes painful journey. In closing, Peggy told me how great it felt to finally tell the whole story to somebody, as if it took away a little piece of the huge weight she had been carrying around with her for the last seven years. As I was leaving she asked me if I would be able to make it to the party on Friday. I told her I would be honored to attend.

That Friday I arrived at the nursing home holding one "Extra Chocolate Blizzard" in my hand. When I gave Edgar that blizzard, the look on his face was unforgettable. He had no idea who I was. He did not remember talking to me, but for that one moment, you could tell he was on top of the world. I soon found out that this was not a good memory day for Edgar. The hospice nurse, other staff, and I could all tell Peggy was a little depressed. I felt sure that this wasn't the way she had pictured spending her 50th wedding anniversary. But what happened next is something I will never forget.



By: William Brodie Adams, BS
M4 Medical Student, University of Kentucky

By: Jennifer M Joyce, MD
Faculty, University of Kentucky

As Peggy brought the cake over to Edgar, he asked her if it was true that they were married. "Yes dear." she replied, "What would you ever do if we weren't?" After a moment of silence he replied, "That's good, because if we weren't, I'd have to ask you to marry me again." Peggy instantly broke into tears. As I was leaving that day, I heard Peggy say to one of the staff members, "This is one of those times, even with all we've been through, that makes it all worthwhile".

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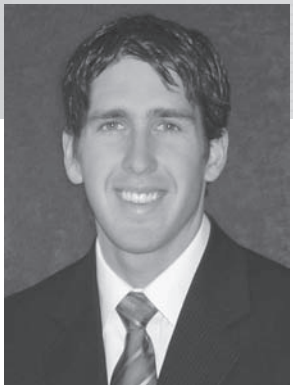
During my first two years of medical school, I thought the best doctors would be the ones with the most knowledge. When I got to the floors this year and did my medicine/surgery block I found that quickness and efficiency were two of the most respected skills. Knowledge, quickness, efficiency - these were the attributes upon which I looked to model my developing skills. During my first days of my family medicine rotation, the notion of spending thirty minutes talking to a patient about diet and exercise seemed crazy to me. I thought to myself that I could see at least two or three more patients in that time.

Over the next few days, however, I began to notice how much more talkative and receptive patients became when you spent extra time with them. I quickly found that compliance rates seemed better. In previous months, compliance problems consistently led to frustration and anger on the part of both patients and physicians. Sometimes medical students, residents, or attendings focus on the disease process, the surgery, or their hectic schedule. The overall situation and its effects on the patients and families are forgotten. We see symptoms, differentials, outcomes, and prognosis instead of people.

My time with hospice and Edgar lead to a revelation that will forever change the way I practice medicine. I realized I could have been the most knowledgeable physician around; know every detail on all the surgical procedures, dementia, and current ways of treating it, but none of these would have meant as much to Edgar in this situation as one Extra Chocolate Blizzard. Recently I was told, "Medicine will never be a science, there are too many unknowns and inconsistencies. Those who are truly successful see medicine and each patient as a work of art." After having had the opportunity to meet Peggy and Edgar, I now understand and agree with this sentiment.

Something for Everyone



By Matt Dawson
M4 Medical Student
University of Kentucky

As a 3rd year medical student, I was eager to learn about the business of medicine in a real private practice. After spending time with Family Practice Associates of Lexington (FPA), I saw that through creativity, the use of technology, and good business practices, the physician partners have created a setting where stakeholders, patients, staff, and providers, all benefit. The patient satisfaction rate is high, with over 95% of FPA patients saying they would come back or recommend the practice to a friend. Competitive compensation and favorable lifestyle has led to high physician retention – in 23 years, not one provider has left the practice. FPA's employee turnover is low as well, because the environment they have created makes employees feel like a valuable part of the team. This has been accomplished over the years because of a willingness to embrace new models of health care delivery.

Satisfied Patients
When a patient calls to set up an appointment they speak with a dedicated staff member assigned to each physician. The patient and staffer get to know each other over time, and, because the patient's computerized medical record is readily accessible, many patient questions can be answered during the initial call. With minimal computer know-how, patients also have the option of requesting their appointment online, printing and filling out registration paperwork, paying their bill online and asking simple questions on FPA's secure interactive website at www.fpalex.com. This allows the patient to communicate with the practice 24 hours a day and streamlines work for staffers, which saves money for the practice.

The average wait time for a patient is within10-15 minutes of their scheduled appointment time. The patients also benefit from working with the same certified medical assistant each visit, much like talking to the same person on the phone each time. FPA's schedule is crafted to allow for same-day appointments.

Since implementing their computerized patient record system in 1999 and adopting electronic prescribing in 2001, FPA has achieved much higher levels of efficiency. This has allowed them to free up staff to dispense a small formulary of prepackaged pharmaceuticals to patients at the end of their visit. Primarily, the drugs dispensed are episodic drugs such as anti-inflammatories, antibiotics, and cough syrups. This is a great service for the patients that saves them a trip to the pharmacy and generates a little extra revenue for the practice. As a result, staff members spend less time calling and faxing prescriptions and more time caring for patients.

