KAFP JOURNAL

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Winter Issue

The Official Publication of the Kentucky Academy of Family Physicans

Kentucky Academy of Family Physicians

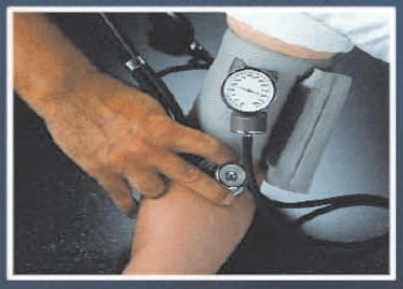
56th Annual Scientific Assembly

April 20-21, 2007

Pediatric Skin Disorders

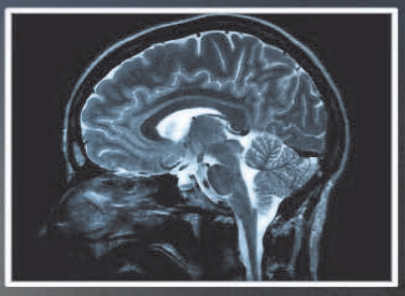
Kidney Disease

EHR Seminar



Brainstorm

SAMs Study Hall



Neurology

Tobacco Cessation

Preventing Cervical Cancer

Louisville Marriott East
Louisville, KY

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KAFP JOURNAL

The Kentucky Academy of Family Physicians

P.O. Box 1444
Ashland, KY 41105-1444
Phone: 1888-287-9339
Fax: 1-888-287-0662

Website: www.kafp.org

Email: gerry.stover@kafp.org
janice.hechesky@kafp.org

KAFP State Officers 2006-2007

FROM YOUR PRESIDENT

by Samuel Matheny, MD
Lexington, KY

Family Medicine and the German Farmers

My family farmed in the same Outer Bluegrass community for almost two hundred years. For the most part, they were fairly successful, in the sense of being able to raise a family, save some money, and pay the bills. Some of them, especially one uncle, were pretty stubborn when anyone tried to tell them that there might be better farming methods than the ones they were using. But my dad had a great deal of respect for the local county extension agent, and through his activity as a 4-H leader, we all developed changes in our farming practices as a result of the agent's knowledge and guidance. The other influence in our community was the influx of a group of German farmers who settled on marginal land in the Knobs, and introduced farming practices common in Europe but not widely practiced in the United States at that time, such as crop rotation, no-till farming, and terracing. In this case, the transfer of new information went from the farmers back to the College of Agriculture, and in turn, influenced the rest of the state.

This is a form of translational research, which in medical terms, can be defined as research from the laboratory to usable technology. It also can be defined as translating something which has been shown to be effective in humans, and putting it into practice. Kerr White has often said that family physicians are the ones positioned to explore some very important questions around illness: what are the circumstances when problems begin, what are the precipitating factors, predisposing factors, ones which influence people to seek health care, and the nature of the therapeutic environment? (1)

Green et. al. found in their updated study in 2001, that of every 1000 people in a given community, over 300 consider seeking health care and 113 visit a primary physician's office. Of these, only 21 visit a hospital outpatient clinic, 13 visit an emergency department, and less than one is hospitalized at an academic health center(2). Yet, the majority of our clinical research is based on that one patient in a thousand, who may be totally unrepresentative of the total population, and certainly is not typical of patients in earlier stages of disease and illness.

There has been an attempt to remedy this situation by the National Institute of Health's (NIH) Roadmap, which will hopefully address some of these issues, by changing the way research is done: breaking down research silos in the academic institutions and involving the community not only in studies, but encouraging the concept of bidirectionality. This concept, much as the German farmers did in Lincoln County, allows the testing of important observations and innovations in the community to undergo the rigors of scientific scrutiny and invigorate the research initiatives of the academic health center.

The development of practice-based research networks has been a major thrust of the AAFP. In this state the Kentucky Ambulatory Network (KAN), with the help of the KAFP, has made great strides in involving family physicians in this effort, and now over 200 clinicians are participants in research studies, investigating questions of interest to the practicing physician. Exciting new facets of research for KAN have been in exploring methodologies that improve quality, improve clinical outcomes, and reduce errors in practice: areas particularly important to practicing physicians faced with the prospects of pay for performance.

This year, both the University of Kentucky and the University of Louisville are applying for Clinical and Translational Science Awards (CTSA) from the NIH to facilitate this effort, and the outreach in the community is central to these endeavors. Networks such as KAN will be crucial to their successes, with strong participation by family doctors and their practices, working collaboratively with academic health centers in the design and implementation of projects, not simply providing the patients and settings for studies. These grants which support the translational research infrastructure are some of the largest grants ever applied for by the universities, and require a level of collaboration and planning that exceeds any former research activity, not only within the medical school, but across all health colleges. In the case of the University of Kentucky, this also includes the Colleges of Agriculture, Communications, and other entities. If these efforts are successful, there will be more

information forthcoming concerning CTSAs in the near future.

Performing research in the communities of practice is not without its share of difficulties and problems. Clinicians are rightfully concerned about anything that may adversely affect productivity in the practice setting or impact on workflow. Adequate time to devote to working on research activities has always been a major concern. And being able to share information across practices, dealing with confidentiality issues, and approval from institutional review boards will continue to be challenges to address.

