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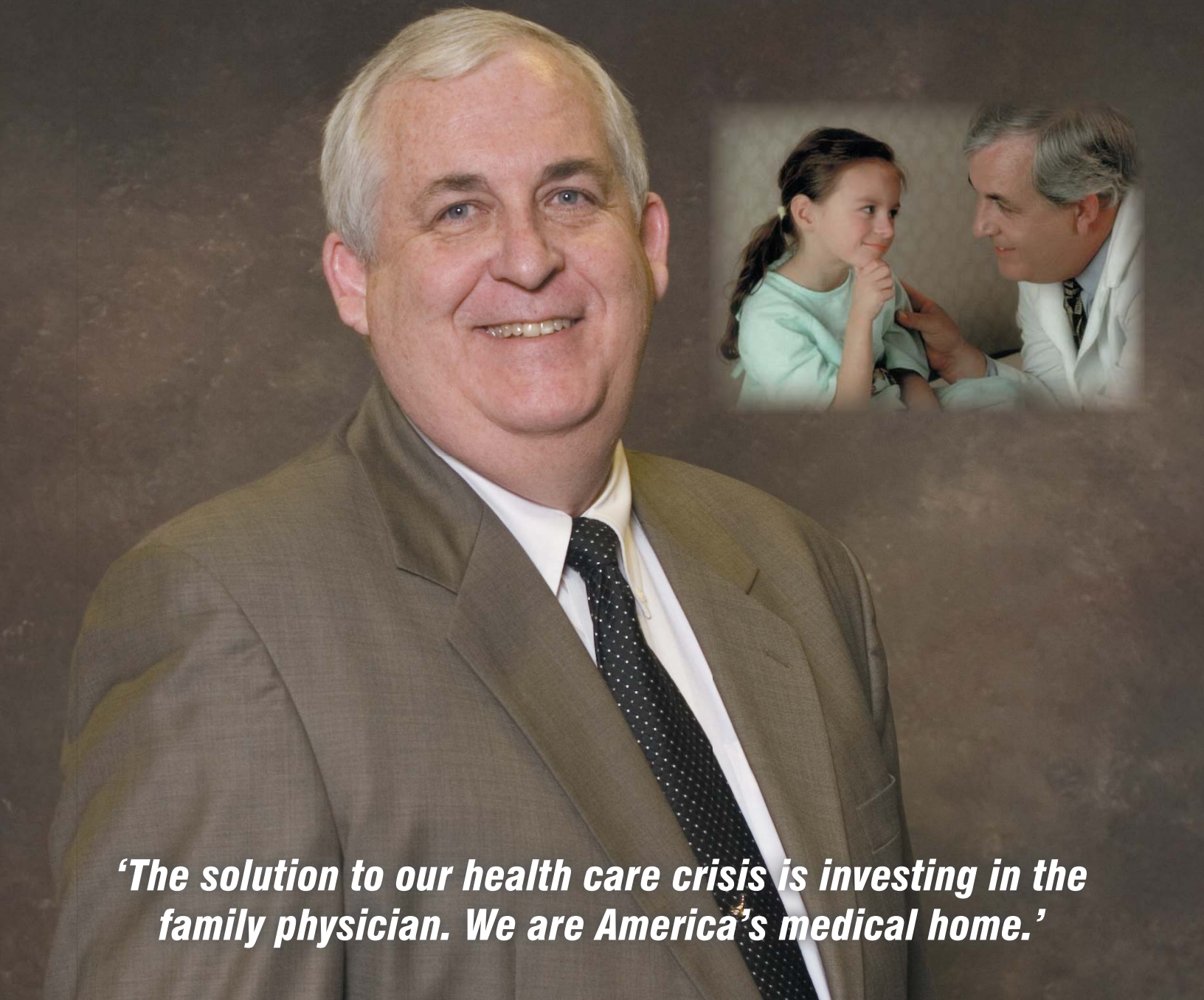
John Darnell, Jr., MD

2008 Candidate for AAFP Board of Directors



'The solution to our health care crisis is investing in the family physician. We are America's medical home.'

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KAFP JOURNAL

The Kentucky Academy of Family Physicians

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KAFP State Officers 2008-2009

From the President

by R. Brent Wright, M.D.
Glasgow, KY

As a Residency Program Director I find myself, like many of my peers, having to make tough decisions regarding how to rank my potential candidates for the National Match. There are many factors and personality traits to consider when evaluating a potential candidate. As my colleagues have pointed out in recent literature – "Character is the trump card. It doesn't matter what your USMILE scores are if you lack the character to be a family physician."

Kentucky has such a man of character in John Darnell, MD. John has demonstrated on numerous occasions his willingness to take on the tough assignments and to follow through with results. During his tenure as Chair of the AAFP's Commission on Finance John put in place policies that have been credited with making the AAFP more fiscally responsible and sound. This is why Kentucky is honored to bring forth his name as a candidate for the AAFP Board of Directors.

Another trait characteristic of John is his willingness to put his 'agenda' [goals] on the table and come prepared to work towards achieving these goals. John has shared with me that these are his goals should he get elected to your AAFP Board of Directors:

1. Develop improved payments from federal, state and commercial payors for family physicians;

2. Ensure solo and small practices can become Patient Centered Medical Home and get the proper payment for achieving NCQA certification as PCMH;

3. Provide adequate funding for family medicine training programs and appropriate funding options for the medical students willing to choose family medicine as a career;

