

A woman with long dark hair, wearing a bright yellow raincoat and yellow boots, is walking through a large puddle on a wet, cracked asphalt street. She is smiling and looking down at the water splashing around her feet. The background is a blurred view of the street and other people in the distance.

KAFP JOURNAL

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- **Stories by William Melahn, M.D.**
- **Building a Road to the “New Model”**

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FROM YOUR PRESIDENT

by Bill Crump, MD



THE PRACTICE OF MEDICINE: MINISTRY OR BUSINESS?

Last fall, as I visited each of our residencies and Family Medicine interest groups, I asked participants to complete a survey sharing their attitudes about what was most important to them in choosing treatment for their patients. They ranked each of the 10 items shown in table 1 from 1= least important to 5= most important. We had used these same surveys with our summer students including pre-med Trover Rural Scholars and UL medical students just before their M-1 year (Prematriculation Program) and just after the M-1 year (Preclinical Program). These programs are described in more detail in a recent publication (1) and on our web site (2). We also placed this survey as a tear-out in a recent journal issue, hoping some practicing family doctors would give us their opinions.

The 10 items can be grouped roughly into issues of basic science, clinical science, a business issue, spirituality, and patient ethnicity. Our expectation was that students would most value whatever they were studying at the time, with those further along in training placing more emphasis on health benefits and ethnicity. We didn't know what to expect on the issues of spirituality and the role of prayer, as this is less frequently discussed among physicians-in-training. The spiritual issues consistently ranked near the bottom of the priority rank among all participants. Interestingly, understanding the patient's ethnic background was ranked only slightly above these two spiritual issues.

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

1. Biochemical Abnormality
2. Anatomy
3. Role of spirituality in the patient's life
4. Laboratory abnormalities
5. Imaging (x-ray, ultrasound, etc) abnormalities

6. Health benefits held by the patient
7. Mechanism of medications used
8. Role of prayer in the patient's life
9. Published expert guidelines
10. Ethnic background of the patient's family

Duke University's Harold Koenig, M.D. speaks regularly concerning religion, spirituality, and medicine (3). He summarizes the literature that makes the case that religion is relevant to health and that most U.S. patients, when facing important treatment decisions, want to discuss this issue with their doctors. In one study, 66% of patients indicated that their religious beliefs would influence their medical decisions. How many of us would choose not to ask about something so important to our patients? The literature says we don't.

I think often we doctors are so careful not to use our position of authority to proselytize that we risk ignoring an important part of our patients' lives. Dr. Koenig summarizes the elements of a spiritual history (see table 2)(4), as well as some techniques to avoid (see table 3). Nowhere is this more delicate than the question of when/if to pray with patients. In our summer sessions, this topic generated the liveliest discussions. Dr. Koenig suggests that shared prayer is most recommended when the patient and doctor share a similar religion, the patient requests it, and the situation warrants it. Our hospital chaplain shares some interesting stories about what happens just after he says the words "can we pray together?" Sometimes there's a prolonged silence, sometimes a clear prayer leader emerges, and sometimes everyone in the family begins praying out loud simultaneously. I guess that even among similar folks, prayer has no hard and fast rules.

It seems that just when I'm getting the most tired and cynical, a patient jolts me back to why I chose to do this in the first place. Seeing the simple strength of their faith in the face of overwhelming stress is

their witness to me. Ministry goes both ways.

It has been an honor to be your President.

Bill Crump, M.D.
Madisonville, KY

Table Two **Spiritual History**

Introduction is necessary (why asking these questions):

1. Do religious/spiritual beliefs provide comfort or cause stress?
2. How might beliefs influence medical decisions?
3. Are there beliefs that might interfere/conflict with medical care?
4. Member of a religious/spiritual community & is it supportive?
5. Any other spiritual needs that someone should address?

Table Three **What is Not Recommended**

1. Prescribe religion to non-religious patients.
2. Force a spiritual history if patient not religious.
3. Coerce patients in any way to believe or practice.
4. Spiritually counsel patients.
5. Any activity that is not patient-centered.
6. Argue with patients over religious matters
(even when it conflicts with medical care/treatment)

References

- 1) Crump WJ, Fricker S, Barnett D. A Sense of Place: Rural training at a regional medical school campus. *Journal of Rural Health*. 2004;20(1):80-84.
- 2) www.troverfoundation.org/octc.
- 3) www.heritage.org/emails/hidden/koenig_presentation.ppt
- 4) Koenig HG. An 83-year-old woman with chronic illness and strong religious beliefs. *JAMA*. 2002;288(4):487-93.

FROM THE ASSOCIATE EDITOR

by A. Stevens Wrightson, MD



What is all this Talk about “Competencies?”

I completed my Family Practice residency at the University of Kentucky in Lexington in June of 1989. Though the residents I work with now will never believe me, that first day in practice was absolutely one of the most difficult I had experienced in my medical career to date. I was the “Doctor on Call” and had to take care of a gravely ill newborn which was frightening, particularly given that I could not call the Neonatal Intensive Care Unit (NICU) fellow like I could 2 weeks earlier. Was I prepared for this situation? Fortunately, I think so. I would credit my program with having a required NICU rotation that I completed. But I must also credit myself to a great extent. I knew I was going to practice in a community where I would provide prenatal and delivery care. I knew I would take care of potentially sick newborns. So I added an elective rotation in my third year of residency attending deliveries to allow for more experience caring for sick and well neonates. It was an invaluable experience, as I especially found out 2 weeks after graduation. I also humbly propose that it demonstrates what it means to be a “competent” physician.