However, the payoffs are enormous. We have the opportunity to direct the questions to those of importance to our patients and communities, address health disparities, and understand how to transform our practices to improve the quality of health care we give.

Like the German farmers, we have a lot to teach the universities. It will be important for all family physicians to consider these opportunities seriously, and become involved in this transformation.

References

1)White KL. Fundamental research at the primary care level. Lancet 2000; 355:1904-06.

2)Green LA et al. The ecology of medical care revisited. NEJM 2001; 344:2021-25.

Official Call for the 2007 KAFP Congress of Delegates

Notice is hereby given of the 56th Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held in Louisville, KY, April 20, 2007 at the Louisville Marriott East.

Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 47th Annual Meeting of the Congress of Delegates will be held in the Embassy Ballroom A & B, April 20, 2007 at 11:45am-1:45pm to receive and act upon reports of officers and committees, to elect officers and to transact any and all business that may be placed before Congress.

All Officers, AAFP Delegates/Alternate Delegates, Regional/District Directors are requested to register in advance. Please complete registration and fax to 1-888-287-0662. If you should have any questions please contact Janice Hechesky at 1-888-287-9339.

Call for Resolutions for 2007 KAFP Congress of Delegates

Please note the following deadlines for submission of Resolutions to be presented to the 2007 KAFP Congress of Delegates:

Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' kits is March 20, 2007. If a Resolution is not received by the KAFP office prior to March 20, 2007, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on April 20th, any Resolutions pertinent to the objectives of the KAFP. Resolutions so offered shall be presented to the Congress of Delegates without debate at that time. Resolutions presented from the floor of the Congress are to be provided in triplicate form, with one copy to the KAFP Speaker, one copy to the KAFP Executive Vice President and one copy retained by the presenter.

Tidbits on Resolution Writing

"Whereas" clauses explain the problem and/or situation the resolution is addressing; and "Resolved" clauses are action statements and/or the desired end result if this resolution is approved.

FROM THE EDITOR

by William Crump, MD
Madisonville, KY

What if Family Doctors were paid for tending the Medical Home?

As I pondered the topic for my editorial for this issue, 2 articles in JAMA a week apart caught my eye. The first was a Commentary promoting changes in the systems we work in (1) and the other was a news summary of the recent publication of an international physician summary done by the Commonwealth Fund (2). The latter noted that physicians in the U.S. lag far behind other industrialized countries in the use of electronic heath records (EHR) and arrangements for after-hours access by patients, excluding the Emergency Department (ED). Any time U.S. physicians are lumped together for ridicule, it both gets my interest and raises my ire (see Dr. Klein's letter to the editor in this issue). Usually, if I put the emotions aside, there's a kernel of truth in what the writer has to say.

Next some random comments to me from my mentors entered my head. I remember when I was in Steve Spann's department in Galveston, his comment in 1993: The enduring symbol of the physician is undoubtedly the stethoscope. In the next millennium, the primary care physician must be as facile with the computer, as managing information will be as important as hearing heart and lung sounds. And from Gayle Stephens, one of Family Medicine's founding fathers, in 1981: The mark of a family doctor is that we do not have the privilege of ignoring any complaint brought to us by our patients, whether it be medical, social, or administrative. And further, you become someone's personal physician when you can hear only their name and conjure up the fullness of that individual in your head.

Next I thought about my regular frustration when I try to force what I do with a patient into ICD-9 and CPT codes. The "bullets" in E and M coding include things like review of systems that every experienced clinician knows are nearly worthless, and parts of the physical exam that are so non-specific we learned long ago to ignore them (after carefully recording them so we can support a 99214). Decision-making is included in the template, but the writers mean interpreting lab and x-ray, mostly.

What family docs do that is priceless is help our patients manage their lives. When their concern is a teenager out of control or an impending job loss, we care. After a few years of practice in the real world, we realize that GERD and depression/anxiety are nice labels that don't begin to express the richness of human distress. There's an old quote that goes: "There's a reason that a general surgery residency lasts 5 years. It only takes a year to learn how to enter the abdomen safely, but it takes another 4 years to learn when not to." Similarly, the mark of a good personal physician is to know when not to consult for the chest pain, or when the best agent for the "soul pain" is not a narcotic or NSAID.

The JAMA commentary points out lessons learned from the fast food industry. The way to increase efficiency is not to cajole the staff to work harder and faster, but to change the system around them to make their job easier. We physicians are receiving plenty of advice on working harder and faster, when what is needed is fundamental change in the way we help our patients. A system that was designed to manage short duration acute illnesses simply can't work for the many chronic diseases we manage today.

The commentary recommended:

1) Make it easier for patients to get access to care and obtain continuity.

Studies have shown that patient and physician satisfaction, as well as the rate of preventive services provided, increase when continuity is the routine. Consider the last time that you made decisions about a patient you didn't know well-it's a qualitatively different task. The focus currently is on easier access to an appointment, and this is important. Perhaps, though, the patient's need could be addressed without an office visit. And maybe it could be met just as well by your nurse or another staff member who knows your routines.