4. Strengthen our political advocacy programs through member participation and training; and

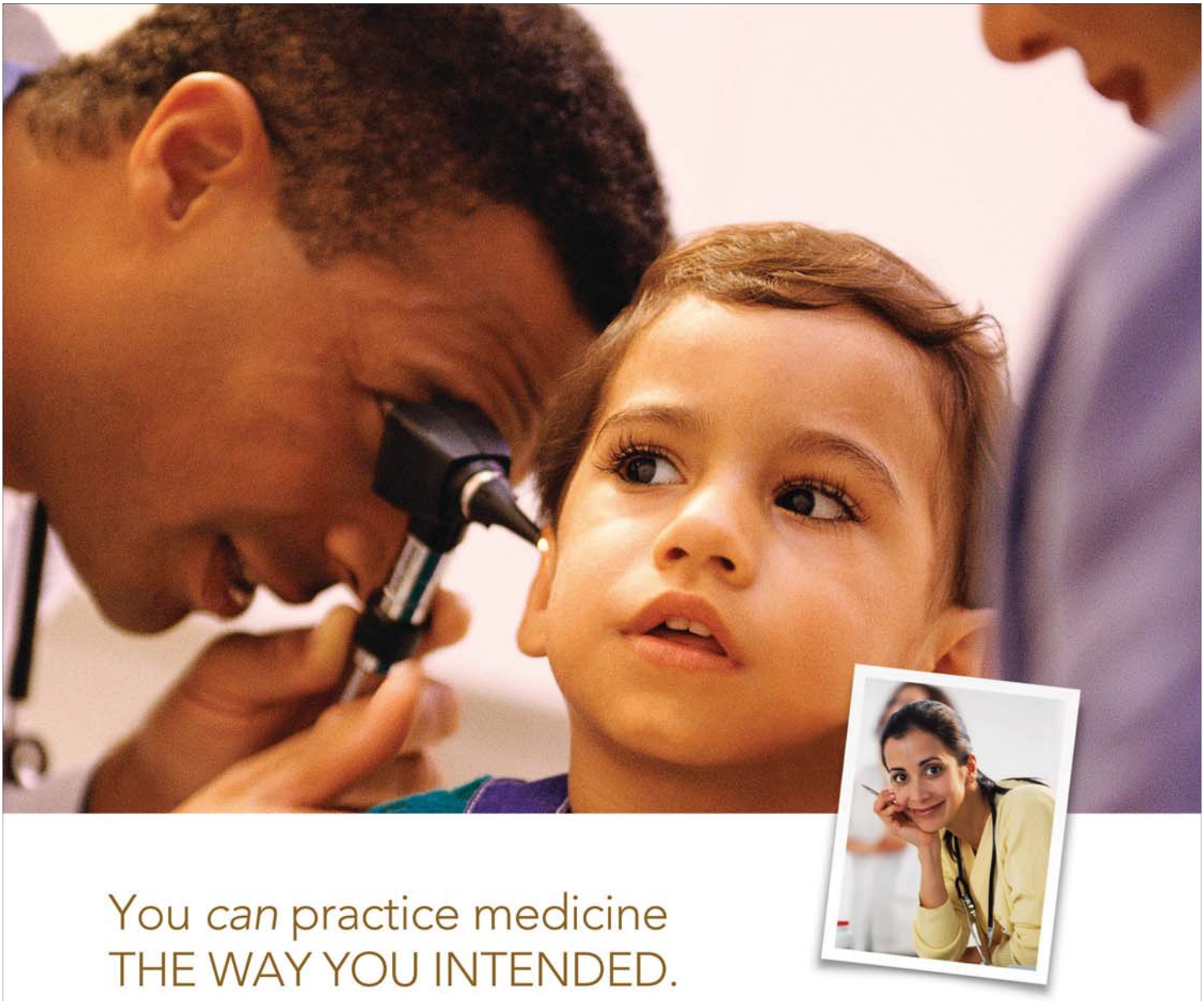
5. Guarantee our academy is a lean, mean, financially sound organization that can and will devote all energies toward the needs of its membership.

It is difficult to assess the character of an applicant in a short interview. As a native of Kentucky and having grown up in the home place of our 16th President Abraham Lincoln I am compelled to use one of his quotes – "Character is like a tree and reputation like a shadow. The shadow is what we think of it; the tree is the real thing."

I am writing to ask you to support Dr. John Darnell's candidacy for the Board of Directors of the American Academy of Family Physicians because he is "the real thing."

Respectfully,

R. Brent Wright, MD
President



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Dr. Fields Letter of Support

by Larry Fields, M.D.
Flatwoods, KY

Dear Delegate:

In a recent speech, John Darnell, MD stated, "family medicine is the only way to save our health system." After thoughtfully outlining the realities and challenges that currently beset family medicine, John concluded, "we can be an unstoppable force for change."

It is that type of vision, leadership, and action that have been characteristic of John's outstanding career and that now makes him a superb candidate for the Board of Directors of the AAFP. Dr. Nancy Swikert and I have signed on to be co-chairs of John's campaign because we believe he is the best individual to help create needed change. We need your help and support to make this a reality.

Gandhi once wrote that you must "Be the change you want to see in the world." Perhaps no one better exemplifies that action than John Darnell.

He joined me in practice after finishing residency, and we both remain in private practice today. That partnership is in its 26th year. We now have grown to a five person group. The full-service office and hospital-based practice, includes home visits, same day appointments, electronic health records, Hospice, 24/7 coverage and medical student training.

John has a passion for helping families in our community, helping kids grow up healthier and enjoying a sense of accomplishment of doing some good in a very difficult environment.

John has fought credentialing and turf battles at hospitals, helped develop the first department of family medicine in his community, and started a hospital quality improvement program.

He has lobbied at both the state and national levels for years, serving the Academy as a key contact. As the FamMedPAC champion for Kentucky, he helped increase donor numbers by 200%. He also served on the AAFP Commission on Finance and Insurance for five years, chairing last year. In particular, he has worked to establish policies that protect the organization's financial standing.

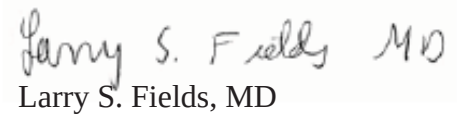
In addition to being an outstanding doctor, he is an exemplary son, husband, father, friend, mentor, coach, and community citizen. He currently serves as district administrator to thousands of Little League Baseball participants. John has coached state champion science Olympiad winners. He has cheered on his own daughter and sons as they won state, national, and international academic competitions as well as participating in a variety of high school sports.

Despite his many activities, the driving force behind him remains his passion for family medicine. "No other words offer more pride than to be identified as a family physician," he said.

That passion has led him to carefully consider the many aspects of our current situation and the role of the AAFP. I firmly believe that John will provide the leadership, teamwork and success that we need in this time of change.

I trust him. He is my Family Doctor and more importantly, my friend. Please join us in electing Dr. John Darnell to the AAFP Board of Directors. Be part of a needed and necessary force for change.

