KAFP JOURNAL

Volume 58
Spring Issue

The Official Publication of the Kentucky Academy of Family Physicans

SPECIAL ISSUE
Kentucky Academy of Family Physicians 56th Annual Scientific Assembly Highlights

Our New President

Baretta R. Casey, MD, MPH

Pikeville, KY

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The Kentucky Academy of Family Physicians

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KAFP State Officers 2007-2008

FROM YOUR PRESIDENT

by Baretta R. Casey, MD, MPH
Lexington, KY

A Win for Patients and Physicians

Governor Ernie Fletcher recently announced a change in the Medicaid payment fee schedule to physicians in the Commonwealth. This will take effect on August 1, 2007 and will greatly improve access to medical care for Kentucky citizens. The Governor and Secretary Birdwhistle want the people to have a patient-centered medical home. This new fee schedule is a great first step to ensuring just that.

The agreement forged between the Cabinet for Health and Family Services and the Kentucky Medical Association on behalf of all patients and all physicians across the Commonwealth will result in the first increase in payments to physicians in twelve years. After numerous meeting beginning in September 2006,
i the working group found that 351 CPT codes accounted for 80% of the total expenditures paid by Medicaid. The following agreed upon increases will result in approximately $44 million dollars in new payments to physicians in the next year. An additional $4 million dollars for Passport is included in the package. The $11 million dollars paid in KenPAC management fees will remain intact for the same year. Some of the details are yet to be worked out.

The agreement includes:

- *Increase 10 E & M Codes to 87.5% of Medicare rate (99201-99205; 99211-99215)*
- *Increase Preventive Codes (EPSDT) by 12.5%*
- *Increase Inpatient & Outpatient Consult Codes to 79% of Medicare rate*
- *Increase Inpatient Consult Codes to 75% of Medicare rate*
- *Increase the remaining 351 CPT codes to 79% of Medicare rates*
- *Encourage expanded Office Hours by paying a flat rate of $72 a visit*
- *No reduction in CPT codes currently paid at greater that 80% of Medicare rate*
- *Increase Level IV & V visits allowed to two per year, with preauthorization for those over two.*
- *Any CPT codes that are greater than 80% of Medicare rate, Medicaid must pay for dual-eligible recipients.*

I hope you will agree with me that this is a moment for which we have all hoped . Involvement of family physicians and other specialists made this increase a reality. As family physicians, we must be supportive of our specialty. Organized medicine is our only unified voice to advocate for both our patients and our profession. I hope the coming year twill continue to bring good news for us all.

Installation of Baretta R. Casey, M.D., as the 2007-2008 President of the Kentucky Academy of Family Physicians; presented by Larry S. Fields, M.D., AAFP Board Chair.

Larry S. Fields, M.D., AAFP Board Chair and Baretta R. Casey, M.D., KAFP President.

Baretta R. Casey, M.D., KAFP President and Samuel C. Matheny, M.D., KAFP Immediate Past President.

Samuel Matheny, M.D., KAFP Immediate Past President, presenting Dr. Casey with the President's plaque.

O'Brien to serve as Associate Editor for KAFP Journal

Dr. James O'Brien is assuming the position of Associate Editor for the Louisville campus edition of the KAFP Journal.

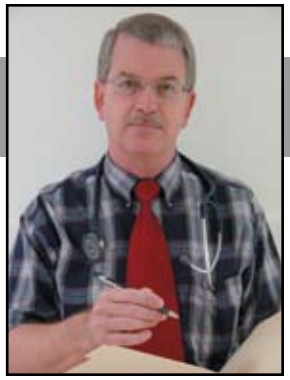
Dr. O'Brien follows Dr. Charles Kodner in the position. We want to extend our gratitude and thanks to Dr. Kodner for all his hard work as Associate Editor.

Dr. O'Brien is the Margaret Dorward Smock Endowed Chair in Geriatrics, as well as Chair and Professor, Family and Geriatric Medicine at the University of Louisville. He received his MB, BCh, BAO from University College, Dublin, Ireland, and completed his family medicine residency at Saginaw Cooperative Hospitals in affiliation with Michigan State University. He completed a fellowship at Duke University in Geriatric Medicine.

Dr. O'Brien is no stranger to publication as he has published more than 40 peer-reviewed journal articles and abstracts and has been a contributor to 12 textbook chapters dealing with issues related to aging and family medicine.

FROM THE EDITOR

by William Crump, MD
Madisonville, KY



Speak with one voice: Our Commonwealth needs more Family Doctors

The leadership of your Academy attended a 4-hour workshop recently to understand the workforce needs of Kentucky. Within the mission of the KAFP, our focus was on improving the health of our population while promoting family medicine as the foundation for healthcare in the commonwealth. The national perspective was brought by Dr. Amy McGaha, with the AAFP Medical Education Department. The scope and workplan of the Kentucky Institute of Medicine to address this issue was presented by the Director, Dr. Emery Wilson, and his staff. The KMA, through funding made available by the Kentucky Rural Scholarship Foundation, Inc., has tasked the KIOM to report their findings by August, and this meeting was the initiation of a process to ensure that the voice of the KAFP is heard.

Referring to a recent report (1), an expert at a recent Association of American Medical Colleges (AAMC) workforce meeting made two points. First, there is currently a physician shortage, and second, it's here to stay. He suggested both that medical schools produce more doctors and that residencies create more positions. The AAFP recently sponsored a study done by the University of Utah School of Medicine that used current assumptions to project the numbers of family physicians needed in each state by 2020. By this method, Kentucky will need 555 new family doctors within the next 14 years. That's roughly 40 FM resident graduates per year, if they all stayed in Kentucky. Currently, about 64% of our resident grads stay here, and that percentage is much lower for physicians who are not native Kentuckians.