Imagine if the revenue you received was not dependent on seeing the patient in the office. Although capitation is no longer in vogue, my practice in Texas in the 1990s discovered a different office system that is made possible by capitation. Being paid the same per member per month whether you saw them or not meant that keeping most patients out of the office and keeping the precious

office slots full with those who needed in-person help managing their lives was a "win-win," and we did well financially. We invested our group's time in establishing protocols for the things we saw repeatedly and training our office staff on the protocols. Eventually we were large enough to pay a nurse to answer our calls at night, using the protocols to get the patient through until their personal physician could make the long-term decisions. Our patients rarely insisted on speaking with the doctor, once they knew that our staff was speaking for us and that they could get in to see us easily when it was really needed.

2) Find ways to increase the patient's participation in their care

Studies show that often the patient's agenda is not fully addressed in the typical office visit. Attention so far has focused on training the doctor to be better at discerning the patient's agenda (i.e., work harder and faster). Shifting some of the responsibility to the patient has been shown to be successful. In some settings "agenda cards" with the most common issues of each clinical condition are provided to patients, either on paper or electronically. In advance of the visit, patients sort through and prioritize what's important to them at that time, increasing the efficiency of the visit. The current attention being given to electronic personal health records may be a way to maximize this process. When a patient has an opportunity to review (and offer corrections to) her medical history, including family history, active illnesses, and medications, she can be empowered to be her own health advocate. The best of these systems allow only the doctor to make changes, facilitating the "negotiation" that should go on before a medical history is finalized.

3) Provide the skills necessary for patient self-care

The commentary points out that patient education in the traditional sense is not enough to get patients to make the lifestyle changes that are critical to their health. Tangible skills must be learned, practiced, and become part of every day life. An often successful technique is individual patient-to-patient interaction or group activities where actual skills are taught. I remember that by far the best way for me to promote weight loss in my patients in one of my practice sites was to connect each with one of my patients who facilitated a weekly weight loss group in her home. Not only did they learn the particulars of "counting points," but they had a ready support group when the inevitable back-sliding begins. Another example was a practice that put some exercise machines in an unused area of the office, allowing staff and patients to use them at no charge in the evening, even paying for healthy snacks and providing bottled water on "team night."

4) Coordinate care among different clinical settings

We all have had situations where a consultant repeated a test or misunderstood our question because of poor communication, or the ED admitted a patient because they didn't have access to a previous EKG or chest radiograph. For now, having a standard referral/consultation form is helpful, and EHRs shared by multiple points of care solve many of these problems. The ultimate frustration of having a patient go to an academic referral center and then return to see us before we receive any information about their stay is less common now. The Neonatology group I use most frequently simply faxes me the computer-generated note on my patient each Friday that lists all the active problems and the status of each. It is very reassuring to the new mother's family that I can explain how things are going in laymen's terms. Our own multi-specialty group has multiple-point access to lab, imaging, and office and hospital notes now, and it has saved me hours of chasing lab or consultants and allows me to explain the results face-to-face during the patient's office visit.

When I reflect on these recommendations, I am struck with just how modern our student-led free clinic has become. We have a very simple EHR, and can access all the reports from our multi-specialty group's system from multiple points. When I attend the students there, it seems so easy: since payment is not an issue, we can just do the history, physical, and lab that are really needed, throwing coding templates out the window. We have just begun a project of assigning these patients to a student for continuity of care. Freed from the need for office visits just to allow billing, we can see these patients less frequently, managing their chronic diseases "virtually" by telephone. Our nurse communicates with the students and me by Email, allowing us to choose the most convenient time to answer and begin the next step of management. We will be able to communicate with some of these patients directly by Email, as they can get access from a public library or a friend's house. This would include reminders to come together for group skills sessions or

individual foot exams, as well as when to go to the lab. The results of the self blood glucose monitors we provide for our diabetics can be downloaded electronically, allowing us to make those decisions without seeing the patient. All of these patients are working uninsured, so this not only saves them time but allows us to serve many more patients, less limited by our brief weekly clinic sessions.

So, imagine how your practice may look in the New Virtual Care World, where you are paid for helping to manage your patients' lives, regardless of how frequently you see them. With well-developed office systems allowing your staff to do much of what you do now, you could actually spend that extra time with that patient on the day he needs it. Most projections have actually shown that a physician in this model should be able to manage about 10-20% more lives without increasing staff or clinic hours. And in this model, covered lives equals revenue.

I invite comments on this version of the brave New Virtual Care World. Are you ready for this?

References

1)Bergeson SC, Dean JD. A Systems Approach to Patient-Centered Care. JAMA 2006;296:2848-51.

2)Mitka M. Electronic Health Records, After-Hours Care Lag in US Primary Care Practices. JAMA 2006:296:2913-4.

Local Physicians Receive the Honorary Degree of Fellow From the American Academy of Family Physicians

Perry Meadows, M.D.-Crestwood, KY
Stephen Toadvine, M.D.-Corbin, KY
Leelamma Varkey, M.D.-Hazard, KY
R. Brent Wright, M.D.-Glasgow, KY

Ask your patients if they use tobacco. Act to help them quit.