Sincerely,



Larry S. Fields, MD
Co-Chair, John Darnell, MD for AAFP Board '08

‘The solution to our health care crisis is investing in th

John Darnell, Jr., MD

Personal Statement

I am a family physician. Before I had my first rotation in medical school, I knew I wanted to be a family physician. I have never wanted to be anything else.

As a young boy, I dreamed of playing basketball for my high school team during the state championship. Like most young boys in Kentucky, I wanted to play on the basketball court that was home to the University of Kentucky Wildcats. I was not able to attain that goal, but was able to play basketball for Centre College during my undergraduate studies.

Personally, I am honored to be a son, husband, father, friend, mentor, coach, and community citizen. I have reached several milestones and had several gratifying moments. I have supported my children and other children in my community though various activities. I am the current district administrator to thousands of Little League Baseball participants. I have coached state champion Science Olympiad winners. I have watched my daughter and sons participate in high school softball, cross-country and golf championships. I have seen my children win state titles and advance to national and international champions in their respective academic competitions. And I have fulfilled my own childhood dream by participating in a boys’ high school basketball state championship on Rupp Arena’s floor as a high school assistant basketball coach. These have been wonderful experiences that I cherish, but none compare to the

John Darnell, Jr., M

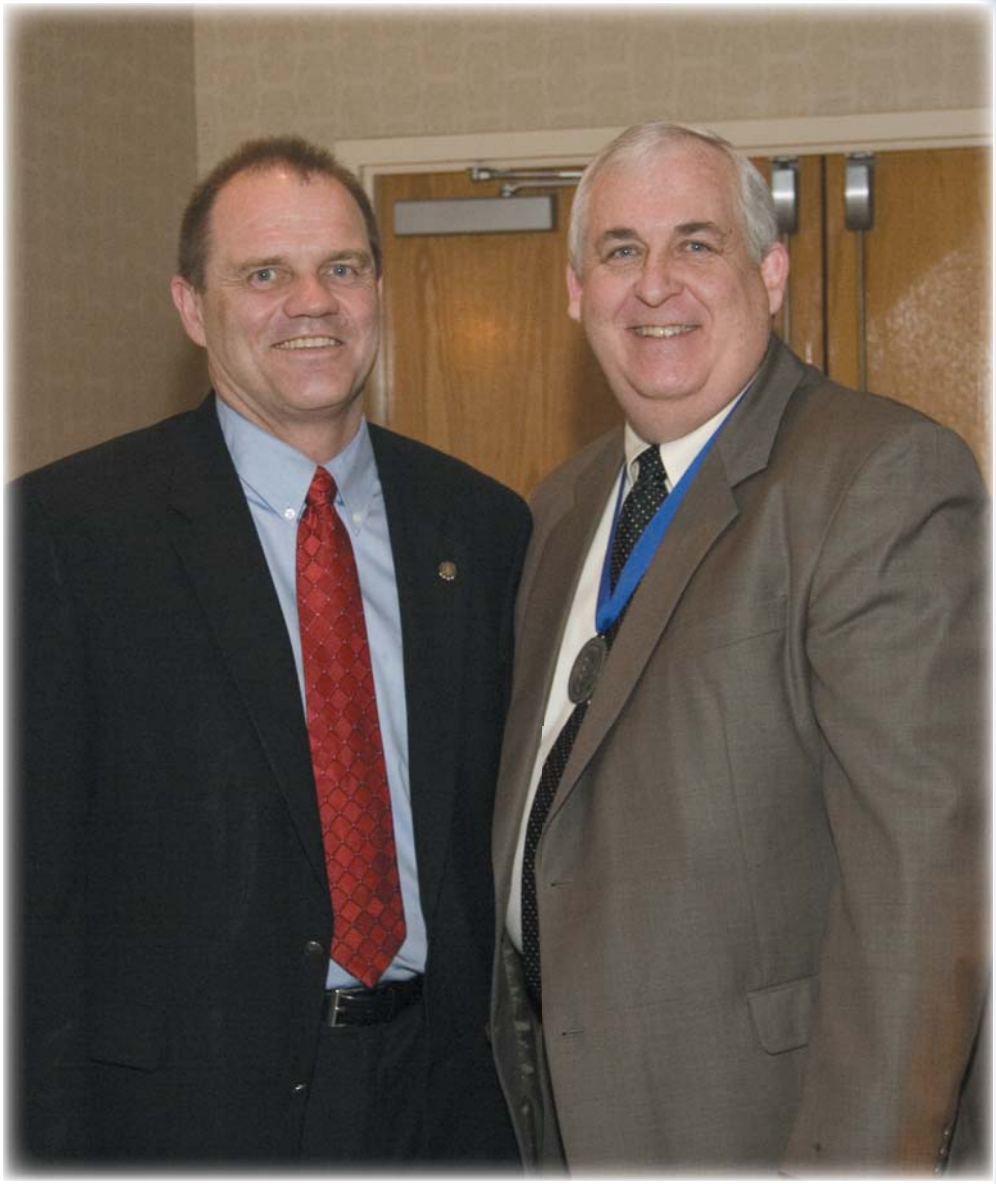
feelings I have about my chosen profession.

As I think about my career choice, no other words offer more pride than *I am a family physician*.

Professionally, no accolades have brought me more pride than to be identified as a family physician. In leading the next generations of doctors, I desire to promote my specialty so others may have the same experiences as a family physician. I want to continue to administer the quality care our patients need. Family Physicians are the cornerstone of a quality, cost-effective healthcare system. With the changing political climate, I want to step up and represent family physicians and our patients.

I am a family physician.

MD and wife Brenda



John Darnell, Jr., MD with Mike King, MD, AAFP President

Biography

John H. Darnell, Jr., M.D. is in private practice at The Family Medicine Center in Flatwoods, Kentucky. A native of Greenup County, Dr. Darnell always wanted to be a Family Physician and return to his home area. To better serve the community, he combined his practice with another physician's to create The Family Medicine Center. The Center has since grown to be the largest private family practice group in Northeastern Kentucky, boasting five physicians and 14 support staff.

As a family physician, Dr. Darnell provides his patients with a full scope of practice from infancy through adulthood. Beyond his extensive office practice, he extends patient care through various medical

venues. These include caring for patients in the hospital (including both ICU and pediatric rounds), visits to local nursing homes, and house calls to Hospice patients in eastern Kentucky and southern Ohio.