The Accreditation Council of Graduate Medical Education (ACGME), the governing body that polices residency education, demands that those of us in residency education insure that the physicians we train are “competent to practice independently” in their chosen fields. Though the ACGME does not define “competent” for us, it has given us six competency areas that should be addressed during training. These six areas, or “competencies,” are patient care, medical knowledge, interpersonal and communication skills, professionalism,

practice-based learning and improvement, and systems-based practice [1]. I would encourage anyone who works with medical students or residents to visit the ACGME web page to learn about these competencies in more detail. In fact, the American Board of Family Medicine is following the ACGME’s lead and language in its new Maintenance of Certification program such that it behooves all family physicians to be aware of the requirements for and the rationale behind the competencies.

The last 2 competency areas, practice-based learning and improvement (PBLI) and systems-based practice (SBP) have been the most difficult for educators and trainees to grasp. These areas are often referred to as the competencies that teach “quality” in medical practice. PBLI has to do with the way we learn from our patients and our practice. How do we react when our patients improve with treatment? Or, perhaps more importantly, how do we react when our patients do not improve or worsen? What can we learn by looking at practice patterns? The number of diabetics with goal HgbA1c? The number of asthmatics who required an emergency department visit? How do we continue that process of life-long learning that is so critical for physicians? What about accessing information and guidelines? How do we keep up? We do it, as all adult learners do it, by setting goals for ourselves. It may be that we read a certain number of journal articles a week or attend so many hours of CME a year. Or we may look at a gap in our knowledge or experience, as I did in my residency with neonatal care, and plan an educational activity geared at filling that gap. We may look at the type of practice

best suited for our needs and those of our patients and employ the use of technology to help achieve that. In this journal, Andrea Skaggs points out how she utilized the “New Model of Family Medicine” to help her achieve her need to provide holistic care for her patients. All of this is included in PBLI.

Systems-based practice teaches us about the big picture that is health care. What systems do we employ outside of our examination room to improve the care of our patients? We truly are a specialty that can integrate many resources for a common goal: nursing, nutrition, physical therapy, home care, consultant services. Will Melahn from Morehead tells a story about how much he has learned from his patients, often when he did not expect it. Very poignant is the story he tells about visiting his patient at home. I am always surprised, though I guess I shouldn’t be by this time, how much I gain from seeing patients on their own turf. The home visit is an art we need to pass on to our new crop of residents. Beyond the individual though, SBP also deals with community and public health and health finance, issues that family doctors have embraced and perhaps shunned (in that order) over the years.

So how does learning about competencies make you a competent physician? We are creating for our residents a roadmap that shows the destination. We are telling them, “This is what you need to accomplish in the next 3-7 years.” Rather than judging them by comparing them to their peers or worse, to ourselves, we show them what a beginning physician in Family Medicine should be able to recognize and do. As for me, I knew I

needed to know a little more about newborn care and so I spent extra time in preparation. I might not have needed to know how to place a Swan-ganz catheter, though I was fairly certain I knew whom to call should the need arise. Better than telling all residents they need to learn the same thing in the same way as all the other residents before and hence, we give them the chance to think on their own, set their own goals and evaluate their own successes. After all, it won't be long before the only ones giving the resident

feedback will be the resident and his or her patients. If we have done our job right, the patients won't need to vote with their feet!

The competencies provide the framework for residency education. It is up to the learner, with the aid of those who teach, to develop goals, meet objectives and demonstrate that he/she is a competent physician. On that first day of practice, all we may be able to hope for is that the newest family physicians "know what

they know and know what they don't know." Usually, I believe, our graduates have progressed well beyond that level by graduation. I commend all of the practicing physicians who share their skills with learners, be they medical students or residents, physician assistants or nurse practitioners. It is my goal, and that of the ACGME, that training residents with the competencies in mind will improve the quality of health care our patients receive.

[1] www.acgme.org

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Building a Road to the “New Model”: Technology in the Practice of Family Medicine

Andrea Skaggs, MD
Fayette Family Medicine
Lexington, KY

The Future of Family Medicine Report (published as a supplement to the Annals of Family Medicine in March/April, 2004 and available online at http://www.annfammed.org/cgi/content/full/2/suppl_1/s3) was the culmination of two years of work by dozens of doctors much more learned than I, involving hundreds of interviews and focus groups, followed by a sophisticated drill-down to identify the key components needed to “transform and renew the discipline of family medicine to meet the needs of patients in a changing health care environment.” It was an ambitious project with far-reaching implications for patient care and training of new doctors. It also provides an outline for the family physician’s role in developing a less fragmented, more cost effective delivery system capable of improving health outcomes. I encourage those who have not done so to read the final report, and those who have to re-read it.

The centerpiece of the final report is the “New Model of Family Medicine”, embodied in eleven key characteristics described in Table 4 of the final report. When I first read the FFM final report, I was struck by how closely the characteristics of the New Model paralleled my own priorities. After all, I didn’t hire any research firms, or hold a single focus group. I simply wanted to find a satisfying, workable way to give my patients the kind of care I think is important. That quest led me to embrace highly technical systems for almost every aspect of my practice except for the decidedly non-technical “laying on of hands” that remains the central feature of my patient contacts. Early adoption of electronic medical records, wireless in-office networking, paperless faxing, high speed internet access, remotely accessible phone messaging and nationwide cell phone service are tools that allow me to manage the administrative and business aspects of medical care in a way that

promotes rather than hinders my direct contact with patients. The result is greater satisfaction for my patients and for me, and unwittingly greater manifestation of the “New Model” than would’ve been possible otherwise.