Free tobacco cessation resources available at **www.askandact.org**:

- Quitline Referral Cards
- Posters
- PowerPoint Presentations
- Patient Education Materials
- Lapel Pins
- Quit Smoking Prescription Pads
- CME

Shipping charges apply.

Many materials available in both English and Spanish!

Join us at the KAFP 56th Annual Scientific Assembly Friday, April 20, 2007 at 4:15 pm

ASK AND ACT
A TOBACCO CESSATION PROGRAM

Ask and Act is supported in part by the Smoking Cessation Leadership Center and Pfizer Inc.

KAFP Annual Meeting

Join us at the Louisville Marriott East
April 20-21, 2007

R. Brent Wright, M.D.
Chair - 2007 KAFP Scientific Program

Yes, the days are long and there are constant demands on our time, but who would want to do anything else besides Family Medicine? We have the capability to make a difference in our patients' lives. Every day, every exam room, we are at the interface of caring. If you are reading this, it is safe to say that you are still fighting the good fight. The HMOs and the benefit managers are a burden to our daily work, but you still possess the passion to care.

We are at a new age in the practice of medicine and poised to reap significant rewards as there is a glimmer that what we do is not only a benefit for the patient, but a benefit to our society. We are challenged to balance the demands that healthcare represents to our global competitiveness.

We are your Kentucky Academy of Family Physicians and we have worked diligently to provide you with a program that is meant to care for you at a time in medicine's history that is so meaningful for Family Physicians. At this year's Scientific Program we have adjusted the format of the presentations to bring exceptional value to all participants.

To begin the session we are going to present up to date information on electronic medical records. Some of the best information available is from your fellow physicians, who will share their expertise and be available throughout the weekend. To serve our resident members we will have concurrent afternoon sessions aimed at optimizing the transformation from resident to practicing physician.

The Second Annual Residency Quiz Bowl will provide great entertainment while serving as the half- way point for our scientific meeting. Physicians are a competitive lot and couple that with a year's worth of bragging rights, and there are surely going to be some fireworks Friday evening. Be sure to come early and get a good seat.

Saturday morning continues with a diverse curriculum aimed at aiding physicians with the SAM modules for their ABFM Certification. To continue with our goal of serving the needs of our Family Physicians, there will be parallel tracks of lectures in multiple disciplines so that those not wishing to work with the SAM modules can seek learning in other areas. Saturday will complete with a lecture on early detection of kidney disease which precedes our Annual Banquet and Award Ceremony.

As a Family Physician you should be proud. We are proud of your work throughout the Commonwealth and we want to enrich your practice with a dynamic Scientific Program that, with your active participation, will continue to enrich the practicing careers of Kentucky's Family Physicians for years to come!

KAFP Member Appointed as AAFP Delegate to the AMA

Jerry Martin, M.D., of Bowling Green, KY was recently re-appointed as an American Academy of Family Physicians (AAFP) Delegate to the American Medical Association (AMA). As a Delegate, Dr. Martin will represent the AAFP at all AMA meetings. Dr. Martin was first appointed in 1998 as AAFP's Alternate Delegate to the AMA and in 2004 was appointed to his current position.

Dr. Martin received his medical degree in 1963 from the University of Louisville, became a Fellow in the AAFP in 1972 and achieved ABFM Diplomate status in 2003. He is a Past President of the Kentucky Academy of Family Physicians.

KAFP 56th ANNUAL S

Program Goals

Registrants for this program will receive current information on Electronic Health Records and 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 topic.

CME Credits

The Scientific Assembly is being reviewed for 15.75 prescribed credits through the AAFP AMA PRA Category I and AOA Category 2-A and 15 credit hours for SAMs Prep Session.

Who Should Attend

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

Why Attend

- Quality cost-effective CME program
- Earn over 15.75 hours of approved CME
- National and Local Speakers
- EHR Demos
- Connect with your Colleagues
- Gather information and knowledge from Local and National Companies displaying their products.

CME HIGHLIGHTS

"The Future Starts Now: Making the Move to Electronic Health Records"

EHR Demo Vendors and EHR exhibitors will offer a comprehensive overview of products, technology and services. Participants will learn from a panel of their PEERS in an informal setting about such issues as:

- Issues/problems with software contracts;
- Issues/problems with too little or too much training;
- Issues/problems with staff computer literacy;
- Issues/problems with software and hardware compatibility;
- Best practices in a successful implementation;
- What '20/20 hindsight' they would give to a prospective EHR buyer.

One-on-one demos will give participants an opportunity to explore:

- How to reduce medical errors, improve clinical decision making and revenue capture, and lower costs through utilizing an EHR.
- Compare and contrast among EHR vendors to evaluate their system on how they may improve the quality, safety, and enhance practice revenue.
- Compare and contrast among EHR vendor's hardware, network, and technical infrastructure requirements to support their software system.

SAMs Prep Session

Attendees at this workshop will work through the first portion (exam) of the American Board of Family Medicine (ABFM) Congestive Heart Failure Self Assessment Module (SAM). Those who complete this workshop will be credited as completing this portion of the SAM by the ABFM. To receive CME credit for this portion, attendees will need to complete the clinical scenarios portion of the SAM online through the ABFM website. CME credit for both portions is currently 15 credit hours and can only be obtained after both portions are completed.