We currently provide 36-39 first-year positions in the match, so that means that we will need to: 1) add more resident slots, and 2) do a better job of filling these with Kentuckians. The larger problem is at the medical school level. In a good year, our 2 allopathic schools match 25 graduates into Family Medicine, with about half staying in Kentucky. So although ultimately more resident slots are needed, the more urgent problem is filling the slots we have with physicians likely to stay in Kentucky. There is also an important maldistribution of physicians in Kentucky, with 61% of our counties (73 of the 120) considered underserved now. So we need to admit persons to medical school who are more likely to choose small town practice.

So where do we start? Dr. McGaha recommends a 3-pronged approach. First, recruit the right students into family medicine. Second, train them in residencies that prepare them for Kentucky practice, with more prepared for rural practice. And third, work to enhance the practice environment to retain these physicians in practice in Kentucky.

RECRUITMENT

Many studies have shown that facilitating medical school entry for college students from small towns with an interest in service as a strong motivating factor will result in more family physicians in small towns in the native state (2). The issue in Kentucky is the very small applicant pool, with perhaps only 2 in-state applicants for each medical school position, with the vast majority of those being students from metropolitan areas. So, nothing of substance can change without getting more successful applicants from small towns. Despite education reform, small town high schools do not routinely prepare students for success in premedical curricula. Most studies have shown that although small town students start out behind those from metro areas in almost every standardized measure of academic performance, this difference disappears during medical school.

So how do we get these targeted students the boost they need to get into medical school and be successful by the time they take Step One (basic science) Board exams? Dr. McGaha summarized the Alabama Rural Medical Scholars program that provides a fifth undergraduate or post-baccalaureate year for selected students, and they have placed 50% of their graduates into rural practice. We have the 3-year, summers-only Trover Rural Scholar premedical program partially modeled after the Alabama program that has also been successful (3,4). Such programs will need to be replicated across our state for the recruitment issue to be addressed.

Another important issue is medical student indebtedness. As I discussed in a previous editorial, there is mounting evidence that the very students who would likely end up in Family Medicine are not choosing medical school because of the potential debt (5,6). To these students who have grown up largely in families of very modest means, incurring a debt of well over $100,000 is daunting. To address this issue, a much larger statewide program of loan repayment for practicing in an underserved area will be required.

TRAINING

Once the right students succeed in the basic science years of medical school, they must enter a clinical environment that fosters their natural tendencies. This means longer FM clerkships, and as many rural experiences for as long as possible. A regional rural campus is the ultimate of this strategy, with the entire last 2 years spent in a supportive environment. The ULSOM Trover Campus has been active now for 9 years, based in Madisonville, a town of 20,000 (3,4). To date about 50% of the grads have chosen family medicine, and 78% of rural students who have finished their residencies, regardless of specialty choice, have chosen small town practice. For a workforce plan to succeed, this model must be replicated across the state.

Once medical students graduate with their interest in FM intact, they must have residencies that build their confidence to practice where they're needed. Although less strong as a predictor than growing up in a small town, residency training in rural areas is associated with ultimate practice in an underserved location. But we will also need replacement of retiring family docs in metro areas, so all our residencies need to be strong and well-funded.

RETENTION

Once we "get 'em there", we've got to "keep 'em there." Much of the daily activities of your AAFP and KAFP is to do just this. Successes are few and far between, but the last few months have brought cause for optimism. Nationally, the relative value of our most common office visits has been increased by 9-13%. Kentucky Medicaid has had the first increase in reimbursement for the common codes in almost 15 years, and the percentage increase is dramatic. The recent interest from IBM and other major employers in an efficient health system managed by generalists may just usher in the next golden era for Family Medicine.

THE BOTTOM LINE

The KAFP Task Force will be meeting and working throughout the summer, and will bring recommendations back to the KAFP Board of Directors. Some of these recommendations, if endorsed, include regular action steps with the legislature to effect change. KAFP leadership will be in communication with members. It will be incumbent on us, with our personal contacts, to make the changes needed.

So, the next legislative session is likely to be busy with issues of physician workforce. We must speak with one voice. Unlike some disciplines that practice professional contraception, family docs have never been afraid of adding another of this special breed in their community – as long as we have enough to keep us busy. Certainly, all of our rural areas can accommodate more family docs. So, if a legislator (or anyone else) asks you: "So, do we need more doctors like you in Kentucky?" we hope you can respond with a resounding "Yes, especially in our rural areas."

Comments appreciated.

Bill Crump, M.D.
Madisonville, KY

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The Kentucky Ambulatory Network and Quality Improvement in Practice

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A day in the life

John Doe, MD arrived at his office at 8:30 AM after finishing rounds on his three patients in the hospital; ahead of schedule for once, since his first patient was scheduled for 9:00 AM. He spent a few minutes next to his waste basket sorting through his pile of mail. He threw away his latest Confidential Clinical Report Card from an insurer (payer) after scanning it to confirm that most of the things it "informed" or "reminded" him about regarding clinical guidelines and his patients were either completely in error or not pertinent, considering his patients' real issues not captured by the billing claims data. He did not notice the new statement in this Clinical Report Card about the payer's new "performance rewards program".

Dr. Doe logged onto his electronic medical record system. He rapidly closed the six new 'primary care alert' messages about new findings in the medical literature that had been posted to his opening page from his medication prescribing program. That day, Dr. Doe saw 30 patients in the office while his two partners had similar and typical days. He managed two or more problems for all but seven of the patients; for each of five patients he managed at least four problems, and he provided preventive services to one-fourth of the patients that day. During the lunch hour Dr. Doe handled messages from eight patients, vetted some rejected Medicare reimbursement claims with his office manager, and looked over the new requirements for Maintenance of Certification from the American Board of Family Medicine (ABFM) that he had been ignoring for too long. After checking in on his hospitalized patients, Dr. Doe got home around 6:30 PM.

The 'quality movement' in primary care

It seems safe to presume that most family physicians want to provide high-quality healthcare. But most also feel the burden of competing demands and missed opportunities for delivering the best possible medical and preventive services to their patients. Indeed, following all current guidelines for prevention and chronic disease management may be impossible under prevailing practice models.[1,2] Physicians like Dr. Doe find it extremely difficult to find the time or the resources to systematically improve quality and demonstrate it to those who might scrutinize their practices. Hard work and hectic days are inherent to comprehensive primary care practice in the U.S.; so why is there now a 'quality movement'?