Each of the eleven characteristics of the New Model is facilitated to a greater or lesser extent by technology in my practice. **ADVANCED INFORMATION SYSTEMS**, of course, depend entirely on technology, and my electronic medical record (EMR) system is truly the “central nervous system of the practice”. The selection, purchase and implementation of an EMR is a daunting task, considering the vast array of choices and range of prices available, but this critical choice deserves careful attention. While inexpensive systems that simply provide electronic storage of traditional paper records may save some money and space, a more robust system is essential to meet the needs of the New Model. Be sure to look for a system that allows full integration with your practice management system for billing and scheduling. An interface with your lab (bidirectional if possible) to receive results directly into the patients’ charts greatly reduces staff time. Direct link to electronically received documents (faxes and emails) also saves steps and cuts down on misplaced results. In-office diagnostics such as EKGs and clinical photographs that can be interfaced to the EMR also improve efficiency. A system capable of automatically populating standardized, electronically transmittable/printable referral notes and consultation reports with patient specific data makes communication with other clinicians a snap.

ELIMINATION OF BARRIERS to access is another New Model characteristic that is greatly facilitated by technology. Today, the typical doctor is only accessible to patients after they have

spoken to at least one staff person. The most direct route is to speak to a scheduler and then come in for an appointment, which may be several weeks away. By taking all calls myself, and by using open access scheduling, I cut down on delays and confusion in communications with patients, but I couldn’t do it without electronic assistance. By using inexpensive voice messaging provided by my phone company, patients who don’t catch me sitting by the phone can leave a message that I can retrieve from any phone. If I am out of the office, all I need is internet access to be able to schedule appointments, fax prescriptions or orders or answer questions about test results, medications prescribed or anything else contained in the record.

PATIENT CENTERED CARE drove me to **REDESIGN MY OFFICE** from a model where staff needs were the primary consideration in every decision from clinic hours to office layout, to one that accommodates patients above all. By using sophisticated technology I have eliminated the need to have staff members available at all times to do everything from find charts to weigh patients to fax referral requests. I discarded a private office in favor of a central work area in sight of the waiting room, front desk and exam rooms so that I am in contact with patients from the moment they arrive. My wireless network allows me instant access to all parts of the patient record, as well as online look-up of information not yet in the chart, such as preliminary radiology reports or emergency room notes, without leaving the patient’s side. The cell phone in my pocket is my link to consultants whose opinions are needed immediately.

Providing a **PERSONAL MEDICAL HOME** with a **WHOLE PERSON ORIENTATION** is more philosophical than technical, and *can* be accomplished

with no more complicated tools than pencil and paper, but the tools of technology make the job much easier and more accessible. Many of my patients go out of their way to be sure that information about their health from ALL sources is included in my records. They send results from the office health fair screening and letters they have gotten from specialists. They say they are glad to have all that information in one safe place and know that will have access to it whenever it might be needed. When I sit face to face with them, we have access to all the information we need to address every problem in some form or fashion, whether I handle the problem myself, or coordinate with another resource to provide services more effectively addressed by another caregiver.

I am in solo practice in a community with lots of medical resources, and one consequence is that certain “ingredients” in the **NEW MODEL BASKET OF SERVICES** can be better provided (more expertly or at less cost) by other clinicians in the community, but that doesn’t have to mean that I am out of the loop. My use of technologic information sharing greatly augments my participation in a **TEAM APPROACH** to care in which patients are better served by involvement with other clinicians. By quickly and easily providing detailed patient information to my colleagues I foster relationships that allow truly shared care. My patients also recognize that they are part of a community that includes not only other doctors, but other patients and community resources such as support groups and social service organizations. They appreciate my efforts to help them connect with those resources.

One of the most exciting advantages of using technology in medical practice is the capability to **EMPHASIZE QUALITY AND SAFETY**. Electronic prescribing provides instant alert of drug interactions or use of drugs to which patients have reported an allergy or adverse reaction. Online access to the most up-to-date evidence-based practice guidelines, combined with electronic tracking of patient-specific details such as weight, blood pressure, lab results and evidenced-based guidelines makes it is

possible to achieve the very best in chronic disease management as well as screening with minimal effort.

The remaining characteristic of the New Model, **ENHANCED PRACTICE REVENUE**, has been perhaps the most controversial aspect of the FFM project. One problem is the perception by many family docs that financial considerations were treated only as an afterthought, with Task Force 6 (Enhancing practice reimbursement and financial issues) not included the Final Report. Even more controversial is the subject of “new revenue streams” as there is scant evidence that third party payers are willing to provide extra funding for chronic disease management or adoption of electronic systems or e-visits. In my experience, enhanced finances are exclusively the result of improved efficiency resulting from reduced staff costs and better coding to allow somewhat higher reimbursement, more in line with care actually provided. Even without any new revenue streams, I have realized a substantial financial benefit from utilizing the technologies described.

The New Model describes key characteristics that can be manifest in a wide array of practice settings, from large multispecialty organizations to single doctor house call practices. In my particular situation, I am working to build my New Model in a solo, low overhead, private practice setting. Located on a hospital campus, my office space is sublet from a general surgeon who uses it only one half day per week. I have exclusive use of about 60 square feet, but share access to about 700 square feet, including the two exam rooms, a waiting room, bathrooms, lab area and central work area/front desk. I pay the surgeon’s office manager on a per draw basis to draw blood and prepare it for pick up by a commercial lab. I have no regular full time staff members, but three students each work part time to help with clerical tasks. I limit my panel to about 850 patients, of which 25% are Medicare beneficiaries. I utilize open access scheduling, and most patients are seen the same day they call if they so desire. Most days I see eight to twelve patients over six hours, doing everything from collecting

the copay to coding the visit. When one of my patients requires admission, the hospitalist service provides expert inpatient care, keeping me available to see patients in the office. I do not share call, which is far less a burden than most doctors think it would be. Every call is from someone I know therefore, my patients never have complaints about how “the on call doctor just didn’t understand.” This “ultralite” solo model, pioneered by Dr. Gordon Moore, is not for everyone, but is a growing movement that really fosters the tenets of the New Model.