Ask and Act: Advances in Tobacco Cessation Treatment and Payment

Participants will learn:

- The evidence on -- and efficacy of -- pharmacotherapy for nicotine dependence.
- How to provide tobacco cessation counseling.
- Opportunities for brief interventions.
- To make office system changes that increase intervention and tobacco cessation rates.
- How to get paid for tobacco-cessation treatment and counseling.
- Where to access free AAFP resources.

CIENTIFIC ASSEMBLY

Friday-April 20, 2007-Morning Session	
7:00 AM 7:50 AM	*Registration/Continental Breakfast/ Exhibit Visitation*
7:50 AM 8:00 AM	*Welcome by:* Gerry D. Stover, EVP KAFP
8:00 AM 8:15 AM	*Overview of Scientific Program*, Brent Wright, MD, Program Chair
8:15 AM 10:15 AM	EHR Panel Members Speakers TBA
10:15 AM 10:45 AM	*Break/Exhibit Visitation*
10:45 AM 11:45 AM	EHR DEMO A/B/C EHR Companies TBA
11:45 AM 1:45 PM	*Lunch/ Exhibit Visitation (2 hours)* *Congress of Delegates Luncheon Meeting (2 hours)*

Friday-April 20, 2007			
PROGRAM #1		*PROGRAM #2*	
1:45 PM 2:45 PM	EHR DEMO B/C/A EHR Companies TBA	1:45 PM 2:45 PM	RESIDENT PROGRAM 180 Degree Vision-What I Wish I Had Known Before I Went Into Practice
2:45 PM 3:45 PM	EHR DEMO C/A/B EHR Companies TBA	2:45 PM 3:45 PM	RESIDENT PROGRAM Practice Management Speaker TBA
3:45 PM 4:15 PM	*Break/Exhibit Visitation*		
4:15 PM 5:45 PM	ASK and ACT A Tobacco Cessation Program Rick Botelho, M.D.-Professor of FM, Univ. of Rochester, NY		
6:30 PM 10:30 PM	*Resident/Student Reception & Quiz Bowl*		

Saturday-April 21, 2007-Morning Session			
7:00 AM 8:00 AM	*Registration/Continental Breakfast/ Exhibit Visitation*		
PROGRAM #1		*PROGRAM #2*	
8:00 AM 10:00 AM	SAMs Prep Session "Congestive Heart Failure" Paul Dassow, MD, MSPH University of Kentucky	8:00 AM 9:00 AM	"Preventing Cancer by Vaccination: The HPV Story" Speaker TBA
		9:00 AM 10:00 AM	"Improving H.Pylori Management Through Appropriate Testing" Speaker TBA
10:00 AM 10:30 AM	*Break/Exhibit Visitation*		
10:30 AM 12:30 PM	Brainstorm American Headache Society/ Speaker TBA		
12:30 PM 1:30 PM	*Lunch/ Exhibit Visitation* *Past Presidents Luncheon*		

Saturday-April 21, 2007-Afternoon Session			
PROGRAM #1		*PROGRAM #2*	
1:30 PM 3:30 PM	SAMs Prep Session "Congestive Heart Failure" Paul Dassow, MD, MSPH University of Kentucky	1:30 PM 2:30 PM	"Disorders Only a Mother Could Love" Pediatric Skin Rashes & Physical Anomalies Paul Berman, MD, University of Texas at San Antonio
		2:30 PM 3:30 PM	Challenging Cases in Neurology for the Primary Care Physician Michael Dobbs, MD, University of Kentucky
3:30 PM 4:00 PM	*Break/ Exhibit Visitation*		
4:00 PM 5:00 PM	Catching Kidney Disease Early in the Primary Care Community Peter Sawaya, MD, FACP, FASN, University of Kentucky		
5:00 PM 5:30 PM	*Audience Question & Answer*		
6:30 PM 10:30 PM	*Reception/Annual Banquet/Award Ceremony*		

REGISTRATION FORM: *KAFP 56th ANNUAL SCIENTIFIC ASSEMBLY*
April 20-21, 2007
PLEASE COMPLETE THIS FORM, KEEP COPY FOR YOUR FILES, & SEND WITH PAYMENT TO:
KAFP, P.O. Box 1444, Ashland, KY 41105, fax to 1-888-287-0662

Name_____ **Profession (MD, PA, RN, etc.)**_____
(PLEASE PRINT)
Address_____

Spouse/Guest Attending_____

City/State_____**Zip**_____

Phone/Work_____**Fax**_____**Email**_____

FULL CONFERENCE	**Before April 1st**	**After April 1st**	
☐ KAFP & Other AAFP Members	**$220.00**	**$270.00**	_____
☐ Life Members	**N/C**	**N/C**	_____
☐ Non Members of the AAFP	**$320.00**	**$375.00**	_____
☐ Health Care Professional (PA, RN, Etc.)	**$100.00**	**$150.00**	_____
☐ Residents & Students (no charge except Banquet)	**N/C**	**N/C**	_____

The following is included in *Full Conference Price.* Please select only if you plan to attend these events only.