As a preceptor for medical students from the University of Louisville and the University of Kentucky, Dr. Darnell and his group offer clinical rotations. Acting as Associate Professors, Dr. Darnell and his group provide opportunities for medical students to experience family practice. He is strongly committed to helping train family physicians of the future.

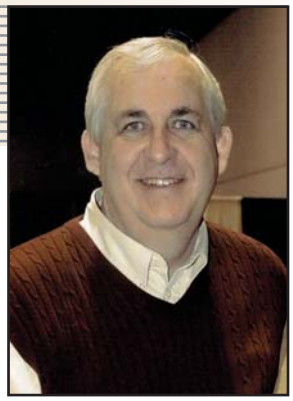
Dr. Darnell has been an active, participating member of the American Academy of Family Physicians (AAFP) as well as the Kentucky Academy of Family Physicians (KAFP) since 1983. He served AAFP as past chair of the Commission on Finance and Insurance, and as a delegate since 2006. As an active participant in KAFP, he served as president in 1997 and as treasurer for four years. He also served as a KAFP Foundation Board Member. In 2004, Dr. Darnell received the "Citizen Doctor of the Year" award.

Dr. Darnell is married to his high school sweetheart Brenda and has three children. Josh, the youngest, will graduate in May, as well as his fiancée, both majoring in marine science. John, the oldest son, and his wife are expecting their first child in August. Jenna is married to a University of Louisville law student. The Darnells also have one grandchild, Ainsley Jane.

As a devoted family physician for more than 25 years, Dr. Darnell looks forward to continuing to serve his patients, his community, and organizations such as the Kentucky Academy that work to promote the future of family medicine. He would welcome the opportunity and challenge of becoming your selection to serve on the AAFP Board.

John Darnell, Jr., MD with Larry Fields, MD, Nancy Swikert, MD and Robert Wood, MD.

A MESSAGE FROM YOUR PAC CHAMPION



John H. Darnell, Jr., M.D.
Flatwoods, KY

Political Action Committee Gives Family Physicians More Powerful Voice

America's health care system is on the cusp of dramatic change, and family medicine is in a prime position to have significant influence on that change. That reality should spur family physicians to invest in advocacy efforts now underway on the state and national levels, say family medicine advocates.

Among the most direct opportunities: supporting the AAFP political action committee, FamMedPAC.

Since its formation in 2005, FamMedPAC has worked to give family medicine a more powerful voice in our nation's capitol. This year, FamMedPAC has helped AAFP promote family medicine as the 110th Congress takes up important healthcare issues such as physician payment reform, Title VII funding for primary care residency programs, and increasing funding for the State Children's Health Insurance Program (SCHIP).

"FamMedPAC helped make this happen," says Michael Fleming, MD, chair of the FamMedPAC Board of Directors. "In the last election, the PAC contributed to 87 incumbents or candidates. The PAC also supported several victorious open seat candidates, running for Congress for the first time. That puts the AAFP in a strong advocacy position."

In the last election cycle, the first for FamMedPAC, more than 1,000 AAFP members contributed almost $400,000 to the PAC. "This is a great success," said Dr. Fleming, "But we can, and need, to do better." So far in 2007, more than 940 AAFP members have contributed over $230,000 to the PAC.

"Every member of AAFP needs to consider supporting the PAC," said John Darnell, MD, KAFP's PAC Champion. "As one of the largest medical societies, AAFP and FamMedPAC have the potential to become one of the most powerful voices in the healthcare debate. As the only political action committee whose sole purpose is promoting the viewpoints of family physicians and family medicine, the PAC will help us elect legislators who support our agenda and help improve healthcare for all Americans."

"I support FamMedPAC," said Nancy Swikert, MD**,** "because I am convinced it will help my practice and my patients." Dr. Swikert is a member of Club George, made up of AAFP members who agree to contribute $365 a year – one dollar a day – to the PAC. "It's easy to think of giving just a dollar a day to the PAC. The PAC can even take the contribution directly from my credit card each month, so I hardly think about it."

The PAC is working with the chapters to promote its activities and to raise awareness about the importance of political involvement. The PAC Chapter Champion program hopes to recruit AAFP members in each chapter to promote the PAC at chapter meetings and to act as liaisons between chapter members and the PAC. The PAC Web site (www.fammedpac.org) tracks each chapter's contributions by total and percentage, and tries to foster competition among them to see which chapter can achieve the highest level of support for the PAC.

"Once we get the word out about the importance of the PAC, I am convinced our Chapter will be one of the leaders in this effort," said Dr. Darnell. "We may not be the largest Chapter in AAFP, but our members will step up and do the right thing if asked."

The potential strength of FamMedPAC is emphasized by Mark Cribben, FamMedPAC's Director, when he speaks to AAFP members. "If every member of AAFP contributed just $100 per year to the PAC, we would have over $8 million to spend on political activities each year. That would make us the largest medical PAC in the country, and allow us to elect more family medicine-friendly candidates to Congress." Cribben adds: "If we reach that level, that's not just a headline in AAFP News Now, that's a headline in the New York Times!"

You can learn more about FamMedPAC at

www.fammedpac.org, or call Mark Cribben at 1-888-271-5853.

Family Physician's View of the Kentucky Institute of Medicine Report

by William L. Melahn, M.D. F.A.A.F.P.

William L. Melahn, MD, FAAFP is originally from Lawrence, Massachusetts and is a graduate of Fairfield University and the Georgetown University School of Medicine. He completed his residency in Family Medicine at Lancaster General Hospital in Lancaster, Pennsylvania in 1997 and entered practice in rural Eastern Kentucky as a National Health Service Corps Scholar. He is currently the site director of the University of Kentucky Family and Community Medicine Rural Training Track residency at St. Claire Regional Medical Center in Morehead, Kentucky and is Medical Director of Student Health Services at Morehead State University. In 2004 he was a winner of an AAFP Foundation/Pfizer Teacher Development Award. His interests include maternity care, rural collaborative practice, and medical informatics.

