FALL 2009
VOLUME 65

The Official Publication of the Kentucky Academy of Family Physicans

Quality and Rural Health: A Professional Odyssey

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STRONG MEDICINE FOR KENTUCKY

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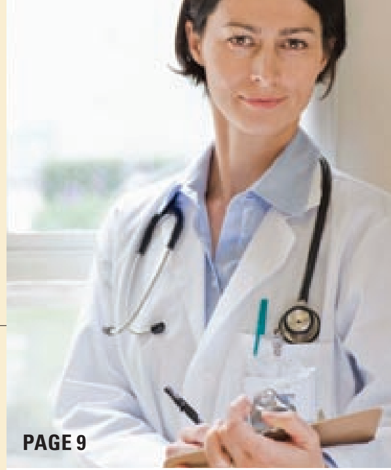

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September 16, 2009
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Hyatt Regency Louisville
Louisville, KY

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October 12-14, 2009
Westin Boston Waterfront/Boston Convention & Expo Center
Boston, MA

2009 AAFP ANNUAL SCIENTIFIC ASSEMBLY

October 14-18, 2009
Boston Convention and Expo Center
Boston, MA

OCTOBER BOARD MEETING

Friday, October 30, 2009
7:00 pm - 10:00 pm
Barren River State Park
Lucas, KY

OCTOBER SAMs PREP SESSION - Care for the Vunerable Elderly

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message from the PRESIDENT

WHEN I WAS THINKING ABOUT WHAT I WAS GOING TO WRITE, I STARTED THINKING ABOUT THE QUESTION, "WHAT ARE THE CHALLENGES OF BEING A FAMILY PHYSICIAN IN KENTUCKY?"

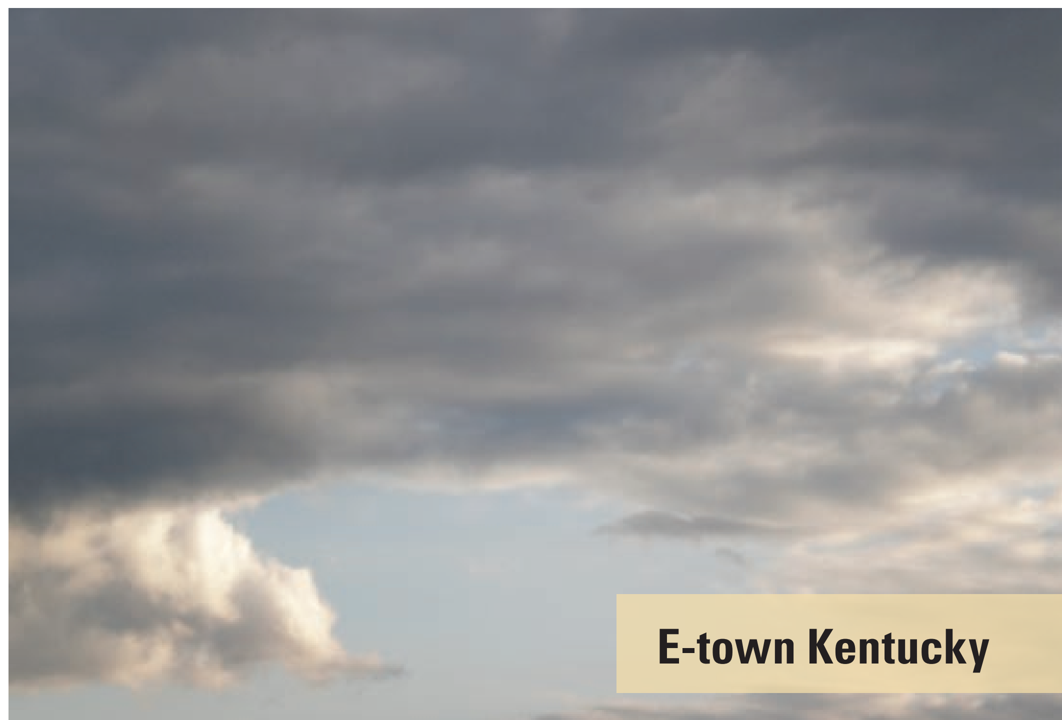
I hope that by the time you read this you will have already written your letter to CMS. We need to take every opportunity to support legislation that will have a positive effect on family medicine. We have quite a bit of power and influence, but we have to make the choice to use it wisely. Hopefully many of you have met with a selected group of your patients to discuss medicine as it is now and how it may change in the future.