FPA also uses their phone system to give patients the ability to call in and get automated results from lab work or other routine tests. Of course sensitive results that should be delivered in person are not available through this system, but more routine results are available. Patients can simply call at their convenience 24 hours a day, seven days a week.

All of this adds up to a much happier and satisfied patient who returns when they have a need. The 95% of patients who would recommend the practice to others is testimony to this satisfaction.

Dedicated Employees
Many employees in the practice have been there for years. A key element to this employee satisfaction is being an important part of the team, which is a direct effect of the patient care team model being utilized and the successful use of health information technology to streamline processes and improve service.

With the implementation of their document imaging and management software, a computerized medical record, FPA became much more efficient. For example, filing pieces of paper into paper charts was eliminated and clerk positions were shifted to expand the capabilities of the practice. These new responsibilities gave the employees a sense of pride and ownership in the practice. This approach of teaching new skill sets and adding revenue instead of simply cutting jobs and expenses has paid off, and they created more dedicated loyal employees in the process.

A service standards team consisting of employees from different areas of the practice is charged with looking at every facet of the practice. They evaluate every

aspect of the practice to define standards of service and develop policies and procedures that represent realistic and attainable guidelines. These employees are leaders in the business, and consequently they are better, more invested employees. Therefore, the practice benefits by gaining valuable protocols and more dedicated employees at the same time.

Technology

There is definitely a push nationally for practices to go towards an electronic medical record (EMR). However, how to implement this is still debated. Some say it should be done all at once within a practice; jumping in with both feet. FPA, though, has taken a different approach. They definitely wanted to become less dependent on paper and move towards an EMR. However, it was apparent that the physicians there were just not ready for the huge change that would have had to take place, and they didn't feel capable of absorbing the great initial costs associated with it. After much searching, their solution turned out to be a document image and management software used to scan documents into computerized charts, as well as, move documents electronically through the practice. With this program they have converted all their patient's charts to a computerized medical record (CMR). Then, slowly, they moved more towards some physician entry through electronic prescribing. The transition happened gradually over time as physicians became more comfortable with the computerized environment. The incremental approach has been relatively, but not completely, a painless process. With the paperless system they were able to save $30,000 annually on transcription costs. Overhead costs, in just the first couple years, dropped from 59% to 52%, adding great value to the practice. Overall, FPA saved more than $160,000 in the first 2½ years, which more than offset the initial start-up costs. Currently, the practice is unable to track disease states and outcomes using this document management system. As Pay for Performance initiatives develop, FPA will need to adapt its CMR to keep pace.

As they become more and more comfortable with the technology, the physicians are finding more ways to add value to the practice. FPA does their own bone density testing, stress testing, 24 hour holter monitoring, has a fully accredited physician office laboratory, and runs the mini-pharmacy. All these services are offered to patients even though FPA's staff to physician ratio is much lower than the national average. This is all possible, at least in part, because of the increased efficiency the computerized medical record has created.

The Good Doctor

The physicians and providers at FPA, likewise, benefit from these changes. FPA has expanded over the years so that currently they have 9 physicians and 2 physician assistants. The physicians at FPA are very satisfied for many reasons.

The increased revenue and efficiency translates to better salaries for the physicians. Each physician has a different schedule depending on their needs which their compensation reflects.

The Future of Family Medicine project, initiated in 2002, has outlined several suggestions that could have a positive impact on practice expenses and revenues. FPA has, to varying degrees, implemented several of these such as open-access scheduling, online appointment scheduling, electronic health record, web-based information, and a team approach. The result has been very positive, just as the project predicted. FPA serves as a model for how this can be implemented and the positive financial impact it can have for a practice. The project predicted that if implemented, these measures would lead to greater compensation for physicians, or less time worked for the same compensation. This is exactly what has happened at FPA.

Better compensation, more time for patient care, and more free time all lead to a much happier physician. This also leads to a more satisfied patient when the doctor-patient relationship becomes more positive due to increased physician happiness. All in all, it creates a great environment to care for patients.

A Model Practice

Future plans for FPA include a move towards a full fledged EMR that everyone can be happy with and that works well with their practice model. This will add even more efficiency and value to the practice and allow for more quality assurance measures for patients. They have shown that with creativity, integration of technology, and flexibility everyone can benefit. As FPA has shown, change can make the future of family medicine look bright and rewarding.

SERVICE IN YOUR ACADEMY IS A REWARDING EXPERIENCE!

The KAFP needs you and your expertise! Do you want to provide direct input into the development of your Academy and to interact with your colleagues? There are numerous opportunities awaiting you! Sign up to serve on a KAFP committee(s).

Appointments to KAFP committees are made by the Chapter President with Board approval. Please complete the form below. Certain committees are not listed, as those appointments are pre-established by our bylaws.

Terms for committee appointments are generally (l) one year. Many committees only meet on an as needed basis or by conference calls.