"The Health of Kentucky, A County Assessment," published in the summer of 2007, described the health status of Kentucky's 120 counties. In it, its co-chairs, Drs. Emery Wilson and Raymond Wells, and the Kentucky Institute of Medicine (KIOM) task force members, laid the foundation for the development of a long term strategic plan to improve the health of Kentuckians[1]. As a rural family physician and residency educator, I see the KIOM report as identifying rural access issues that I face every day in practice. Most significantly, we struggle with the costs of training rural family doctors here in Morehead as the level of support received does not cover our expenses.

Making a commitment to training rural family doctors for Kentucky is the most cost-effective long-term strategy to improve health outcomes in the state. This is because wherever health inequalities are most severe, family physicians have the greatest positive impact.

In general, the addition of one family physician for every 10,000 citizens will decrease the mortality rate by between 3% and 10%. In counties where there is high income inequality, the mortality rate from all causes drops by a stunning 17% when there is adequate primary care resources. [2] Kentucky's poorest counties are rural. In contrast, when primary care resources are low, the mortality actually increases! The Kentucky Institute of Medicine report on the Health of Kentucky clearly shows that the least healthy regions of the state are its poorest and most rural. Rural family doctors can save lives.

Low birth weight infants represent a significant social and economic burden, which in part may be reduced by simply providing primary health care nearby. Nationally, the rate of low birth weight infants is the lowest in areas served by rural health centers, which are almost invariably staffed by family physicians. The rate of low birth weight infants drops by 6% compared with non-primary care oriented healthcare delivery systems. Rural family doctors can reduce low birth weight incidence.

The rate of deaths from colorectal cancer in the Commonwealth are exceedingly high, with all but 5 of the state's 120 counties having rates of death higher than the national average.[1] Family physician supply greater than 40% of the total physicians correlates with an Odds Ratio of <1.0 for late stage diagnosis of colorectal cancer. In other words, having a higher proportion of family physicians in a community can lower the rate of death from colon cancer. Increasing specialty physician supply does not lower the odds. Rural family physicians can reduce the burden of death from colon cancer.[3]

Family physicians are good for the local economy as well, with every family doctor generating an average of $878,000 in economic activity each year they practice. They produce other economic benefits in addition to the health care services they provide by creating employment, purchasing goods, and by preventing the out flux of such expenditures, as they

are very likely to live in the areas they serve, and thus make and spend their income locally.[4]

An orientation to primary care reduces socio-economic disparities in healthcare, both in terms of access and in terms of population health,[2] disparities which, according to the Kentucky Institute of Medicine report disproportionally affect rural Kentuckians.[1] Additionally, adults with a primary care physician rather than a specialist as a personal doctor had 1/3 lower costs of care with 19% lower mortality.[5]

How should we improve access to appropriate primary care to rural Kentuckians? One way is to provide enough resources to the development and retention of family physicians. The Kentucky Institute of Medicine issued their report on the state's physician workforce shortfall which presents several challenges to our policymakers and educators.[6] According to the report, there are significant physician supply challenges in all areas of the state with rural areas being particularly challenged, both in total numbers of physicians on hand as well as in specialty distributions.

At St. Claire Regional, family medicine, specialty medicine, and certified nurse midwifery collaborate in a Rural Training Track with the University of Kentucky graduating two rural family doctors every year. The residency practice provides highly effective care including prenatal and delivery care with a 12 to 13% caesarean section rate. Other rural training programs in Kentucky are located in Hazard, Glasgow, and Madisonville. Seventy-six percent of rural training track graduates practice in rural America, making them the most effective strategy for increasing the rural family physician supply in Kentucky.[7]

Increasing the supply of rural family physicians in the state will help in the provision of health services in our communities. However, talking about access is not enough. We must talk about access to comprehensive healthcare which reduces morbidity and mortality, improves the quality of the lives of our patients, and is cost-effective for our community and our state. In rural areas, family physicians are the dominant source of this care.[8]

In view of the Kentucky Institute of Medicine report, legislators should strongly consider significantly increasing direct state funding to our rural training programs in Family Medicine as a cost-effective, life saving, and positive economic measure. Certainly the legacy of such sponsorship will be celebrated by the Commonwealth's healthier citizens.

1. *The Health of Kentucky: A County Assessment*. 2007, Kentucky Institute of Medicine: Lexington, KY.
2. Barbara Starfield, M.D., M.P.H. *The Vision for Primary Care: Realizing, Renewing, and Supporting*. in *Society of Teachers of Family Medicine Annual Conference*. April 2006. San Francisco, CA.
3. Roetzheim, R.G., *The effects of physician supply on the early detection of colorectal cancer.* Journal of Family Practice, 1999. **48**(11): p. 850-8.
4. *Economic Impact of Family Physicians in Kentucky*, A.G. Relations, Editor. June 2007, American Academy of Family Physicians.
5. Franks, P., *Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience.* Journal of Family Practice, 1998. **47**(2): p. 105-9.
6. *Task Force Report: Comprehensive Statewide Physician Workforce Study*. 2007, Kentucky Institute of Medicine: Lexington, KY.
7. Thomas Rosenthal, M.D., *Outcomes of Rural Training Tracks: A Review.* The Journal of Rural Health, 2000. **16**(3): p. 4.
8. Howard K. Rabinowitz, M., *Caring for the Country: Family Doctors in Small Rural Towns*. 2004, New York: Springer.

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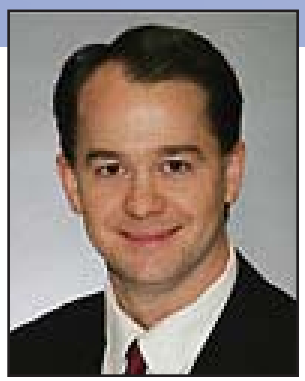
Who will care for Kentucky?
The Kentucky IOM Workforce Report

by Michael King, M.D.



Michael King, M.D., is an Assistant Professor of medicine in the Department of Family and Community Medicine, University of Kentucky in Lexington. A native of Russellville, Kentucky, he completed his medical training and family medicine residency at the University of Kentucky. Dr. King did a faculty development fellowship with Kevin Pearce, M.D., MPH, in the College of Public Health in Lexington. He has served on several national committees through the AAFP as a medical student, resident and Family Medicine faculty.