Quality improvement (QI) programs in healthcare are not new, but a widespread quality movement has been catalyzed by the Institute of Medicine (IOM) 2001 Quality Chasm Report, as well as the earlier IOM report on medical errors and patient safety.[3,4] These highly publicized reports, along with omnipresent concerns over cost, access and satisfaction with health care, have pushed quality to center stage as employers, public payers, private payers, and individual patients try to get the most for their money. Professional credentialing bodies have added their muscle to the demands for measurable quality.[5,6] While hospitals felt the impacts of this latest quality movement first, attention is rapidly turning to the ambulatory care settings where most people get most of their medical care, most of the time.[7]

These demands for demonstrated quality in ambulatory care are being translated into prescribed measures of quality using indicators that physicians are being either encouraged or required to embrace. At present, encouragement comes mainly in the form of Pay for Performance (P4P) programs being rolled out by Medicare and by private insurers (payers).[8-10] The degree to which reimbursement levels become tied to quality measures in the future will determine whether these encouragements become de facto requirements. Physicians are already faced with requirements from their specialty boards to measure and improve quality, and some payers require quality indicator reporting for all physicians on their preferred provider lists.[5,9]

Many physicians and professional organizations, including the American Academy of Family Physicians, embrace QI as a good thing.[11-13] However, the paucity of methods for improving quality and measuring it in meaningful ways in ambulatory practices has caused a new sort of quality chasm between QI theory and QI practice. Like Dr. Doe, many primary care physicians do not have adequate resources or preparation to engage in QI programs; nor are they ready to produce reports of quality indicators to satisfy payers or medical specialty boards. Methods to accomplish these things that are reasonable and effective in large integrated medical groups often translate poorly into small private practice environments. Physicians in small practices who expected electronic medical records

(EMRs) to make QI and quality indicator reporting easy for them have been largely disappointed. Primary care EMRs are rare (if they exist) that efficiently link updated evidence and guidelines to individual or aggregated patient care data, provide point of care decision support, facilitate self-audit, provide accurate alerts or reminders and facilitate patients' involvement in their own care.

What the Kentucky Ambulatory Network is doing

Most primary care physicians practice in small private groups,[14] and most small medical groups lack strategies and methods to keep them from being left behind as the quality movement rolls on.[15] The Kentucky Ambulatory Network (KAN) has embraced developing QI strategies and methods for small practices as central to its mission to enhance the ability of office-based clinicians to deliver high-quality primary care to their patients through collaborative and translational research. KAN is a practice-based research network with over 200 community-based clinician members plus over 75 members from the University of Kentucky and the University of Louisville. The Kentucky Academy of Family Physicians (KAFP) supports the QI-related work of KAN though the KAFP foundation.

In 2005, KAN began concentrating on QI strategies in practice by conducting a faxed survey of a random sample of Kentucky primary care physicians to gauge their interest in tailored change facilitation for systems-oriented quality improvement, in anticipation of P4P incentives and maintenance of board certification requirements. Tailored practice change facilitation (TPCF) would consist of centralized services tailored to specific objectives and capacities of each practice and would be adjusted according to each practice's achievements and/or setbacks. Best practices for achieving QI goals would be shared among participating practices. The survey asked physicians to indicate general interest in such an endeavor as well as specific clinical areas of interest. Among 86 respondents, 69 indicated interest in collaborative QI work using TPCF. The most common areas of interest were diabetes (68 respondents), cardiovascular disease (66 respondents), and substance abuse or smoking (43 respondents).

EQUIP-4-PCPs

In response to this survey, KAN developed a program in collaboration with the KAFP to pilot-test the TPCF concept for QI in small private practices. The program was dubbed Enabling Quality Improvement in Practice for Primary Care Physicians (EQUIP-4-PCPs). EQUIP-4-PCPs is designed to adapt proven methods for QI in healthcare to the problems faced by small practices. It relies on a sustainable model in which centralized (but limited) resources external to the practice are deployed to help each practice set QI goals and achieve them in gradual, step-wise fashion; keeping objectives as realistic as possible. The basic components of the prototype EQUIP-4-PCPs service are:

1) People: KAN personnel trained to serve as Change Facilitators visit each practice at least twice, then interact via telephone and the internet with practice personnel. A Physician Champion at each practice leads the QI effort, and a staff member at each practice manages the project (QI Coordinator).
2) Preparation: A brief web-based QI training program is provided for each practice's QI Coordinator. The KAN Change Facilitator visits the practice, orients the Physician Champion and the QI Coordinator to the EQUIP program and helps them set targets for QI (such as improving the proportions of diabetic patients that get foot exams or a urine microalbumin test). A focused self-audit of medical records against selected benchmarks for the QI target(s) is facilitated by the Change Facilitator, who also guides the practice through a self assessment of their readiness for change. The self-audit helps Physician Champions and their QI Coordinators determine their QI goals and set tailored, realistic goals for their practices. The KAN change facilitator performs a larger audit of medical records to provide the practice with more baseline data related to their QI target.
3) Support and follow-up: The Change Facilitator stays in touch with the practice via telephone and email to coach and offer advice to the QI Coordinator at each practice. A library of selected tools and guidelines for preventive services and chronic disease management, chosen for practical use in primary care, is provided in a manual and on a website. The website also has other information and web-links dedicated to helping Kentucky PCPs pursue their QI goals. In the future the website will include a secure area for the exchange of ideas among PCPs to facilitate a best-practices approach to QI. After a set period of time, a repeat audit of medical records is performed by the Change Facilitator and compared with the baseline audit.
4) Immediate rewards: Participants in the EQUIP-4-PCPs pilot project will receive up to 10 hours of free CME credit. They can use the data that they gather during their self audits to fulfill an ABFM maintenance of certification requirement.