ELECTRONIC HEALTH RECORD PORTION ONLY			
Physicians	**$75.00**	**$85.00**	_____
Office Staff	**$25.00**	**$30.00**	_____
SAMs PREP SESSION "Congestive Heart Failure" ONLY	**$75.00**	**$85.00**	_____
ASK and ACT TOBACCO CESSATION ONLY	**$35.00**	**$35.00**	_____

The following is not included in *Full Conference Price.* Please indicate which event you would like to attend.

SPECIAL EVENTS:

☐ **Friday, April 20, 2007**
Resident & Student Reception /Quiz Bowl **N/C** _____

☐ **Friday, April 20, 2007 Spouse Tea Social (2:00pm-4:00pm)** **N/C** _____

☐ **Saturday, April 21, 2007 Past Presidents' Luncheon** (Past Presidents & Spouses only) **N/C** _____

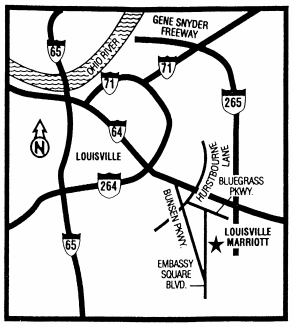
☐ **Saturday, April 21, 2007**
Reception/Awards Banquet **$55 per couple or $30 each** _____

TOTAL AMOUNT _____

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 1, 2007****.*

☐ **Check Enclosed** ☐ **Please Bill Me** ☐ **VISA** ☐ **Mastercard** ☐ **American Express**
Card#_____**Security Code**_____ **Exp**_____
Name on Card_____
Signature_____
We cannot process your credit card payment without a Name on Card/Signature/Expiration Date/Security Code.
A 3% Service Charge for credit cards will be added.

HOTEL RESERVATION INFORMATION: Cut-Off Date: April 3, 2007
Contact: The Louisville Marriot East Hotel
1903 Embassy Square Blvd.
Louisville, KY 40299
Phone (502) 499-6220 Fax (502) 493-8465
Group Name: Kentucky Chapter American Academy of Family Physicians
Conference Date: Friday, April 20, 2007 – Saturday, April 21, 2007
Rate: Single/Double $94.00 (+ 15.01% tax) & King $124.00 (+ 15.01% tax)



FAX REGISTRATION FORM TO KAFP 1-888-287-0662

KENTUCKY ACADEMY OF FAMILY PHYSICIANS

Jan 2, 2007

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

Washington State Family Physicians wants to know if you are interested.

David A. Lynch, MD, ABFM with Family Care Network in Bellingham, Washington and several hundred Washington State family physicians have worked with C. Paul Gauthier, retired insurance executive, to develop a Medicare Advantage contract that will compensate them $15 PMPM in addition to the standard CPT reimbursement for providing the AAFP-ACP's personal medical home to Medicare beneficiaries. Within 3 months of their development of their plan they were able to locate an insurer that assisted in designing a benefit package. The insurer filed with CMS in May of 2006 for the calendar year 2007. The project is intended to help cure the problem with access to primary care for Medicare Beneficiaries as well as pay for the AAFP-ACP's personal medical home for family physicians' existing patients. More information on the initiative is available at www.DrDaveLynch.blogspot.com.

Personal Medical Home Care Enhancement Services Under Lynch's Plan:

- Maintain the patient's "personal medical home" electronic health care records.
- Systematically remind members of covered preventive screening services.
- Apply the Wagner Chronic Care Model.
- Provide regular quality reports.
- Conduct an annual risk assessment for each member at which time the member's chronic medical problems are identified, reviewed and updated.
- Maintain the patient-doctor health care relationship between office visits by using telephone care and secure web messaging when appropriate.

INTEREST SURVEY

4. (Yes / No) Is your practice currently 'closed' to new Medicare Patients?

5. (Yes / No) I would be interested in learning more about this initiative.
- **If Yes, (Yes / No) I would be willing to participate in a conference call to learn more about this initiative.**
- **If Yes, (Yes / No) I would like to receive future faxes/emails/snail mail information on this initiative.**

PLEASE FAX YOUR REPLIES TO 888-287-0662 by February 1, 2007

PRINT NAME: _____

CONTACT PHONE: _____

EMAIL: _____

Note from the Editor: *As physicians consider implementing Electronic Health Records (EHR), a major concern is the cost. Until recently, a physician working with a hospital or other organization to share these costs was limited by what has been termed the Stark Law, named after the Congressman who promoted regulation of entities that could provide a "kickback" to their physician owners. The article below was recently published in the Ohio Family Physician Journal, and we republish it here with their permission to update our readers on some important recent changes in this area. There are also Bills under consideration in Congress to provide public sector funding for EHRs. As these become law, we will share similar information with our readers at that time.*

WJC

Stark Law and Safe Harbor Changes Allowing Donation of EHR Technology

Ken Bertka, M.D.
Toledo, Ohio

In August 2006, the Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS) announced changes under the Stark and Anti-kickback laws that allow for the partial donation of electronic health record (EHR) technology to physicians. These changes became effective Oct. 10, 2006, and remain in effect until Dec. 31, 2013.