Similar to many states and the nation as a whole, Kentucky's healthcare system is experiencing significant strain and is facing worsening physician shortages that will adversely affect patients and their access to care. Kentucky's decades of physician shortages, especially in rural areas, along with its citizens' poor lifestyle choices, has resulted in unfavorable health status for the state.

Workforce Issues and Kentucky

A strong physician workforce is critical for reform, but many variables like population growth and aging, the U.S. economy, healthcare technology innovations and overall health indices influence the reliability of workforce predictions. The aging of the population will increase demand for services right when many physicians are likewise aging and expected to retire. Simply increasing the number of physicians may not mean more access to care or enhance quality of care for patients all over Kentucky given the ongoing maldistribution of physician practices. If unresolved, the lack of equitable distribution of physician services within the population will result in more severe shortages or no care in the places that need it the most, rural and underserved areas.

On a national level there is a predicted national physician shortage by 2020. The Association of American Medical Colleges (AAMC) in 2006 endorsed a 30% increase in medical school enrollment by 2015. Similarly, the national Council on Graduate Medical Education (COGME) recommended to increase residency training slots by 2015 to create about a 3% (30,000 physicians) increase in the nation's physician workforce by 2020. Most admit that this increase is insufficient to meet future needs.

As a result of growing concerns over national and state workforce trends, the Kentucky Institute of Medicine was asked to examine the trends in Kentucky's population and changing physician characteristics. Their task was to determine how these forces are likely to influence the State's number of active physicians by the year 2020. The purpose was to give an accurate assessment of Kentucky's workforce and make projections for workforce needs to guide strategy, decision making and policy.

As the 6th most rural state in the nation, Kentucky's 85 rural counties (out of 120 total) have a high proportion of chronic illness, placing significant stress on physician practices and medical resources. Kentucky has the highest cancer and heart disease mortality rates in the US, which are most severe in the rural counties. Nearly half of Kentucky's counties, 55, are designated Health Professional Shortage Areas (HPSA) for primary care which means there is fewer than one full-time-equivalent primary care physician per 3,500 population. Approximately 400 of Kentucky's family physicians are currently age 60 or above and likely nearing retirement. Kentucky's Family Medicine training programs can not realistically replace this loss over the next decade.[1]

Even worse is the fact that student interest in Family Medicine and primary care at Kentucky's medical schools and across the country has waned, as has the number of residency positions. In the 2007 National Residents Matching Program, only 7.8% of U.S. medical school seniors chose family medicine as their specialty, a significant decline compared to 10 years ago when 17.3% chose family medicine.[1] Other GME trends suggest that the number of general internists, general pediatricians and even American Osteopathic Association (AOA) trained family physicians has been declining as well.[2] There is no doubt that the current health care environment, comparatively low physician salaries of primary care providers and worsening educational indebtedness has played a role in specialty choice, away from primary care. In the end rural areas lose because overall other primary care specialties, general pediatricians, general internists, and even obstetrician-gynecologists do not enter practice in rural areas enough to impact the shortages.[1]

Table 1: Kentucky's Population and Physicians, 2007

Population: 4,206,074 (43 % Rural)

Active physicians per 100,000 population: 213.5 (Ranks 32nd)

Total Active physicians: 8981

- 76% Male
- Median age: 51 for males, 44 for females
- 81.6% Caucasian, 10% Asian, 2% African American
- 96.1% MDs (allopathic)
- 22% International Medical Graduates
- 35% Primary Care
    - 16% FM, 12% IM, 6.5% Peds

Kentucky's Current Physician Workforce

Currently there are 8,981 active physicians practicing in Kentucky. They are mainly comprised of allopathic MDs. It is important to note that only in the last few years have the graduates of the Pikeville School of Osteopathic Medicine entered the workforce. Other descriptive and demographic data is listed in Table 1 from the KIOM Workforce Report. Nationally, there are 267.9 active physicians per 100,000 people. Kentucky ranks 32nd in the U.S. with 213.5 physicians per 100,000. For comparison this trails bordering states' ratios, Tennessee (253), Missouri (235), and West Virginia (222). Kentucky would need to increase its workforce by 2298 (25.6%) physicians just to reach the current national ratio. Compounding this undersupply of physicians is the maldistribution of physicians, with only 28% living and practicing in rural areas even though 43% of the state's 4.2 million residents live in rural areas (Table 2). Rural and urban ratios differ dramatically, with 160 FTE per 100,000 in rural areas vs. 306 in urban areas.

Primary care physicians comprise 35% of the physician workforce in Kentucky. Family medicine remains the specialty of choice among Kentucky physicians (1,435), with internal medicine (1,108) and general pediatrics (585) following. Family medicine is the only specialty that distributes with the population with 56.5% of family physicians living in rural counties. Osteopathic physicians and International Medical Graduates are represented in higher proportion in rural areas compared to allopathic and U.S. medical

Table 2: Kentucky Physicians:Distribution Issues and Rural Areas
➢ Maldistribution of physicians • FTE per 100,000 Population: **164** for Rural, **306** for urban ➢ 22% of counties with <5 physicians ➢ Rural areas: • 28% of total physicians • 56.5% of Family Physicians • 44% of Osteopathic Physician • 36% of International Medical Graduates

graduates respectively. Kentucky's high levels of rurality, poverty and chronic disease, suggest an even greater need for primary care, specifically family physicians, in rural areas.

Kentucky also has a maldistribution of medical, surgical, and other specialists, severely limiting rural residents' ability to access specialty services because they are mainly concentrated around large urban areas. Like nationally, Kentucky has turned to international medical graduates (IMGs) through the J-1 visa program to help fill shortage areas, particularly those in rural areas. IMGs make up 22% of Kentucky's physician workforce, similar to national levels.

Kentucky's medical students' choices of specialty in 2006 followed closely with national trends. Forty-three percent of allopathic medical students selected primary care (family medicine, internal medicine, or pediatrics) compared to 66% of osteopathic students. However, only 19% of allopathic students plan to practice in rural locations compared to 60% of osteopathic students. Many variables affect specialty choice; these include strong personal commitment to certain specialties early in a medical career, expectations about lifetime earnings, and the understanding that most physicians can find a way to manage their debt through loan repayment programs, hospital buyouts and programs used to attract specialties in demand, including primary care.[1]

Projected 2020 Physician Workforce for Kentucky

Factors such as age of physicians, retirement rates, gender, work ethic and type of practice all influence the supply of physicians and their work. The fact that half of all medical students nationwide are women will have a tremendous workforce impact since there is a higher proportion of women practicing in urban areas and they are twice as likely to go into primary care and serve minority, urban and poor populations. Women already outnumber men in family medicine, pediatrics, obstetrics and gynecology, psychiatry and dermatology.