Development of the New Model is a work in progress. This year will mark my fourth anniversary since adopting electronic records and I continue to refine the ways I use technologic resources to enhance the care I give patients and to improve my professional and personal satisfaction. The marriage of old fashioned, face-to-face, hands-on care with new-fangled, slick electronic tools is giving me the professional life I never knew I wanted. Every day is a new adventure in the New Model.



Andrea Skaggs, MD



Pediatricians Call for Calcium Check-up

The 2006 American Academy of Pediatrics report³ on optimizing bone health supports dairy's role in the bone health of children and adolescents.

Talk to your patients about including three servings of dairy a day (milk, cheese or yogurt) to help build stronger bones.

- **Assess Calcium Intake:**

The AAP suggests periodically assessing calcium intake and risk factors for sub-optimal bone health at 2 or 3 years of age, after the infant is no longer taking human milk or formula; during preadolescence (8-9 years of age); and during early adolescence, when peak accumulation of calcium occurs. Refer to the AAP report, "Optimizing Bone Health and Calcium Intakes of Infants, Children, and Adolescents" for an assessment questionnaire.

- **Share Bone Building Tips:**

Most people can achieve the recommended dietary intake of calcium by eating three servings of milk, cheese, or yogurt each day. Low-fat and fat-free versions are encouraged.² Non-dairy food sources and supplements are an alternative, but these products do not offer the same nutrient benefits of dairy foods.

- **Model Healthy Habits:**

All family members should evaluate their calcium intake and consider three servings of dairy a day (4 for adolescents) for building stronger bones.

- **Be Active:**

Encourage physical activity, primarily weight-bearing exercise as part of an overall healthy bone program.

Visit www.nationaldairyCouncil.org to download a calcium assessment questionnaire for use with patients and www.aap.org for additional resources.

Recommendations for Adequate Dietary Calcium Intake (mg/day) and Servings of Dairy per Day in the United States

Kids/Adolescents		
Age	Calcium Intake, mg/day ²	Servings of Dairy per Day ³
1-3 years	500	3 [*]
4-8 years	800	3 ^{**}
9-18 years	1300	4 ^{**}

^{*} Age-appropriate servings

^{**} One serving equals 8 ounces of milk or milk equivalent



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¹US Department of Agriculture, Agricultural Research Service. Data tables: results from USDA's 1994-96 continuing survey of food intakes by individuals and 1994-96 diet and knowledge survey. Riverdale, MD: US Department of Agriculture; 1999; (data for males and females ages 12-19 years).

²Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride*. Washington, DC: National Academy Press; 1997.

³American Academy of Pediatrics, Optimizing bone health and calcium intakes of infants, children, and adolescents. *Pediatrics*, 117 (2):578-585; February, 2006.

Mark Your Calendar for Upcoming Meetings!



**AAFP Annual Leadership Forum &
National Conference of Special Constituencies**

May 4-6, 2006

Hyatt Regency Crown Center, Kansas City, Missouri

KAFP 55th Annual Scientific Assembly

May 12-14, 2006

Louisville Marriott East, Louisville, KY

National Conference of Family Medicine Residency Programs

August 2-5, 2006

Bartle Convention Center/KC Marriot, Kansas City

AAFP Annual Scientific Assembly

August 26-October 1, 2006

Washington, DC

2006 Southeastern Family Medicine Forum

August 17-20, 2006

Casa Monica Hotel, St. Augustine, FL

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PLAN TO ATTEND TODAY!

2006 KAFP 55th Annual

Schedule at a Glance

Thursday, May 11, 2006

7:00 PM *Board of Directors Dinner Meeting*

Friday, May 12, 2006 (8 CME)

7:00 AM *Registration/Continental Breakfast/Exhibits*

7:50 AM *Welcome by: Gerry D. Stover, EVP KAFP*

8:00 AM *Overview of Scientific Program,*
Gay Fulkerson, MD Program Chair

8:15 AM *Migraine*

9:15 AM *What's New in Vaccines*

10:15 AM *Break/Exhibit Visitation*

10:45 AM *Respiratory Tract Infection*

11:45 AM *Registrants & Exhibitors - Lunch & Exhibit Visitation*

11:45 AM *Congress of Delegates Luncheon Meeting*

1:45 PM *Type 2 Diabetes*

2:45 PM *Stress Urinary Incontinence What Matters?*

3:45 PM *Break/Exhibit Visitation*

4:15 PM *Cardiovascular Disease Update*

5:15 -5:45 PM *Audience Question & Answer Session*

6:00 PM *Resident/Student Reception*

Saturday, May 13, 2006 (8.5 CME)

7:00 AM *Registration and Continental Breakfast/Exhibits*

8:00 AM *Gastroesophageal Reflux: Much More Than Heartburn*

9:00 AM *Botulinum Toxin Therapy in Neurology*

10:00 AM *Break/Exhibit Visitation*

10:30 AM *AECB Bronchitis 2hr Workshop*

12:30 PM *Registrants & Exhibitors - Lunch & Exhibit Visitation*

12:30 PM *Past Presidents Luncheon*

1:30 PM *CAM and You: How Physicians can Benefit from*
Complementary and Alternative Medicine

2:30 PM *Update on State Health Issues*

3:30 PM *Break/Exhibit Visitation*

4:00 PM *Alzheimer's/Dementia*

5:00-5:30 PM *Audience Question & Answer Session*

6:30 PM *Reception/Annual Banquet*

Sunday, May 14, 2006 (4.5)

7:30 AM *Registration/Continental Breakfast/ Exhibits*

8:00 AM *Clearing the Confusion: Osteoarthritis Family Medicine Physicians & Their Patients: A Case Based Approach*

9:00 AM *The Hidden Disorder: Practical Approaches to Proper Diagnosis and Treatment of Adult ADHD*