We must focus on the positive things that we have now and use them. On the way home from the Southeast Forum yesterday, I looked up in the Kentucky sky to see the sun coming through the clouds and I stopped to take a picture. I am sure that the people in the Towne Mall parking lot thought, "What is she doing?" The Maryland folks did not seem to notice that I was taking a picture of their sunset on Saturday. Each picture was very beautiful, but how often do we stop and look at the sunset that we have been given in Kentucky? How often do we continue to look at the clouds instead of the sunlight? We have the talent to take the healthcare of Kentucky forward and we need to share with our patients and the legislature what we can provide that other medical specialties cannot. As I heard at the Forum, we are 30% less expensive and

a Maryland sunset

the patient is 19% less likely to die with our care than with care from other specialties, especially hospitalists. Knowing our patients is invaluable.

Let me share a recent example with you from my practice. One of my patients is widowed who I had seen at the Farmer's Market every Wednesday and Saturday as I passed by on my way to the gym to workout. One day I noticed she was not there. The next time she came to the office, she made no complaint about chest pain or feeling bad. She just stated that she needed refills. I asked why I had not seen her at the Farmer's Market. She stated that she did not feel like going. After further questions, I ordered a stress test. She ended up having coronary artery disease, which required intervention. You have to know the patient well enough in rural America to ask the right questions. We are irreplaceable and we need to stand up for Family Medicine now! Most Americans desire to have a family physician for their primary care.



At the Southeast Forum we had great speakers and we listened to what other chapters have done and what they have found that works the best. We will be trying to provide CME that cannot be obtained online - as much as we can because the double credit for evidence based CME ends at the beginning of 2011.

We also heard from Delegate Shirley Nathan-Pulliam, a legislator from the state of Maryland. She reviewed the health care legislation from the past few years. Many states have problems similar to Kentucky's. We have more power and influence when we band together. Keep focusing on the positive things we have to offer. Thank you for sending me to learn from other states. Go out today and everyday and have a positive influence on Family Medicine. We have great sunlight that we can share.

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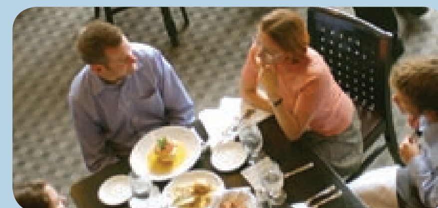

LETTER FROM THE EDITOR: MECHANICS, WAR, AND DOCTORS

As I reflect on the breadth of the articles in this month's journal issue, I am struck with something special about our discipline. As this idea forms in my head, I'm thinking about a radio segment I heard this a.m. that likened doctoring to the role a mechanic plays in our culture. The "car guy" is basically a businessman, and has information and understanding of our car's workings that the "lay" person doesn't have. So when he suggests that we need a $350 repair to keep us moving and safe, we tend to accept his recommendation. And then when the equivalent of the car MRI is completed and something more significant is found, we swallow hard and come up with the additional $850 that's now required.

Even the radio commentators noted some differences between this analogy and modern American medicine. First, if the repairs cost more than we think the car is worth, we'd just scrap it. Despite talk show drivel that says otherwise, we're just not a country of euthanizers. The second difference is that the $1,200 repair bill would likely just cost us about $150 to $250 in co-pay if we are privately insured and zero if we're covered by automobile Medicaid. A trusted, knowledgeable person is recommending something that may save my car's life and it seems like quite a bargain, so why not proceed?

This analogy generates something akin to nausea in me. How did we get here? The concept of health insurance began as accident and disability insurance around the time of the Civil War and transitioned to sickness insurance around the time of the First World War.[1] Employer-based health insurance that is tax exempt arose as a way for companies to attract scarce workers during World War 2, at a time when wages were frozen by law. Then came Medicare and Medicaid around the time of the Vietnam War. What is it about war time that is associated with health payment changes? Now we are fighting on two fronts in Iraq and Afghanistan and we've decided we can't afford the health payment system we have. Both the left and the right of the political spectrum have staked out their territory. Will it end like the days of the Clinton plan of 15 years ago?