In terms of future demand for physician services, national projections predict an increase of 22% over 2005 levels. Reasons behind the increase demand include a rapidly growing elderly population, poor health status of children and teenagers, higher rates of chronic disease, poor health literacy rates, higher poverty rates and increased number of uninsured patients. Nearly all of those issues are more prevalent in Kentucky and further exacerbated by the rural nature of the state.

Recognizing the current inadequate workforce in Kentucky, the data for Kentucky's workforce supply was compared to national statistics and adjusted to meet the U.S. ratio of 267.9 physicians per 100,000. As stated previously, this amounted to an additional 2,298 physicians

or a 25.6% increase over current numbers (Table 3). The adjusted Kentucky workforce data was then used to project the supply, need and demand for physicians using the Physicians Supply Model (PSM) and Physician Requirement Model (PRM) developed by the Health Resources and Services Administration (HRSA). The demand projections are based on the continuation of current population and economic trends. All the projections using the models assume that current patterns of new graduates, specialty choice and practice behavior continue.

The supply, need and demand for physicians in Kentucky projected for 2020 would require 12,846, 13,422 and 14,989 physicians, or an increase of 43.0%, 49.4% and 66.9% over current numbers (Table 3). Much of this projected increase would be in the primary care specialties (49.7-59.6%). The other specialties projected to be most undersupplied, in need or in demand in 2020 would be general surgery (62.2-231.5%) and psychiatry (62.8-208.0%), although all specialties require an increase in workforce. Emergency medicine would require the fewest number of physicians by 2020, but this would depend on continued utilization rates. For the past 10 years the average annual growth in active physicians for Kentucky is 2.4%. If this rate were to continue, this would add 3,243 physicians by 2020. Kentucky, however, would still need 622 more active physicians to reach the projected supply requirement, 1,198 to meet need, and 2,765 to meet demand, or an increase ranging from 7-30%.

All projection models are based on some workforce and healthcare environment assumptions, so variations differ based on the approach. The American Academy of Family Physicians put together its own needs based workforce policy to specifically identify the workforce needs for family physicians in 2020. This report considered the current trends in specialty care and included declining primary care choice by other specialties such as internal medicine and pediatrics. It also makes an assessment that there is an imbalance of sub-specialization over primary care and that the healthcare system needs a certain percentage of primary care to improve health outcomes. The AAFP workforce study concluded that a needs based projection would result in a need for 2,409 family

Table 3: Kentucky Physicians 2007 and Projected 2020 Workforce

	2007				Kentucky 2020		
	KY Ratio[1]	US Ratio[1]	Current Number	Current Need[2]	Supply	Need[2]	Demand[2]
Kentucky Total	213.5	267.9	8981	25.6%	12,846 (43%)	13,422 (49.4%)	14,989 (66.9%)
Primary Care	94.1	74.4	3128	26.7%	4,684 (49.7%)	4,636 (48.2%)	4,993 (59.6%)
Family Medicine	34.1	38.0	1435	11.6%	1,893 (31.9%)	1,858 (29.5%)	2,018 (40.6%)

[1]Number physicians per 100,000 people
[2]Based on Current US Physician to Population Ratios

physicians for Kentucky to achieve a ratio of 41.6 family physicians per 100,000 population.

Improving the Physician Supply

To address the shortage of Kentucky's physician workforce, the KIOM report proposes strategies to increase the state's supply of physicians, improve the diversity of its physician workforce, address the uneven distribution of physicians, increase physician productivity, and facilitate more effective workforce planning. Overall, Kentucky simply needs to supply more physicians and the rural communities clearly are in the greatest need. The state must continue to attract physicians to the rural areas, but most importantly students from rural Kentucky need to be increasingly enrolling and be accepted into medical school.

The Area Health Education Centers (AHECs) and Health Career Opportunity Programs both currently act to encourage and increase rural, underserved and minority students pursuing careers in health professions. The M-1 Trover Rural Pathways Program also acts to maintain interest in rural practice among students. With the establishment of the Pikeville School of Osteopathic Medicine in 1997, the state got a school that trains students in a rural setting and is more likely to produce family physicians than allopathic schools (46% vs. 11%) and to have graduates choose rural practice (18.1% vs. 11.5%).

Some nationally recognized programs like the Physician Shortage Area Program (PSAP) at Jefferson Medical College could be emulated to create more comprehensive selection and training programs to target rural and minority primary care physicians. Since 1974 it has included only 7% of graduates yearly but now accounts for 21% of the Pennsylvania's Family Physicians in rural practices. Elements of these types of programs already exist with the already established Trover Rural Track at the University of Louisville medical school as well as rural training opportunities at the other medical schools. Each has had varied success. Continuing to develop both a rural and minority "pipeline" will go a long way towards combating the maldistribution in the Kentucky physician workforce.[1]

All of Kentucky's medical schools have increased annual admissions in recent years to act on the shortages and the University of Kentucky is pursuing an expansion of its class specifically for a rural clinical campus in Morehead similar to the UL-Trover Rural Track in Madisonville. Other potential rural campuses are being considered as well. Expansion of graduate medical education is also a consideration to aid the workforce shortage, but caps on Medicare funding limit this option. Successful expansion of GME slots for primary care, specifically Family Medicine, would likely show immediate gains in rural physician supply. Legislative efforts nationally could help to increase these positions.

Other federal governmental advocacy efforts such as the support and expansion of the National Health Service Corps, the development of more Federally Qualified Health Centers and improved reimbursement for primary care and underserved areas could help the alleviate the maldistribution and workforce problems. State legislative efforts to provide incentives or funds for loan repayment could also help improve the success of retaining resident trainees and recruiting physicians to Kentucky.