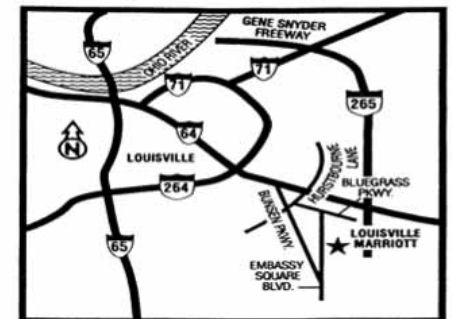
10:00 AM *Break*

10:15 AM *Treating Opioid Dependence with Buprenorphine: Assistance with New Medication; 1hr Workshop*

11:15 AM *Risk Management*

12:15-12:45 PM *Audience Question & Answer Session*

Schedule is subject to change.



al Scientific Assembly

Program Goals

Registrants for this program will receive current information on a variety of medical subjects pertinent to patient care in the daily practice of family medicine. Subject matter was chosen based on assessed education needs of the KAFP membership. At the conclusion of the program, registrants should have a working and applicable understanding of the topics.

CME Credit

This activity is being reviewed for 21 prescribed credits by the American Academy of Family Physicians and 21 hours of AOA Category 2-A credit.

Who Should Attend

Family Physicians and other health care providers including MD/DO specialties, PAs, RNs, etc.

Why Attend

- Quality cost-effective CME program
- Earn over 21 hours of approved CME
- National and Local Speakers
- Connect with your Colleagues
- Gather information and knowledge from Local and National Companies displaying their products

REGISTRATION FORM for the KAFP 55th ANNUAL SCIENTIFIC ASSEMBLY

PLEASE COMPLETE THIS FORM, **KEEP COPY FOR YOUR FILES**, & SEND WITH PAYMENT TO:
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	<u>Before April 1st</u>	<u>After April 1st</u>	
<input type="checkbox"/> KAFP & Other AAFP Members	375.00	425.00	_____
<input type="checkbox"/> Life Members	N/C	N/C	_____
<input type="checkbox"/> Non Members of the AAFP	380.00	455.00	_____
<input type="checkbox"/> Health Care Professional (PA, RN, Etc.)	130.00	180.00	_____
<input type="checkbox"/> Residents & Students (no charge except Banquet)	N/C	N/C	_____

EXHIBIT AREA IS RESTRICTED TO REGISTRANTS ONLY.

SPECIAL EVENTS:

- Friday, May 12, 2006 at 6:00pm
Resident & Student Reception N/C _____
- Saturday, May 13, 2006 Past President's Luncheon (Past President's & Spouses only) N/C _____
- Saturday, May 13, 2006 Spouse Tea Social N/C _____
- Saturday, May 13, 2006 at 6:30 pm
Reception/Banquet \$55 per couple or \$30 each _____

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Cancellation Policy: We encourage you to register early to help with our counts and avoid any delays the day of meeting. We will give 100% refund if notified in writing or by phone by April 12, 2006.

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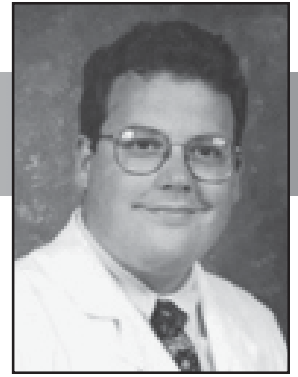
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Stories



By William Melahn, M.D.
St. Claire Regional Medical Center
Morehead, Kentucky

Everybody has a story to tell. Storytellers have long held a high place in our society as the fabric weavers of local culture. We physicians have the preeminent job in the world when it comes to stories. Everyone wants to tell us theirs. We do our best not to harm our patients. The best way we have to do that is by listening to their stories. Our specialty sits at the crossroads between evidence-based medicine and narrative history.

My wife sometimes asks me if I would be interested in joining the local book club in reading and discussing the latest best-selling fiction. What I hear at work is better than fiction.

I'd like to share a few stories with you.

There are few truly joyful times in day to day clinical practice, and this was one of them. I twisted the knob on the door to the room in the clinic with expectation. My patient's pregnancy test was finally positive. Sarah and her husband John had been through so much over the last years with me working with them as patients and also seeing them as a couple close to my age going through the struggles many of us experience.

Sarah had developed secondary infertility after the birth of her first child, her daughter Kirsten, now nearly three years old. I had been privileged to be there for the birth. She did a great job of laboring, delivering in a lateral Sims position using no medications, just what she had wanted from her birth plan. A few months after her birth we found out with the help of some caring specialists that Sarah and John's daughter had neurofibromatosis. They had struggled to decide that another child was the right thing to hope for given the diagnosis. Of course since Sarah and John worked very hard at customer service jobs to barely make ends meet, there was a

difficult decision about whether they could afford another child, healthy or not. All of us privileged enough to be family physicians have known a Sarah and a John and their kids I am certain, so you know who I am writing about.

As you also know from your own experiences, I knew more of their extended family because they too were my patients. Sarah's parents, although they had little of their own money, were always quite supportive of their kids and I think taught them well to enjoy what life gave them. They helped with taking Kirsten to her doctor visits, with child care in general, and I am sure, with some money. They were also at the hospital in the waiting room when she was born, and were so proud.

Once they had finally decided to try for another child, they had been unable to conceive. Sarah and John came together to see me and we decided after a long talk to evaluate their infertility. After the testing and basal body temperature monitoring we decided to stimulate ovulation with clomiphene which I had prescribed with the usual instructions. Now they were back, and the chart in the door had a laboratory report slip with a positive urine pregnancy result. I was not prepared for the next part.

Sarah was in tears when I entered the room. Frankly, I was shocked since I knew she and her husband had been anticipating this for quite a while. I stood in the door for a few seconds not knowing what to say. Had there been bleeding? Pain?

She spoke first.