The EQUIP-4-PCPs pilot focused on the management of type 2 diabetes, because of its popularity as an area for QI in the initial survey. Nine small Kentucky primary care practices are participating in this pilot phase, which will be completed by the summer of 2007. These PCPs and their staffs are being encouraged to share ideas and successful strategies for QI in practice and obtaining maximum quality-based reimbursement. They are also

providing feedback on the most (and least) useful components of the program and will be asked for suggestions for its improvement.

PEAs

KAN recently explored an alternative model of external facilitation of QI based on having a trained graduate student spend one to two days per week at a practice to help the practice identify and pursue QI goals. These facilitators were provided at no charge to participating practices. This service adapted the Practice Enhancement Assistant (PEA) concept developed by J. Mold, MD and others for small primary care practices in Oklahoma.[16] PEAs are trained to facilitate planning, implementation and evaluation of QI and research projects. In Oklahoma, PEAs are paid employees of the research network, with funding from organizations interested in improving the cost-effectiveness of primary care. In our model, PEAs were graduate students in public health who spent 6 months working as PEAs for no salary, as a practicum experience. Our senior Research RN also served as a PEA in this project in order to maximize her validity as a trainer for the student PEAs

In 2005, KAN first piloted this PEA concept in four KAN member practices. The PEAs were trained and supported by University of Kentucky (UK) faculty and the KAN Research RN. By design, they all pursued the goal of improving breast cancer screening at each practice. Each PEA was assigned to one practice, visiting once or twice per week on a predictable schedule. Each PEA spent her time at her assigned practice in different ways, according to the practice's needs, but all pursued the goal of assisting the practice with their QI objectives related to breast cancer screening. The PEAs met regularly together with faculty and KAN staff at UK. Typical PEA activities included meeting with the physicians and their support staff about practice patterns and barriers to breast cancer screening, observing work-flow patterns, analyzing information management, and helping design systems-based improvements such as reminders or mammography referral forms. Each PEA also performed standardized medical record audits to provide the practice with data on their rates of appropriate breast cancer screening. Although the pilot PEA project focused on breast cancer screening, it could be easily adapted to multiple areas of clinical interests. The results of this pilot project were mixed. Its main strength was also its main weakness: graduate students represent an excellent resource that could be sustainable, but their preparation to serve as PEAs is expensive and medical practices probably need more than five or six months of PEA service to bring about lasting positive changes.

KAN's current goals

KAN aims to create a sustainable infrastructure that will help PCPs improve measurable quality in their practices, and promote quality improvement (QI) research. The results of the pilot work are being used to improve KAN's models for facilitation of QI in practice. KAN's leaders envision the network earning support from various sources that are interested in improving quality and/or advancing knowledge about QI through research. Grant applications to the NIH from KAN for QI research and the translation of research into practice are under review, and explorations for other sources of funding, including a fee-based service are ongoing.

If you are interested in learning more about KAN and/or the EQUIP-4-PCPs program, please contact any of the authors of this paper at (859) 323-4889, or send an email message to Mary Barron at mabarr2@email.uky.edu.

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56th Annual Scientific

The Kentucky Academy of Family Physicians honored physician members who graduated from medical school 50 years ago at the 56th Annual Scientific Assembly Banquet. Samuel Matheny, M.D., Master of Ceremonies, presented awards to the 1957 Medical School Graduates.

A special award was given to Robert L. Nold, M.D. honoring him as the KAFP Volunteer of the Year Award.

Samuel Matheny, M.D. presented awards to James Carter, M.D., Tompkinsville, KY and Hoover Perry, M.D, Whitley City, KY.

Robert L. Nold, M.D. and his wife Arlene

The following 1957 Medical School Graduates were not able to attend ceremony:
Joseph Braun, M.D., Jensen Beach, FL; Ferris Larsen, M.D., Madisonville, KY; Robert Longshore, M.D., Lakeside Park, KY; James Monin, M.D., Jamestown, KY; Gerald Sasser, M.D., Louisville, KY; Henry Spaulding, M.D., Bardstown, KY; William Ward, M.D., Owensboro, KY; Mary Ann Woodring, M.D., Pineville, KY and Nandalah Yepuri, M.D., Louisville, KY.

c Assembly Highlights

CITIZEN DOCTOR OF THE YEAR

The Kentucky Academy of Family Physicians honored one of its finest family physicians at a special dinner on May 21, 2007 at the Marriott-East in Louisville, KY. Dr. Nancy Swikert, of Florence, KY was the 2007 recipient of the "Citizen Doctor of the Year".

This award originated to recognize a family physician of strong moral values whose deeds and actions exemplify the characteristic of service before self, and that magnify the principle of the specialty of family medicine's focus on compassion and caring for the well-being of those we serve. Past recipients of this award have pioneered advances in medical education, research, patient care, and community service for the Commonwealth of Kentucky.

The Kentucky Academy of Family Physicians 2007 Citizen Doctor of the Year Nancy Swikert, MD from Florence, KY

Dr. Swikert has been an active member of the KAFP since graduating from residency at the University of Louisville in 1980 and has served on every committee of the KAFP and as President from 1996-1997. She currently serves as co-Chair of the KAFP's Advocacy Committee and is the 'founding mother' of the Kentucky Academy of Family Physician's Foundation serving as President. The KAFP Foundation under her leadership has funded over $120,000 in practice-based research grants, and travel and educational stipends to medical students and resident family physicians in Kentucky for the past three years.

Larry Fields, MD, AAFP Board Chair, presented Nancy Swikert, MD with a plaque honoring her as the 2007 Citizen Doctor of the Year.

In addition to her devotion to family medicine, she and her family physician husband Don, have served on numerous committees with the Kentucky Medical Association and the Southern Medical Association.

Dr. Larry Fields, Chair of the Board of the American Academy of Family Physicians was on hand to present the award. Dr. Fields added to her accomplishment his special gratitude for the hard work she had put forth on his successful campaign for AAFP office. He stated, "Nancy is a loyal friend, mother, wife and dedicated family physician who puts the interests of her patients first. She has truly earned the title of "Citizen Doc of the Year".