The new exceptions to the Stark law and Safe Harbors for the Anti-kickback laws establish similar conditions for the donation of dedicated electronic prescribing and EHR technology with a few significant differences.

Electronic Prescribing

The changes allow specific healthcare entities (primarily hospitals) to furnish hardware, software and training needed to implement and maintain an electronic prescribing system that is used solely to receive and transmit prescription-related information. The system must meet standards established under Medicare Part D. The arrangement for providing this technology and services must be set forth in writing by both parties. Although this is a significant change to promote the use of electronic prescribing, it is limited to that single function and, therefore, not expected to be as attractive to physicians as the EHR Stark law and Safe Harbor changes. The remainder of this article will focus on EHR promotion under these changes.

EHR

The Stark law and Anti-kickback changes allow healthcare entities (again primarily hospitals) to donate EHR software or technology, implementation services, training services and maintenance, and upgrade services up to 85 percent of costs through Dec 31, 2013. To qualify, the EHR must be "interoperable" at the time it is

KAFP Member Selected for AAFP Commission on Science

Rob W. Prassad Steiner, M.D., MPH, PhD, FAFFP, FACPM, of Louisville, was selected to serve as a member of the American Academy of Family Physician's Commission on Science. This commission's scope of work focuses on vaccines, guidelines/clinical policies, research agenda, research networks, practice based research networks, and preventive services. The American Academy of Family Physicians is the national association of family doctors. It is one of the largest national medical organizations, with more than 85,000 members in 50 states, D.C., Puerto Rico, the Virgin Islands, and Guam.

Dr. Steiner is a professor in the Department of Public Health and Information Sciences at the University of Louisville. His research interests include: Organizational aspects of value networks for quality improvement; Evolving concepts in population health, including evaluating intangibles; Healthy Communities approach to improving quality of life; Methods for measuring minimally important differences in quality of life; Clinical Epidemiology; and Quality of Life Assessments.

Dr. Steiner's current project focus is on 'Detecting Major Depressive Episodes in Primary Care Sites Using the Patient Health Questionnaire.' His contact information and other items of interest can be found at http://sphis.louisville.edu/facultystaffdisplay.cfm?CFID=811614&CFTOKEN=90684820.

provided. "Interoperable" is defined as being able to "communicate and exchange data accurately, effectively, securely and consistently with different information technology systems, software applications and networks in various settings; and exchange data such that clinical or operational purpose and meaning of the data are preserved and unaltered." This definition is open for debate; however, HHS has recognized the Certification Commission for Healthcare Information Technology (CCHIT), as the EHR certifying body. For more information, visit http://www.cchit.org. CCHIT certification includes standards for interoperability. As of October 2006, 33 EHRs were certified by CCHIT and, therefore, should meet requirements for interoperability. EHRs furnished under these new regulations must be capable of doing electronic prescribing. Like the rules for donation of electronic prescribing technology, the agreement to furnish EHR technology must be in writing and signed by both parties. However, the donation of EHR technology cannot include donation of hardware.

Please see the chart for a summary of the changes.

Most hospitals that participate in EHR technology donation will most likely establish an enterprise-wide EHR and make it available to physicians rather than establishing free-standing systems in each office. This approach has potential advantages and disadvantages for physician offices. Physicians considering entering into an agreement for donation of EHR technology should investigate the pros and cons in the following areas:

•Data hosting, maintenance, security (including HIPAA) and backup

•Data ownership and transfer if the physician and/or hospital opts out of the agreement in the future

•Schedule for planned downtime and system upgrades

•Segregation of practice-specific business and clinical information

•Development of shared templates across a virtual community of physicians rather than individual practice-specific templates

•Physician control of data for appropriate reporting of clinical data to third parties (such as pay-for-performance programs and direct contracting with employers)

•Interface development to outside labs and other health systems

•Sharing of data among practices when a patient is referred or enters the hospital

•Vendor support agreements (who is the vendor directly responsible to?)

•Overall physician governance of the system

Summary of Stark Law and Anti-kickback Changes for EHR Technology Donation

Protected Donors	• Hospitals • Other entities that provide covered services and submit claims to Federal healthcare programs • Excludes – pharmaceutical manufacturers, health information technology vendors and regional health information organizations (RHIOs)
Protected Recipients	• Physicians • Other individuals engaged in healthcare delivery (needs to be further defined)
Covered Technology	• Software predominately to create, maintain, transmit or receive EHRs • Must include electronic prescribing • May include Internet connectivity
Hardware	• Excluded
Interfaces to Other Clinical Systems	• May be included
Training, Help Desk Support and Software Maintenance	• May be included
Value	• Recipient must pay at least 15 percent of donor's cost • Donor may not provide financing
Electronic Prescribing	• EHR must do electronic prescribing to qualify
Interoperable	• EHR must be interoperable – certification by CCHIT has been deemed by HHS to meet this requirement
Practice Management (PM) Software	• If PM software is integrated into the donated EHR, it may be included in the donation if there is a commitment to implement the EHR
Staffing Assistance	• Not covered (Example: A hospital cannot donate or pay for staff to scan old records into the new EHR.)
Expiration	• Dec. 31, 2013
Other	• Tax implication to the recipient is unknown. However, most consultants feel that physicians will not be liable for gift tax on the donated value especially if the hospital claims it as a community benefit donation. • Physicians upgrading from an existing system, especially if a "home grown" EHR, may qualify. • A physician can take advantage of EHR donation only once (services and technology donated may continue through Dec. 31, 2013)