"I found out yesterday because we did a home test, and it came back positive," she sobbed. "We made this appointment

about that, but something else happened. We needed to tell you that my father died this morning. This was supposed to be a happy visit, and part of it is, but we really wanted you to know."

I was stunned.

"We just wanted you to know. He had a heart attack and died in the emergency room."

I will never forget that moment.

After we sat together for awhile and their tears had dried, they left. I was really humbled they chose to come and tell me in person. Obviously Sarah and John's family felt we were their medical home. I was again there for the birth of their healthy son.

Stories we share are universal, related mostly to our human condition and not to our geography.

At a Society of Teachers of Family Medicine (STFM) meeting several years ago, South African family physician, Jack Medalie told a sad, humbling story about his first job as a doctor working on a rural kibbutz in Israel. He had been taking care of an elderly retired farmer with significant coronary disease who had recently been suffering from declining health. His wife had really been doing a marvelous job taking care of him at home as he was stoutly opposed to being in a hospital. How many of us have worked with patients like that farmer, fiercely independent and used to being strong in his earlier life, now having to process his decline?

One night Dr. Medalie received an urgent call from the community health nurse asking for him to drive out the couple's

house as there was something terribly wrong. Jack got out of bed, got dressed, climbed into his truck and during the cold, bumpy ride he turned over and over in his mind the possible scene which awaited him. Was it another heart attack, unstable angina or pulmonary edema? Was his patient in pain or short of breath? Would he go to the hospital this time? He was quite unprepared for what he found.

The farmer's wife had committed suicide.

All had been so focused on the care of the farmer that the health care team had missed the wife's depression and distress related to her caregiver role. From that moment on, Jack Medalie became a much better family physician always looking for his "hidden patients." He remembered to ask himself how an illness affects the roles we play in families and how our roles are always changing and how that can be overwhelmingly stressful sometimes.

Each year Rowan County hosts the Cave Run Storytelling Festival. I don't think it's a coincidence that several physicians from the area are involved in its planning and development. It is through stories that we relate to each other.

Some stories develop over many visits. Several years ago I made a home visit on a new patient in Elliott County, a 75 year old man named Gene with a history of lung disease. Our clinic had been called about him by a home health nurse because doctors in Lexington were no longer able to refill his prednisone since he had not left his house in months and was refusing to go to them for a visit. Could we go see him?

It took me a while to find his house, but once I did he came to the door to let me in. It was obvious from seeing him he

was suffering the ill effects of chronic steroid use. His arms had little muscle mass; his face was round, his skin thinned. I did my usual casing out of the home. It seemed like he had everything he needed brought to him. He had someone deliver his groceries and his medicines. A friend up the holler would get his mail for him everyday. The ladies at the bank knew him and helped him get his banking done without his leaving the easy chair. He had worked out a deal with the home medical equipment guy to pick up his purchases from the Wal-Mart in Morehead when he would call and order things by phone.

He was not too happy about the prednisone since it did not seem to have affected his breathing in a positive way. It took me a couple of visits to convince him to start weaning it slowly down because he still would get severely suddenly short of breath every time he tried to leave the house. His agoraphobia was the most severe I had ever seen.

I became concerned about some significant right axillary lymphadenopathy he had noticed and brought up to me on one of my visits. He related to me that years ago at a clinic a doctor had taken a dark mole off his right shoulder. I recommended he get a biopsy urgently. Well, the bottom line was the only way we were going to get a sample was if I got it myself. I talked to my friend Jeff Ellis, one of our pathologists at the hospital, who showed me how to use some equipment I would need. Then I performed my first fine needle aspiration in a holler in Elliott County. As I was finishing up, Gene, who had started getting more talkative the last few visits, looked at me with a nervous grin and said, "I bet you didn't know I used to be a big, bad bank robber."

Specimens to bring to the hospital or not, I was not going to leave and let that story go by.

"Oh yeah, Gene?"

"Yeah, I was one of the last prisoners to leave Alcatraz. I got put in there because they said I was a problem inmate since I tried to escape from another place."

He went on to tell me about his previous life both in and out of the federal penitentiaries (facts since verified by the National Park Service) and how he got caught "the last time." It turned out that Gene had spent many years on the Rock, with many stints in solitary confinement in the bottom of the prison. He knew the Birdman of Alcatraz.

After that revelation, his severely agoraphobic behavior, though tragic, started to make sense from his context. Like many long-term inmates Gene had created his own little world in his cell and now house, with lots of people doing little favors here and there to make life a little more tolerable, more survivable. It took him quite a while to feel comfortable enough to tell about this part of his life story. I really think it helped him a lot for me to understand his background as we worked with him about his malignant melanoma.

As physicians, people who hardly know us will tell us things they would never share with anyone else. Sometimes our biggest gift as family physicians is our capacity to sit and listen over time. Multiple fragments of visits are woven over time into more complete stories of our patients' lives. Because we see entire families, we have opportunities to weave more intricately than any other specialty. Use your gift wisely.

“Performance in Practice”

Modules in the American Board of Family Medicine Maintenance of Certification for Family Physicians Process

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Vice President – Assessment Methods Development American Board of Family Medicine



The American Board of Medical Specialties (ABMS) adopted in 2000 the concept of “Maintenance of Certification” (MOC) for the 24 U.S. medical specialty boards [1]. The MOC concept entails 4 main components: evidence of professional standing, evidence of commitment to lifelong learning, evidence of cognitive expertise as demonstrated by performance on a secure examination, and evidence of evaluation of performance in practice. The American Board of Family Medicine (ABFM) has traditionally assessed professional standing by requiring certification candidates to possess an unrestricted license to practice medicine. Continuing education activities have served as a proxy for demonstrating a commitment to life-long learning, and minimal chart audits have served as evidence for evaluation of performance in practice. With implementation of the Maintenance of Certification for Family Physicians (MC-FP) process in 2004, ABFM has modified these activities to reflect the prospective on-going assessment approach adopted by ABMS.