> SO WHAT STRIKES ME IS THAT FAMILY PHYSICIANS SIMPLY DO WHAT NEEDS TO BE DONE, WHERE IT NEEDS TO HAPPEN, WITHOUT REGARD FOR SPECIALTY LINES OR WHETHER IT LEADS TO PERSONAL GAIN.

Then there's the whole "businessman" thing. When did medicine transition from ministering to the needy to "providers" apportioning "services" to "consumers?" Historians argue, but I believe that something was lost when the "third parties" entered the exam room.

Back to what strikes me in this journal issue. Dr. French doesn't mention the business model in his carefully crafted letter to the editor. This despite the fact that data from Barbara Starfield summarized by the AAFP Graham Center makes the clear case that family physicians provide the best care with the lowest overall cost.[2] And Dr. Calico's thoughtful summary of the new center in Danville talks about engaging the physician with the community and improving population health – neither of which have a CPT code nor payment associated with them. Drs. Wrightson and Stone describe fearlessly venturing into the mouths of toddlers to prevent caries, a scourge of our rural areas. Dr. Bennett's complete analysis of changes in Medicare payment for rural care highlights just how important these changes can be for family physicians.

So what strikes me is that family physicians simply do what needs to be done, where it needs to happen, without regard for specialty lines or whether it leads to personal gain. And our gaze goes beyond the walls of our offices and hospitals, to where our patients live. The modern John Snows point out the pump that spreads cholera[3] and the modern Maimonides consider that man can only seek God in His fullness when his basic health needs are met.[4] The modern Semmelweis notes when the traditions of medical training may be harming more than they help.[5]

So find some time, sit back and enjoy this journal issue- you deserve it.

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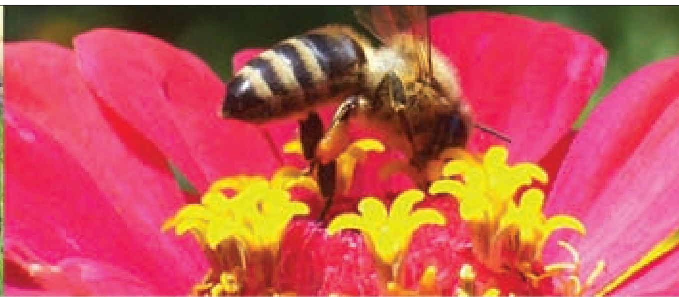

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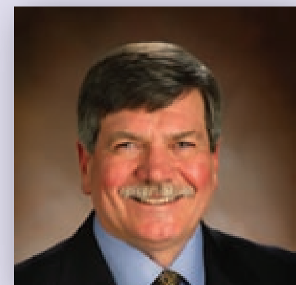

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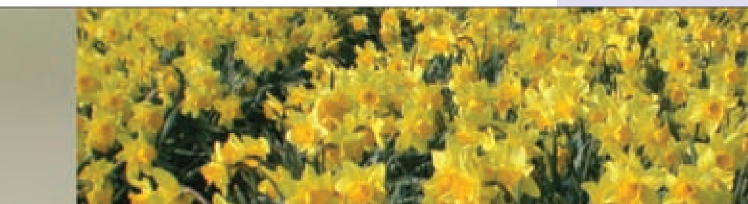
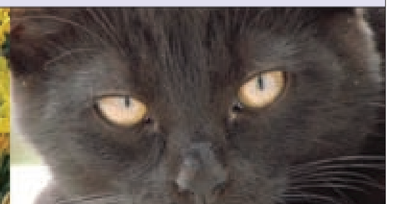

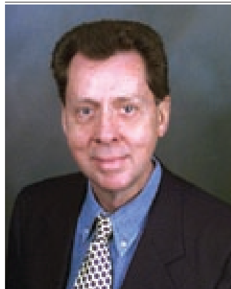

QUALITY AND RURAL HEALTH: A PROFESSIONAL ODYSSEY

BACKGROUND

How do health professionals reach beyond daily activities required in caring for people to make a difference in the larger health arena? For example, how do we develop programs to improve the health of the population in our service area? How do we positively influence the future of health, health care and the health professions? Here is the story of one Kentuckian who was inspired in Medical School at the University of Kentucky (UK) to approach his profession with that intention. The story starts on a poor farm in Garrard County; its last chapter is being written as the director of a new UK Center for Rural Health.