Letters to the Editor

Note from the Editor: *Many believe that the value of a print journal is demonstrated by the number of readers who take the time to send written responses concerning the published articles as Letters to the Editor. The editorial Board seeks to promote the free exchange of ideas in its pages. To this end we include the following letter. Such letters represent only the opinion of the writer, and we sincerely hope that other responses will follow.* WJC

I read with a sigh of resignation the article 'Fix It Now!' by Dr Matheny in the fall 2006 issue of The Journal. The usual unchallenged assumptions permeated the piece.

'Fix it' only makes sense if something is truly broken. I will take issue with the diagnosis that the U.S. medical 'system' is 'broken,' in 2 ways.

First, that there are problems with the system doesn't necessarily mean that it's 'broken' such that massive change is necessary to fix it. If only moderate adjustments are needed, calling the system 'broken' would seem to be uncalled-for hyperbole. In fact, compared to other medical 'systems' in the world, I would say our system does pretty well. I am suspicious of the usual measures: infant mortality, life expectancy, etc. Before I would accept 'expert opinion' on our performance versus other nations, I would need to know a great deal more about the 'expert.' This is a highly political topic and therefore subject to bias, both conscious and unconscious. A measure one rarely hears about is the measure by 'feet': when people and doctors 'vote with their feet,' where do they go for their health care and to practice? When the prince of Slobbovia needs cancer treatment, where does he go? How many people go across the border from Detroit to Canada to get medical care, versus the number going the other way? How many physicians come here from Canada or vice versa? For a 'broken' system, it seems to be pretty popular.

Secondly, in order to treat a problem effectively, one must accurately diagnose it. To whatever degree our 'system' is 'sick,' it isn't because of too few family physicians, or too restrictive insurance companies, or too low Medicare reimbursement. All these are simply symptoms of the true underlying cause, which must be addressed. Otherwise, we will be forever chasing our tail as the system truly does break down and become Canadian, or British, or some other government monstrosity.

Consider this: if medical care were as cheap as groceries, there would be no 'crisis.' No one would think the system was 'broken.' Indeed, there would be no 'system': no Medicare, no Medicaid, no health insurance, etc. There would just be doctors and patients. So we ought to be asking why medical care is expensive.

When one asks that question, one gets the usual litany of research and training costs, high technology, etc, plus the dark murmurings of defensive medicine, over-testing and treating, physician and corporate greed, and so forth. And all of these are true to some extent. But I would maintain that none of those is the real reason that medical care is expensive.

The real reason is lack of competition, which results from government establishment of a monopoly on medical care by the few. This monopoly is established in the name of protection of the patient, but in fact does little towards that end, and whatever it does is done at an unnecessarily high price. How is that monopoly established? Through the FDA and the state medical practice acts. Abolish those, and you will see costs drop like a rock as availability of medical care skyrockets. Will there be snake-oil salesmen, quacks, charlatans? There are already. That there would be more of them is the contention, of course. To that question I would answer three things.

First, whatever damage might be done by such scoundrels would be offset by the greatly increased availability of medical care absent the government restrictions. Many more of my patients would be able to afford their medicines, specialist care, and diagnostic testing were the FDA and medical practice acts to be removed. The very few people so desperately poor that they were unable to afford the much lower prices of drugs and doctoring would be easily taken care of by churches and other charitable organizations.

Secondly, I strongly suspect that, were the FDA and the medical licensing boards to be removed, private entities would immediately spring up to take their place. These would review drugs and doctors at a substantially lower cost than the government agencies, and provide the information to the public much like Consumer Reports and Underwriters Listed do. The prototypes for this are already in place: the ABFP, and other boards. Those who cared enough to make use of the information would be free to do so.

Thirdly, it is simply unjust (no matter what one expects to be the outcome) to take money by threat of force (i.e., taxes) from one person to pay for another person's medical care, or to protect him from his own (presumed) incompetence in choosing a doctor or a drug. Any child can see that. It is charitable if done voluntarily. It is theft if it is compulsory.

So, if the system is 'broken,' it is broken because of government action. Calling for more government action won't fix it. It will exacerbate the problem.

Sincerely,
Jeremy Klein, M.D., F.A.A.F.P.
Louisa, KY

Dr. Klein's letter was shared with Dr. Matheny, who recommended that it be published without a further response from him. Let us hear from you! WJC

Mark Your Calendar for Upcoming Meetings!

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

National Conference of Special Constituencies
May 3-5, 2007
Kansas City Convention Center - Kansas City, MO

Annual Leadership Forum
May 4-5, 2007
Hyatt Regency - Kansas City, MO

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

AAFP Annual Scientific Assembly
Oct. 3-7, 2007
McCormick Place - Chicago, IL

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The Kentucky Academy of Family Physicians

P.O. Box 1444 • Ashland, KY 41105-1444 • Office #1-888-287-9339 • Fax #1-888-287-0662
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