Part I of MC-FP remains as in the past: certification and recertification candidates must demonstrate a valid and unrestricted license in all jurisdictions in which they hold licenses. Part II (evidence of lifelong learning) continues to require 300 continuing education credits over the six years prior to the Part III cognitive examination in the seventh year, but now also includes Self-assessment Modules (SAMs). Each SAM consists of a 60 item knowledge assessment

(with critiques and references), followed by a clinical simulation that focuses on patient management in the SAM domain. SAMs currently exist for essential hypertension, type 2 diabetes mellitus, asthma, and coronary artery disease. Major depression and chronic heart failure will become available early spring 2006. In developing the SAM content areas, the ABFM has focused on the 20 priority areas identified by the Institute of Medicine in its “Transforming Health Care Quality (2003)” report [2].

Part III consists of the traditional cognitive examination taken in the sixth or seventh year of the recertification cycle or upon completion of residency training. The ABFM Board of Directors recently approved a modification to MC-FP that will allow Diplomates to extend their certificates to tens years’ duration; current Diplomates should have received notification of this change by the time this article appears, and further details are available at the ABFM website, <http://www.theabfm.org>.

Part IV represents the greatest departure from historical ABFM assessment activities. Previously, the recertification process included a retrospective clinical performance audit that relied on abstracting data from clinical records. This process evolved over time to include only two charts in each of two domains. With implementation of MC-FP, Part IV now entails more extensive introduction to, and implementation of, prospective quality improvement activities. The Part IV Performance in Practice

Modules (PPMs) include an introduction to quality improvement methods and instruction in how to conduct “PDSA” (Plan, Do, Study, Act) activities in clinical practice [3]. For each clinical domain (e.g. diabetes), the module development team has selected six or seven widely-accepted quality indicators (example indicators include measurement of HbA1c and foot examination in diabetic patients) for analysis and improvement activities. The team has focused on indicators and measures developed by the Physicians Consortium for Performance Improvement, a group that includes representatives from over 70 national and state organizations, including the American Academy of Family Physicians [4].

To conduct a PPM activity, the Diplomate selects a topic from her portfolio at the ABFM web portal (www.theabfm.org). Currently available PPMs include offerings in hypertension, type 2 diabetes mellitus, asthma and coronary artery disease. After selecting a topic, the Diplomate can access an introduction and view a tutorial for orientation to the process. The site also includes a “roadmap” that provides step-by-step guidance for progressing through the module.

To begin a PDSA cycle, the Diplomate first downloads patient and physician

survey instruments that she will use in assessing the appropriate indicators. The patient survey includes questions that help identify how familiar a patient might be with the care he has received (e.g. "Have you had your hemoglobin A1c (a test of how much sugar is in your blood) checked in the last six months?"), and corresponding questions answered by the Diplomate from information in the medical record (e.g. "Have you tested the hemoglobin A1c in the last six months?"). The process includes this dual source of data to help the Diplomate identify areas where her patient might need more information about the care he has received.

After completing data collection on ten successive patient visits (the process relies on prospective data collection rather than retrospective chart audit), the Diplomate enters the information on-line through the web portal, and receives in return a summary of her performance on all of the indicators, as well as a comparison to her peers' performance on the same indicators. On the basis of this summary, the Diplomate then selects an indicator on which to conduct a quality improvement effort. For example, assume that the Diplomate discovers that she has performed foot examinations on only 20% of her diabetic patients in the past year, which is well below what she had expected. On the basis of this, she selects foot examinations as the indicator she wants to improve. She next proceeds to the quality improvement "wizard" included in the module to create a quality improvement plan. The wizard

includes interventions in each of several categories: standing orders, flow-sheets, registries, reminder systems, chart sticker systems, patient education, group visits, plan of care systems, and patient and physician communication aids. Each of these categories contains hyperlinks to Internet resources for use in creating a quality improvement plan.

After reviewing the available interventions, the Diplomate selects at least one intervention from at least two of the intervention categories, and uses these as the nidus for a quality improvement project over the following several months. After using these interventions for 3 to 6 months, the Diplomate repeats the patient and physician surveys during another 10 patient visits and submits the data for analysis. Completion of the process fulfills the Part IV requirement (i.e. there is no specific improvement criterion for successful participation.) In order to minimize duplication of work that Diplomates might do to satisfy other organizations' requirements (e.g. managed care organizations), the ABFM has created a process for approving those activities for Part IV credit. Additionally, the Board is planning optional enhancements that could be used to qualify for payment for performance and practice certification programs.

Beginning in 2007, the Part IV modules will place much greater emphasis on concepts included in the Chronic Care Model: community resources and policies, organization of health care,

self management support, decision support and clinical information systems [5, 6]. Interventions provided in the quality improvement wizard will relate specifically to these Chronic Care Model components.

In addition to the Chronic Care Model concepts, the ABFM will introduce in late 2006 activities that will provide Diplomates who practice in alternative environments (approximately 20% work in emergency rooms, serve as administrators, practice occupational health, etc) a means to complete Part IV requirements. The ABFM has begun development of Methods in Medicine Modules (MIMMs) that will focus on core clinical skills that transcend particular practice settings. The first module, Information Management, should be available toward the end of 2006. This module will focus on the development of refined clinical questions that can be used to obtain high quality answers at the point of care from existing on-line resources. Further MIMM offerings in critical appraisal and generic systems improvement will appear in 2007-2008. Additionally, the ABMS has begun development of a patient safety module that should appear in 2007.