The concept of Centers for Rural Health became a reality in Kentucky in the early 1990s, after the legislature designated the UK College of Medicine as the agency responsible for establishing the first Center in Hazard, Ky. Dr. Wayne Myers, a physician with extensive experience and impeccable credentials in rural health and health care, was recruited from the WWAMI (Washington - Wyoming - Alaska - Montana - Idaho) system to be the founder of Centers for Rural Health in Kentucky. He and his spouse JoAnne, a rural health expert in her own right, came to Hazard and became 20th century Kentucky pioneers in rural health. Dr. Myers eventually accepted the position of director of the Federal Office of Rural Health Policy, later moving to his farm in Maine. Subsequently, the decision was made to develop other centers so that rural Kentucky could be completely served and centers sprang up in Morehead, Madisonville and Murray. Now the fifth center has emerged in Danville to serve central Kentucky.

To undertake development of the new center, yours truly was recruited, leaving a very pleasant retirement. The opportunity to focus the learning from a lifetime of experience and interest in rural health was just too attractive to ignore—farm and grandchildren notwithstanding. Deep roots in rural Kentucky and a desire to contribute to that environment were also persuasive. Additionally, extensive experience in rural quality improvement at the national level should enhance the effectiveness and relevance of a Center for Rural Health.

The acquisition of this experience began as part of a farming family in Garrard County. Influenced by a high school biology teacher, this young UK college student decided to reach far beyond his comfort zone and try for a medical education. Through great good fortune, my professional trajectory progressed through the UK College of Medicine (with special emphasis on the Department of Community Medicine) and into the Air Force for Preventive Medicine and Family Medicine Residencies. Subsequent Family Medicine Residency faculty and directorship positions were followed by several years as a physician executive in a rural health care organization and then a tour with the Federal Office of Rural Health Policy. In this setting, working with small rural hospitals across the country and with the National Academy of Sciences Institute of Medicine, deeper understanding about rural systems of care and quality began to take shape. The requirements and the opportunities for improvement became increasingly clear. Rural providers must work together (collaboration); care must be a continuous process over time, with different providers and in different settings (continuity); communication among providers, with recipients of care, and with all stakeholders must become a fine art; and the community must participate intimately and meaningfully in health decision making and priority setting in an environment of complete transparency and accountability. These four characteristics formed a conceptual framework for a comprehensive approach to rural quality. Clearly, rural communities are much better prepared to build functioning systems of care based on these concepts than is possible in intensely competitive urban settings.

Upon returning to KY in 2006, many voluntary opportunities presented themselves, including membership on several health boards (Foundation for a Healthy Kentucky, our local hospital and health department, our Medicare quality improvement organization, the Kentucky Institute of Medicine and a new group called the Friedell Committee for Health System Transformation, which is based on the belief that transformation must be designed on a foundation of accepted principles of health and health care rather than economics). These connections, combined with experience and interest, made the opportunity of a Center for Rural Health project irresistible. It should be the perfect setting to apply everything learned in a long career and to optimize the contributions to other affiliated organizations.

A Center for Rural Health is simultaneously integrated with the educational and research capabilities of UK and the health infrastructure of the geographic region it serves. Functionally, it is responsible, in its designated rural area and in collaboration with the other centers:

- To promote the education of health professional students in rural settings
- To facilitate research relevant to rural health issues
- To assist in improving service in any feasible manner in rural communities
- To engage communities around health services and health status improvement

Of particular interest in the Danville Center will be developing healthy community coalitions and building collaborative systems (in which the "moving parts" of a health system that exist in a community actually work together in a collaborative system mode). Additionally, the center will focus on our youth and work with schools, as this represents the most effective way to exert leverage for health improvement that may propagate into the future. The center is to be a virtual organization with full

continued on page 12

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THE CONCEPT OF CENTERS FOR RURAL HEALTH BECAME A REALITY IN KENTUCKY IN THE EARLY 1990S, AFTER THE LEGISLATURE DESIGNATED THE UK COLLEGE OF MEDICINE AS THE AGENCY RESPONSIBLE FOR ESTABLISHING THE FIRST CENTER IN HAZARD, KY.

active partnership of stake holders. These partnerships will extend far beyond the "usual suspects" in the health care arena. Faith communities, local government, business, schools, parks/recreation, UK Ag extension and many others must join the entire provider community including health departments in collaborative efforts to make meaningful impacts on population health. Centers for Rural Health, rural systems of care, quality and health status improvement fit together nicely as we contemplate health transformation!