Family Practice to Palliative Care: A Journey

Ann L. Colbert, MD
Morehead, KY

Ann Colbert, M.D. is a family physician in Morehead, Kentucky, practicing Palliative Care for St. Claire Regional Medical Center. Dr. Colbert received her doctorate from Michigan State University and completed her residency at the University of Rochester in New York. She currently serves as Medical Director for the St. Claire Palliative Care Service.

When I first considered a shift in my practice to Palliative Medicine, I had several motives. I thought there would be less call. After 17 years of obstetrics and hospital call as a Family Physician in Olive Hill, Kentucky, I wanted to be home more often with my daughter. I liked the logic and reasoning that went into making medically complex decisions- both from the physician's and the patient's perspectives. Finally, I thought I could do it: I thought I could handle the emotional aspects, including the depressing factor of patients dying and not being able to "cure" them.

Now, five year later, I have discovered other aspects of practicing Palliative Care that have dramatically changed my perspective on health care.

Palliative Care is for patients with a life-threatening or debilitating illness. In my practice, I have nearly equal numbers of chronically ill home-bound, non-cancer patients and oncology patients. Palliative Care, in contrast to hospice, can be provided at any time during an illness, not just in the last six months of life.

Palliative Care is delivered by an interdisciplinary team including nurses, doctors, social workers, chaplains, therapists, dieticians, and others who identify and address the physical, psychological, spiritual, and practical burdens of illness. Thomas Moore, a popular writer and theologian, encapsulated the mission philosophy fairly well with his quote; "A major difference between care and cure is that cure implies the end of trouble but care has a sense of ongoing attention."

Hospice and Palliative Care intersect at many levels but patients in Palliative Care are able to choose additional aggressive treatments whether it be chemotherapy, radiation or hospitalization. There is no Medicare "Package Benefit" for palliative care as there is for Hospice patients. The only reimbursement for the "team's" effort is the charge for the physician or nurse practitioner visits.

In 2002, I was accepted to the University of Wales, United Kingdom, in a post- graduate degree program in Palliative Medicine and had the privilege of exposure to the superb end-of-life care in England and Wales. This course of study prepared me for board certification in Hospice and Palliative Medicine and I have focused on that specialty since 2003. Recently, ten medical specialties, including the American Board of Family Medicine, have accepted certification in Hospice and Palliative Medicine as an accredited specialty.

My impression is that Palliative Care will not be around forever as a specialty because doctors will get better at taking care of the incurable patients. Two years in a row I have attended a Supportive Oncology Conference that educates oncologists to do what Palliative Care physicians do. This approach to non-fractionation of care will mean patients reap the benefits of Palliative Care earlier in their disease course.

We started St. Claire Palliative Care at St. Claire Regional Medical Center in Morehead in 2003 with a designated team of four: an experienced hospice RN, a social worker, nurse aide/receptionist and myself. We are employees of St. Claire Regional and our budget, mostly salaries and benefits, is about $300,000 per year. I work 24 – 30 hours per week and we all split our time between hospice and palliative care. Much of our focus early on was educating the medical and non -medical community about Palliative Care, specifically pain and symptom management, advance directives, prognostication and communication.

I see patients referred by their physician in several settings: as a consultant or occasionally attending physician at the hospital; at our office for ambulatory patients; at the chemotherapy or radiation center; at the local nursing home; and at home. We try not to burden patients further. For example, it's easier for me to see a patient at home than for them to come to me in an ambulance, easier to fax an opioid prescription to their pharmacy than require a visit to pick it up. We call patients at least every other week to address problems, answer questions the patients and families may have and adjust medicines. Most of our patients have been in and out of the hospital so many times their goal is to stay home. We use all our resources to accomplish that. These range from commonly used home IV or subcutaneous infusions and wound debridements to rarely performed home paracentesis for recurrent ascites or tracheotomy change on a ventilator dependent ALS patient.

RURAL PALLIATIVE CARE

Palliative Care in a rural setting is different from an urban setting because of the distance between patients, and between patients and the hospital. I think patients in rural areas want to stay home or return home sooner because of

the power and beauty of their land. I go to houses where poverty leaks through every crack but step outside and the scenery is breathtaking. Rural families and health providers who live here understand the profound nurturing of nature.

The financial realities of rural Palliative Care are discouraging and a hospital has to embrace the cost savings of the program, such as shorter length of stays in the hospital, to support it. The average Medicare reimbursement for a home visit is around $100 but travel time to some of our patients is 30-45 minutes. I try to group visits to more distant counties every 3-4 weeks but we are sometimes unable to visit patients as often as needed. We have used telemedicine in the past, but this technology doesn't lend itself to detailed discussions about end of life care.

Another difference between a rural and urban Palliative Care Practice is that with the smaller hospital in Morehead, most of my patients are outpatients. At most, I consult on one or two new inpatients a week but many weeks we have three to five new outpatient referrals. There is, though, the same need for our service for both hospitalized and home-residing patients to coordinate care to prevent lengthy hospitalizations, crisis ER visits and unnecessary admissions.

Someone once said, "Often we gain the greatest insights on how to live from those closest to death." Here are the unexpected insights that I have learned as a Family Doctor practicing Palliative Medicine.

First, a transdisciplinary or interdisciplinary team is the ideal approach to treating patients. Physicians and patients can benefit from the added expertise of a team and the stress relief of unloading the burden of sole responsibility for patients from the doctor. This is never as apparent as in a conference to discuss a patient's resuscitation wishes where each member of the team can contribute to clarify and discern the family and patient's wishes and concerns.

Second, seeing patients outside of a busy and hectic office promotes good care. I'm lucky that our office, because of financial constraints, is simple, small and intimate. Because of this or possibly the nature of our referrals, people talk about what's important to them. We ask patients and they tell us their goals for the rest of their lives. This interview time should correlate proportionally with the seriousness of the illness. That is why our visits are rarely less than 40 minutes and why I mostly bill using the time codes.