The *To Err is Human* and *Crossing the Quality Chasm* reports from the Institute of Medicine highlighted existing quality problems in the American health care system [7, 8]. Activities traditionally emphasized in board recertification processes (e.g. didactic continuing education) have been shown to have minimal impact on practice performance, while interactive

techniques (such as audit and feedback and reminder systems) do yield quality improvements [9]. Part IV of the MC-FP process has therefore evolved to emphasize active and interactive quality improvement activities that have been demonstrated in other venues to enhance care quality. While this process will continue to evolve, the activities included in MC-FP Part IV will serve to further assure the American public that ABFM Diplomates provide, and strive to improve, the highest possible quality of care.

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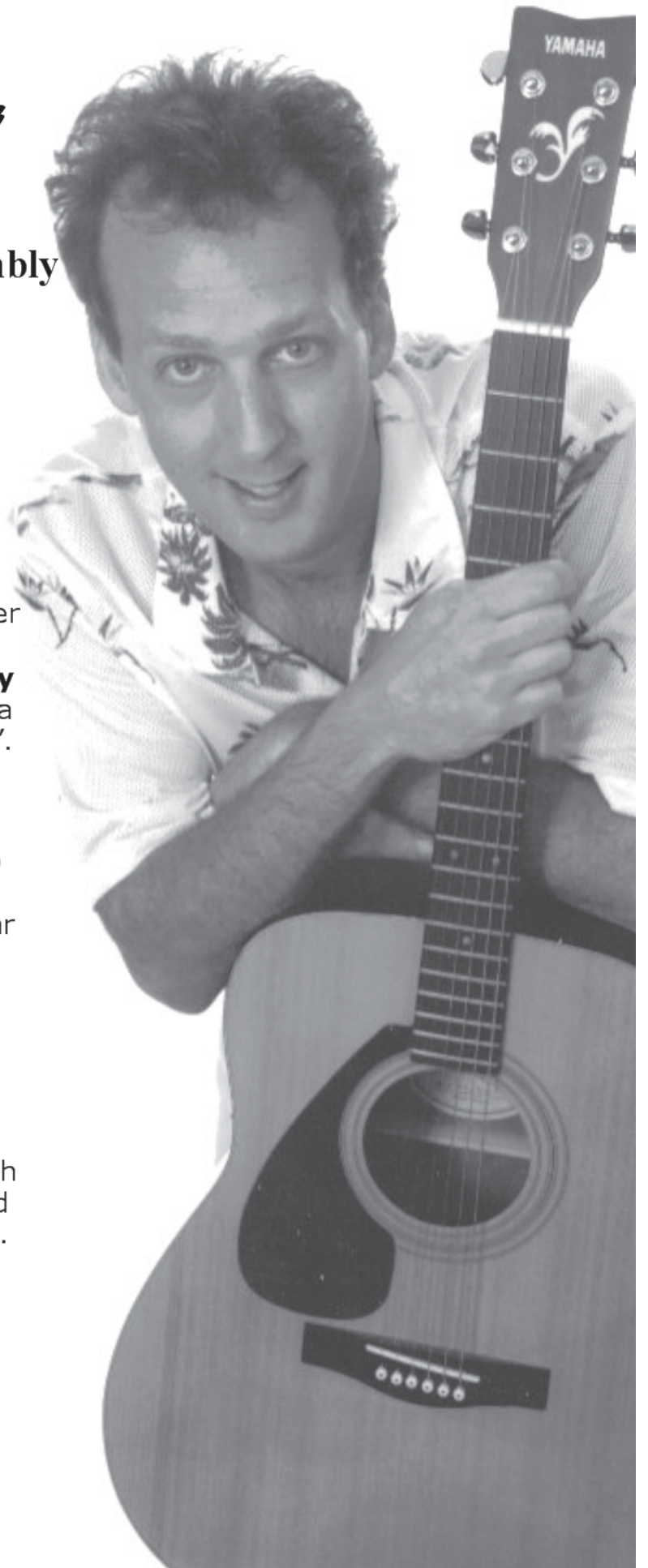
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2006 Kentucky Tar Wars® Winner

My name is Shelly Young and I teach Physical Education at Taylor County Elementary School. I taught the Tar Wars Program to approximately 400 4th and 5th grade students at my school this year. This tobacco-free education program from the American Academy of Family Physicians was very user friendly and easy to follow.

My students really liked the straw activity. They couldn't believe how hard it was to exercise and breathe through that straw. Many of them commented that they didn't want to smoke and feel that way someday. They really got into the advertisements!

They searched through magazines and brought in several pictures. They were amazed at how the people pictured looked so different from the people they see daily using tobacco products. They realized how the advertisers were trying to make them believe that's what they would be like if they used their product. They said they were not going to fall for that trick.



4th & 5th Grade Students from Taylor County, KY



Back Row left to right: Karen Hayes (representative from Campbellsville/Taylor County Anti-Drug Coalition), Jane Wheatley (CEO Taylor Regional Hospital) and Dr. Bill Mattingly (TCES Principal)
Front Row: Dylan Quinn-3rd Place Winner, LeAnna Kirtley-2nd Place Winner and Christopher Whitley-1st Place Winner

Teaching about the financial implications was very difficult. So many of them have parents and grandparents that use tobacco products and when we started multiplying the cost, they were stunned. The sad looks on their faces and the comments they made were so terrible.

The question that sticks with me the most from this experience was "If the tobacco products are so bad for us and cause some families to be in financial trouble, then why is it not outlawed?"

I know this program had a positive impact on my students. I know they remembered the lessons because the counselor visited the classrooms to teach some similar lessons and the students told her they already knew the information she was talking about! They quoted the lessons taught and named all 5 to me in a review session before the poster contest. I will continue to use these lessons in the future and I am thankful that Richard Phillips from Taylor Regional Hospital introduced this program to me.

*Christopher Whitley's poster will be entered into the National Tar Wars® Poster Contest scheduled for July 2006 in Washington, D.C.
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