Please indicate your preference by numbering (1-highest) your choices and returning this form to the address below.

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___I am interested in representing my District as a Delegate/Alternate (circle one) to the KAFP's Congress of Delegates.
___I am interested in presenting a lecture at the KAFP Annual Meeting.

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Detach and Return

Mark Your Calendar for Upcoming Meetings!

UK 38th Annual Family Medicine Review
10/29-11/03/06
Lexington, KY

KAFP 56th Annual Scientific Assembly
April 20-21, 2007
Louisville Marriott East
Louisville, KY

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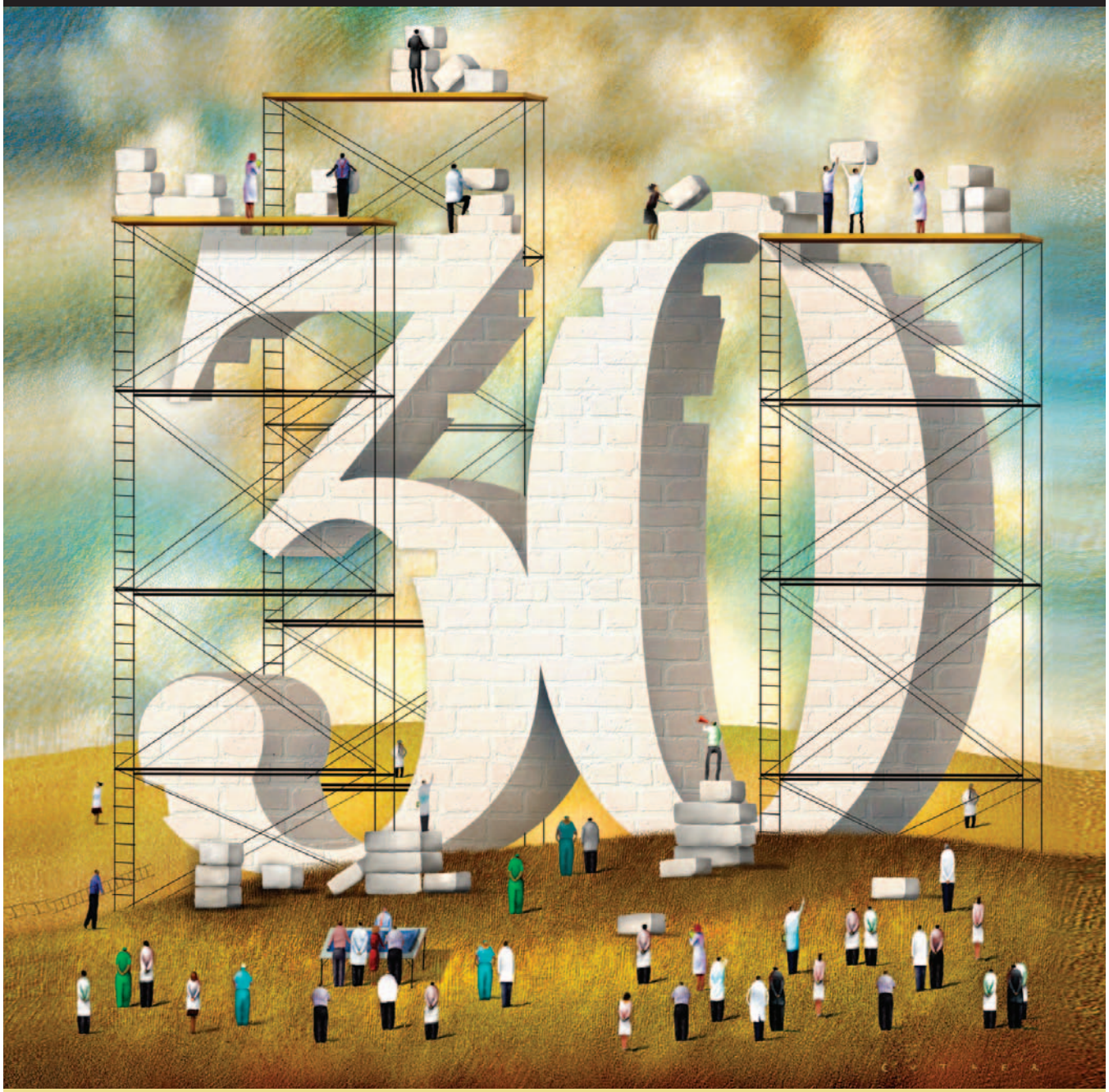

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GUIDE TO HEALTH ISSUES FOR VOTERS

Vote for America's HEALTH

For too long, our nation's elected leaders have spent more time discussing the problems with America's health care system than working toward solutions.

America faces important decisions on health care this election year. Many say the U.S. health care system is at a breaking point and that action is needed now more than ever. Although the abilities of America's doctors and the technology available to them are the best in the world, too many people cannot see a doctor when they need to.

Isn't It Time We Focus on Fixing Health Care?

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