This depth of discussion promotes patients' expression of their choices. Satirist Art Buchwald, who recently died after deciding to discontinue dialysis the year before, wrote about his decision. "When you make your choice, then a lot of the stress is gone. Everything is great because you accept that you are the one who made the choice." I found that with this approach, a lot of the stress is gone for the doctor as well as a lot of the anger and frustration. The delineation of needs and associated care plan evolves from collaboration and genuine engagement. This level of interaction has allowed me to feel comfortable, at times, writing letters to patients expressing admiration, sadness or apologies.

Almost all of my patients chronicle their medical journey for me for the last-ever telling. I am invited and allowed to see how the story ends. Almost always, their courage and acceptance are astounding and their behavior is more admirable than at any other time in their life. I would encourage family doctors to stay involved during that last chapter. Learn how to prescribe opioids to relieve the changing pain of oncology patients, devise a plan in your practice that allows close phone follow-up using a team approach, learn how to give an accurate prognosis, work out ways to do home visits and, especially, listen to patients' goals for their remaining days.

For more specific information, I recommend two organizations and their web sites: Center to Advance Palliative Care, www.capc.org ; and American Academy of Hospice and Palliative Medicine, www.abhpm.org. The CAPC site is genuinely dedicated to helping doctors and hospitals start providing palliative care, at whatever level possible.

KAFP Member Appointed as AAFP New Physician Representative to the AMA

Michael King, MD, MPH, Lexington, KY won appointment as the AAFP's Delegate to the American Medical Association Young Physicians Section at the AAFP's National Conference for Special Consistency held at Kansas City, MO on May 5, 2007. As the New Physician Delegate, Dr. King will be working on projects focused on enhancing young physician practice of medicine, including the transition into practice; facilitating the participation of young physicians in policy development and other activities of the AMA and the Academy; and promoting young physician leadership throughout organized medicine.

Dr. King is currently on faculty at the University of Kentucky and recently completed his Master in Public Health.

Quiz Bowl: KAFP's Residents have the Right Answers

Q: When does giving a correct diagnosis generate cheers and shouts from fans and coaches?
A: When you're at the KAFP Resident Quiz Bowl!

Cheering squads and coaches spontaneously rallied behind their teams on Friday, April 20, 2007 at the Second Annual KAFP Resident Quiz Bowl. The Bowl, created to further competition and excellence among residents, took on a new energy with the addition of these unexpected supporters.

Participation in the Quiz was open to KAFP Family Medicine Residency Programs. Each team consists of two residents. Teams were given a toss-up question, with five seconds allowed to signal an answer. If the answering team responded correctly, a bonus question was given. While the toss-up questions all pertain to medicine and family practice, bonus questions were drawn from a variety of sources, including government and current events.

This year's Quiz Show Moderator was Bill Goodman from Kentucky Educational Television. Goodman is a renowned moderator and broadcast journalist and has recently gained further recognition for his series of interviews on KET with candidates running in the May 22 Kentucky primary.

Dr. Don Swikert served as Director, overseeing the event. Judges this year were Dr. Drema Hunt from Ashland, Dr. Liza Levy from Paris, and Paul Sanders from Lexington.

In addition, Dr. Levy was a special Honor Guest of the Quiz Bowl. A long-time aficionado of all types of quizzes and puzzles, she is a recent national winner of Will Short's National Public Radio's weekly puzzler. Will Short is the puzzle master on NPR's Weekend Edition Sunday and director of the U.S. Puzzle Team. He also is the crossword puzzle editor for The New York Times. Dr. Levy's success in the NPR puzzle places her among a select group of individuals who have solved the NPR puzzlers.

The KAFP's Quiz Bowl included the following competitors: UK-East Kentucky-– Minni Malholtra, MD, PGY-2 and Rangaraj Gopalraj, MD, PGY-2; Glasgow – Ryan Flamion, MD, PGY-2 and Josh Benge, MD, PGY-1; UK-St. Claire – Denis Aliker, MD, PGY-2 and Tetyana Tackett, MD, PGY-2; St. Elizabeth – Jason Castle, MD, PGY-2 and Martha Knighton, MD, PGY-2; Trover – Mark Roback, DO, PGY-2 and Hope Henson, MD, PGY-2; UK=Lexington – Jennifer Fletcher, MD, PGY-3 and Maria Castro, MD, PGY-3; and UofL – Yasier Basheer, MD, PGY-3 and Thomas Stratton, MD, PGY-1.

At the 'closing bell' it was 1st place University of Louisville, 2nd place University of Kentucky, and 3rd place, Glasgow. There was a run-off for 3rd place between Glasgow and St. Claire.

Dr. Nancy Swikert, President of the KAFP Foundation presented checks of $3,000, $2,000 and $1,000 to the respective 1st, 2nd, and 3rd place teams.

Dr. Paul Dassow from The University of Kentucky has agreed to be the 2008 Quiz Bowl Director and Bill Goodman has been invited back as Moderator. As for the cheering fans, they seem certain to return in even greater force.

Dr. Nancy Swikert presented the First Place Team from University of Louisville, Yasier Basheer, MD/PGY-3 and Thomas Stratton, MD/PGY-1, with a plaque and a check for $3,000

Dr. Nancy Swikert presented the Second Place Team from University of Kentucky, Jennifer Fletcher, MD/PGY-3, Maria Castro, MD/PGY-3 and Paul Dassow, MD/UK Residency Director, with a check for $2,000

The Kentucky Academy of Family Physician's Second Annual Resident Quiz Bowl participants.

Dr. Nancy Swikert presented the Third Place Team from Glasgow, Ryan Flamion, MD/PGY-2 and Josh Benge, MD/PGY-1, with a check for $1,000.