Impressions

There are some limitations in the KIOM workforce study

specifically related to the prediction models. The baseline projection assumes that current patterns of new graduates, specialty choice and practice behavior continue. It also assumes that national 2007 workforce ratios represent an appropriate healthcare workforce with regards to proportions of specialties, primary care vs. sub-specialty care. Fifty years ago, half of the US physicians were generalists or primary care providers. Currently, primary care physicians represent only 35% of all physicians. Is a physician workforce that is predominantly sub-specialty physicians good for Kentucky and the U.S. Healthcare System? An expansive amount of research supports that a primary care-based healthcare system matters. Higher concentrations of primary care, in contrast to specialty to care, has proven to lower mortality, reduce cost and over utilization of health care resources, and achieve more equitable health for populations at the county, state, national and international levels.[3,4.5] Above a certain acceptable level of sub-specialist supply, health outcomes worsen. Specifically, an increase of one primary care physician per 10,000 population, results in a decrease of 14.4 deaths per 100,000 with an enhanced effect on racial disparities.[6] In some instances, having a primary care physician as a usual source of care is a stronger predictor of good health outcomes than insurance status.[7] Among primary care specialties, only Family Medicine was consistently associated with lower mortality when controlling for other factors.[3] The optimum ratio of sub-specialists to primary care is not clear, but evidence supports that in the US, we are too sub-specialized as a healthcare system.

Who will care for Kentucky in the future? Based on the workforce data it is clear that primary care physicians, specifically family physicians, provide the vital access to care for rural Kentucky. No doubt that in the future they will continue to do so. No other specialty has proven they will distribute within, and to, the entire population. The real question is will we support the rural workforce financially and as a healthcare priority?

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Help Patients with Lactose Intolerance Enjoy Dairy Foods

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Lactose intolerance is a widely known condition, but people who don't know the whole story can end up limiting their diets more than necessary – and may put their health at risk. Lactose intolerance is sometimes mischaracterized as an allergy, which typically requires complete avoidance of a food. Lactose intolerance is actually the group of symptoms some people experience resulting from the inability to digest lactose, the natural sugar in milk, because of a genetically low level of the enzyme lactase. Gas, bloating and diarrhea are common symptoms, which may occur as early as 3 years old or become more evident with advancing age. But no matter when the onset is, lactose intolerance is manageable. Some cases are even temporary, caused by medication or illness. The real problem lies in removing dairy foods from the diet, because they supply a variety of important nutrients.

In addition to calcium, people who don't eat or drink enough dairy foods miss out on the key vitamins and minerals that are naturally present in them. The Dietary Guidelines identified calcium, potassium, fiber, magnesium and vitamins A, C and E as "nutrients of concern" for adults and calcium, potassium, fiber, magnesium and vitamin E as "nutrients of concern" for children.[1] Dairy foods supply four of the seven "nutrients of concern" for which American adults have low intakes and three of the five nutrients of concern for which children have low intakes.

The importance of getting dairy's nutrients is especially critical for certain populations. For children, a clinical report from the American Academy of Pediatrics encourages that even those with lactose intolerance consume dairy foods to obtain nutrients essential for bone health and overall growth.[2] Recently, the *Journal of the American Dietetic Association* reported that African-Americans of all ages consume fewer than three servings of dairy a day on average, and have lower-than-average intakes of calcium, magnesium, and phosphorus.[3] Another study, published in the September, 2007 issue of *Pediatrics*, tested adolescent girls who believed they were milk intolerant and found that of this group, only 55 percent actually were. But the girls who thought they were milk intolerant consumed an average of 212 mg less calcium each day than their counterparts, and had significantly lower bone mineral content in their spines.[4]

"The good news is even if you've experienced difficulty before, you can still drink milk and eat cheese and yogurt with a few simple steps," says Dr. Winston Price, pediatrician and former president of the National Medical Association. "Missing out on the tremendous nutrient value in dairy foods can be a big mistake.

Easy Strategies Keep Dairy in the Diet

"As with most dietary issues, the key is starting with small changes," says Dr. Price. "I tell my clients to try drinking small portions of milk with their meals. The other foods in the meal help slow digestion and give the body more time to digest the lactose. If the milk is tolerated, portions can gradually be increased over time." A meta-analysis of clinical studies showed that people with lactose maldigestion could drink up to a cup of milk with a meal and remain symptom-free.[5]

There are other easy ways your lactose-intolerant patients can keep milk, cheese, and yogurt in their diets:

- Drink milk with food, introduce dairy foods slowly, and increase your intake gradually.
- Cultured dairy products like yogurt contain live, active bacteria that help with digestion.
- Cheese is another great source of nutrients, and harder varieties like Cheddar, Colby, Swiss, and Parmesan are low in lactose.
- Lactose-free milk is available in most stores.
- Another option is lactase supplements in pill or liquid form. They should be taken with the first sip or bite of a dairy food.

Don't Take Their Word For It

Before they have the facts, it is common for people to assume that lactose intolerance means that dairy products are "out." It is the role of a health professional to intervene with a clinical diagnosis and professional guidance. Most people will be relieved to learn that not every digestive problem is dairy-related, and that even people who have difficulty digesting lactose can continue enjoying milk, cheese, and yogurt. Giving up these foods unnecessarily can deny a person the health benefits that dairy foods provide.

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Most people with lactose intolerance *can* enjoy dairy foods. They can reduce symptoms by drinking small portions of milk as part of a meal, and gradually increase their intake over time. A meta-analysis of clinical studies showed that those diagnosed with lactose maldigestion could consume up to 1 cup of milk with a meal and stay symptom-free.[1] The 2005 Dietary Guidelines recommends three servings of low-fat or fat-free dairy foods every day as part of a healthy diet. It also recommends lactose-free milk or yogurt containing live, active cultures as alternatives to milk for those with lactose intolerance.[2] Hard cheese, which is naturally low in lactose, is another calcium-rich choice.

For children, the 2006 American Academy of Pediatrics report, *Lactose Intolerance in Infants, Children, and Adolescents*, recommends consumption of dairy foods in order to get enough calcium, vitamin D, protein and other nutrients essential for bone health and overall growth. The AAP report recommends several dairy options for children that are often well-tolerated, including lactose-free or lactose-reduced milk, yogurt or hard cheese such as Cheddar or Swiss.[3]

Encourage your patients to meet recommendations for 3 servings of dairy foods every day.

For more information on lactose intolerance visit www.nationaldairycouncil.org

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