The Sentinel Physician: Identifying Drug Diversion in Primary Care

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John M. Bennett, MD, MPH
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In 2005, Kentucky saw a 16 percent rise in drug related criminal activity.[1] The rural nature of the state decreases the effectiveness of law enforcement in preventing the growing of marijuana, construction of methamphetamine laboratories or the illicit sale of prescription medications among the population. Controlled or scheduled prescription medications have become the new "legal tender" in the illicit drug trade, with high value associated with relatively small quantities; a single pill of OxyContin® may be worth upwards of 80 dollars.[2] The abuse of prescription medications is a growing problem in Kentucky. Kentucky has led the nation in misuse of controlled prescription medications for the last three years that data have been reported (2003-2005).[3] During this same time period, patients in Kentucky received 7.7 million prescriptions per year for controlled prescription medication. The number of people nationwide who abuse prescription medications is reported to be between two and four percent per year for the entire United States,[4] although up to 20 percent of patients receiving narcotic therapy for chronic non-malignant pain have reported addiction as a complication of therapy.[5]

Kentucky physicians, through the capabilities of the Kentucky All Scheduled Prescription Electronic Record (KASPER), have become more aware of the role that physicians/practitioners play as a source for licit drugs being diverted to the illicit market. KASPER is a reporting system designed to be a source of information for practitioners and pharmacists as well as an investigative tool for law enforcement. KASPER reports show all controlled prescriptions, the date, amount, prescriber, and pharmacy where the prescription was filled for a given patient.

Nationally an emerging pattern of primary care physicians treating chronic pain conditions has been recognized.[6-9] This pattern is not new to Kentucky, with only 57 physicians specializing in chronic pain treatment and 2590 adult primary care physicians for the population of 4.1 million people. Thus the lion's share of treating chronic pain falls to primary care practitioners, particularly in rural environments. [10, 11] Addressing the valid use of chronic controlled medications is not the purpose of this article, but rather to highlight the characteristics associated with those patients who plan to misuse or divert the medications. In addition this paper makes recommendations to the practitioner that ensures that controlled medications continue to be available for legitimate medical purposes while preventing their diversion into illicit markets.

Drug misuse is defined as using illegal drugs, or using prescription medications in a manner not recommended by a physician. Nonmedical use is defined as use of prescription-type drugs not prescribed for the individual by a physician or used only for the experience or feeling they cause.[12] Diversion of prescription medications is the resale or use of legally obtained medications for illicit or non-medical use. Understanding patient characteristics that are associated with controlled prescription drug misuse, nonmedical use, and diversion can assist the practitioner in mitigating the diversion of medications.

Primary care physicians are responsive to the needs of society and are impacted by these requests in their daily clinical activity, especially in addressing the patient with chronic medical conditions that require controlled medication prescriptions. In order to protect the ability of the practitioner to treat all of their patients, systems ideally should be designed and in place for each practice that minimizes the risk of diversion of these medications.

Numerous studies cite the source for controlled medications in the illicit market as being from a family member or a single physician.[3, 12, 13] These two sources account for almost 75 percent of the controlled medications diverted into the illicit market. The source for controlled prescription drug misuse is usually a family member, with persons aged 12 or older who used pain relievers nonmedically in the past 12 months reporting that 59.8 percent obtained them "from a friend or relative for free."[14] Another 16.8 percent reported that they were prescribed the drug from one doctor, 4.3 percent reported pain relievers came from a drug dealer or other stranger, and only 0.8 percent reported buying the drugs on the Internet.[15,16,17]

Besides being a potential source for prescriptions that are diverted to the illicit market, what is the role of the primary care practitioner? Legally and ethically, healthcare professionals share in the responsibility not only to uphold the law but to protect society from the abuse of these medications.[18] Awareness of the potential for diversion is the first step in addressing this issue.

Patient traits or "modus operandi" of drug abusers include unusual behavior in the waiting room with acting out, assertive or aggressive interactions with staff, or appearance that may be different than local norms (they may be over-dressed or appear slovenly).[19, 20] These patients may be new to the practitioner, but may be known patients who exaggerate a casual friendship or acquaintance with the provider. Prior knowledge of controlled substances does not signify abuse, but a depth of knowledge for various controlled medications beyond the norm is often seen. Patients may request a particular drug. They may report vague components of their medical history, or a history or symptoms that are out of proportion to clinical findings, e.g. 10 out of 10 on a pain scale with no physical findings.

Patients who misuse prescription drugs may be reluctant or unwilling to provide information about prior treatments or treating physicians. They may report no regular source of care or health insurance. These patients may show a lack of interest in alternative therapies (physical therapy, massage therapy) or further work-up of an underlying clinical problem. In addition, those who are suspected of misuse may fail to keep appointments, consultations, or diagnostic procedures that have been scheduled for them.

Other characteristics that have been associated with the drug-seeking patient include: unreasonable demands such as wanting to be seen right away, making appointments towards the end of office hours, presenting or calling after hours, requesting controlled prescriptions, or professing to be just visiting or traveling through town, the "one hit wonders."

These patients may report a history of disease or symptoms that are out of proportion to physical findings or diagnoses and state that non-controlled medications are ineffective (often going against the medical judgment of the physician). The practitioner who has been caring for the patient's condition is often not currently

available to contact or retrieve records. Patients have a pattern of lost or stolen prescriptions that need to be acutely replaced (usually with only a few of the pills having been taken). Patients may apply undue pressure on the practitioner's sense of empathy or guilt toward their underlying condition or even threaten to report the physician to the licensing board if they do not treat their condition. Drug-seeking individuals may even use a child or elder person to be the patient so that they can access the controlled medication prescribed.

A particular type of drug-seeking patient is the "doctor shopper." These are patients who go from one doctor to another in hopes of obtaining controlled prescription medications.[21] Thus one patient may end up with multiple sources for prescriptions.

The response of the practitioner should be to perform a thorough history and physical, and document the results obtained. Practitioners should request photo identification (driver's license, passport with social security number) to be provided for the patient's record in the event that a controlled prescription is written. Providers should document the source of care prior to this visit, including hospitals, practitioners and pharmacies. Offices, staff and providers should confirm current demographics, such as address and phone number at each visit. Medications should be prescribed in limited quantities.

Practices to avoid include "taking the patient at their word," prescribing or dispensing medications just to get rid of the patient, prescribing controlled medications outside the usual scope of practice or in the absence of a formal practitioner-patient relationship.

Guidelines developed by the Kentucky Board of Medical Licensure to decrease diversion of controlled prescription medications and protect access to care for patients needing treatment with controlled medications include[22]:

1) Documentation of the history, physical and assessment of the patient's condition at each visit, along with documentation of prior therapeutic modalities,

2) Statement of a treatment plan with specific objectives that will be used to measure the effectiveness of the treatment,

3) Early referral for additional evaluation in order to achieve specific objectives,

4) Keeping accurate and complete medical records,

5) Ensuring that practice routines and procedures are in place to facilitate compliance with regulations and laws pertaining to controlled substances,

6) Documenting a diagnosis that is consistent with symptoms for each medication prescribed,

7) Establishing a system of caring for all patients who receive controlled prescription medications that could include regular KASPER reports, random urine drug screens and written controlled prescription medication contracts or agreements between the patient and the practitioner. Policies that prevent or reduce controlled prescriptions for chronic conditions in first-time patients can also be effective.

In summary, abuse of prescription medications is a growing problem in Kentucky and awareness of behavior patterns that may suggest patients' intent to divert legally obtained prescriptions for illicit purposes is important. The sentinel role of practitioners and their staff in identifying misuse and diversion is key to addressing this issue.

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Mark Your Calendar for Upcoming Meetings!

National Conference of Family Medicine Residents & Medical Students
August 1-4, 2007
Kansas City Convention Center • Kansas City, MO

Kentucky Medical Association Annual Meeting
September 24-26, 2007
Kentucky International Convention Center • Louisville, KY

Kentucky Academy of Family Physicians Board of Directors Meeting
September 26, 2007 • 3:00 pm to 5:00 pm Eastern Time
Hyatt Regency Hotel • Louisville, KY

AAFP Annual Scientific Assembly
October 3-7, 2007
McCormick Place • Chicago, IL

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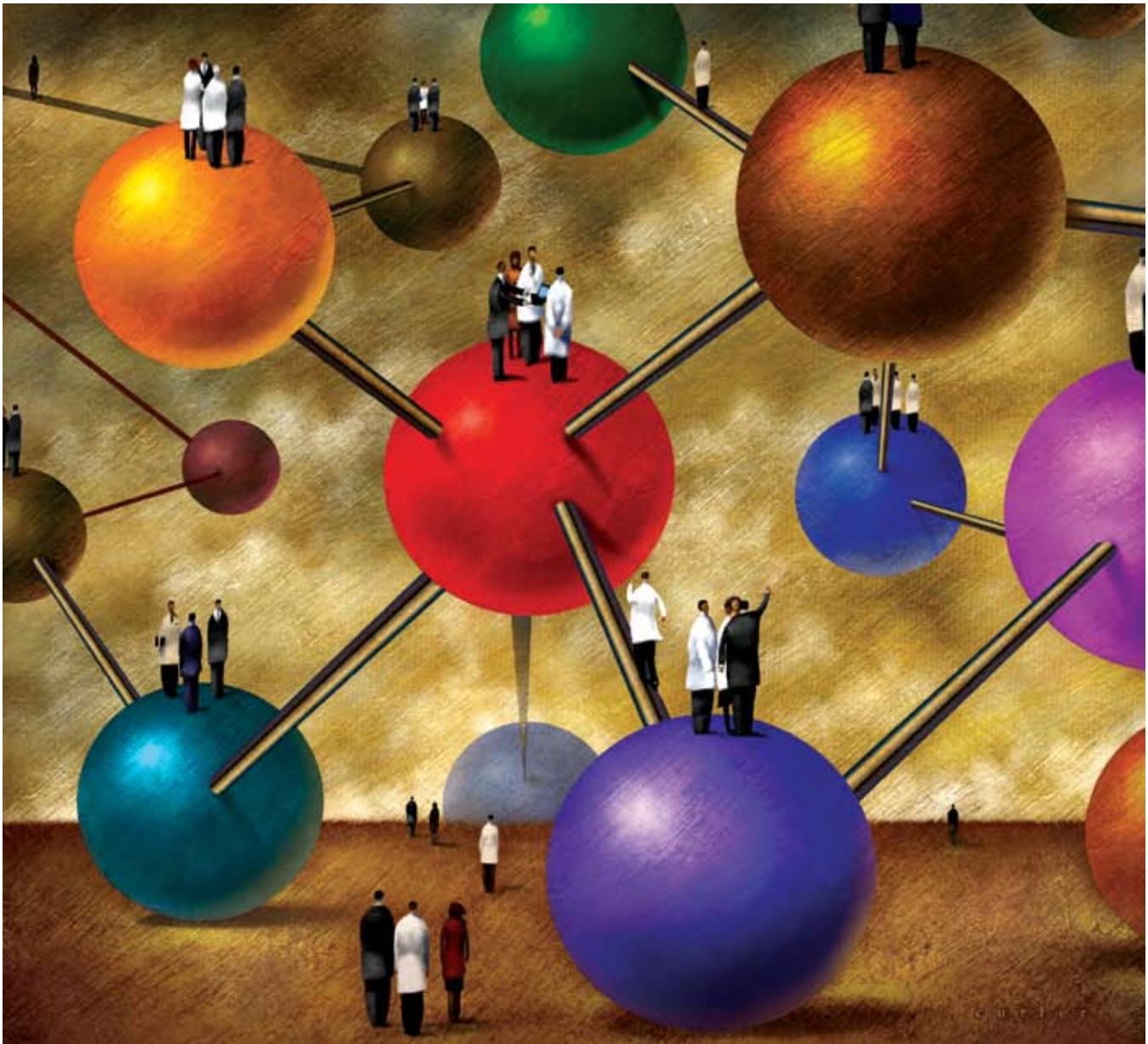

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