QUALITY AND THE CENTER FOR EXCELLENCE IN RURAL HEALTH—DANVILLE

The new Center for Rural Health aspires to impact the 'big three' of health system transformation: access, quality and cost, for the rural population of central Kentucky. Consider that cost is a major factor that blocks access, and that quality is a meaningless term in the absence of access; ultimately, since the three aspects are interdependent and cannot easily be teased apart, we could say the discussion is all about quality! So this section of the essay will address rural quality as a core driver of health system transformation.

Three experiences led me to recognize how the usual discussion of quality of care, based primarily on experiences in hospitals, was necessary but entirely insufficient for improving quality in rural settings. The reasons are fairly obvious. Most of our hospitals are small and while doing things very well is enormously important, the impact on overall health status of our communities will be small. Rural America is often characterized by remoteness and sparseness of resources, staff and technology and care in such settings is mostly ambulatory, highly dependent on effective transportation and transitions ("hand-offs") of care from provider to provider and setting to setting. Working with small rural hospitals across the nation, as program director for the Medicare Rural Hospital Flexibility grant program, made these factors increasingly clear and pressing. It was in this setting that it became apparent that the competitive urban model was not appropriate in rural settings and that collaboration had to become the centerpiece of quality improvement for Rural America. Collaboration had to occur across the complex continuum of care and required excellent and effective communication. In order to effectively serve the community and improve rural utilization (deal with the outmigration phenomenon), active community engagement had to be an operational characteristic of successful rural health organizations. Such transformation required drastic change in management philosophy and organizational culture. So the new focus of the grant program noted above became quality and community engagement rather than continuing to play reimbursement games.

The second formative experience as a federal employee was working with the Institute of Medicine in the production of their first publication directly addressing rural health issues. It was a great privilege to be both instrumental in the decision to do the work and subsequently to assist in acquiring funding for the project. Some Calico ideas even found their way into the book! The title is **Quality Through Collaboration: The Future of Rural Health**, published by the National Academies Press in 2005. It is part of the Quality Chasm series and merits your close attention. The Committee that produced the book was chaired by Mary Wakefield, the new Administrator of the Health Resources and Services Administration. The book makes twelve policy-level recommendations for improving all aspects of rural health care; it addresses quality improvement, finance, personnel, technology and integration.

Another significant experience merits mention. The two years following retirement from Federal service were filled with travel

throughout the nation under the auspices of the National Rural Health Association (NRHA), studying highly effective, exceptional programs that provided examples of excellence in rural health care. These studies were documented in an NRHA publication entitled **"What Makes Rural Health Care Work"** (2007). Characteristics leading to success of these highly varied programs were addressed in considerable detail, with the hope that such innovation could become normal instead of the exception. Note that these successes became reality in the existing policy and reimbursement environment, showing that much is possible even without total transformation if the will to innovate and create exists.

How does all this relate to a new Center for Rural Health? Consider this: a center serves as a catalyst for innovation in the areas of rural health professions education, research, service and community engagement. Transforming vision into reality by implementing evidence-based best practices to improve quality and reduce cost will improve rural health status and serve as a model for improving health for all Americans, building on the strengths of rural communities. The center can develop activities and programs that lead to converting exceptional islands of excellence into standard practice in many more rural communities. In addition to services, research and education, three general areas of community engagement might include:

- Facilitate problem-solving at the community level
- Develop coalitions for healthy communities
- Initiate conversations about:
  - Caring for all in the community
  - Improving population health status
  - Solving pressing health issues
  - Gaining community support for local services (improve utilization)
  - Building systems to assure that rural people have quality of care equal to the best

CONCLUSION

This 'odyssey' was introduced with three questions. How shall they be answered? First, all the actions above are undertaken using the principles of collaboration, continuity, communication and community engagement and the learning reflected in the sources above. In my experience, these: (1) relate directly to quality; (2) get the physician engaged with the community and outside the practice; and (3) improve health status of the population of the service area. None of this is esoteric; rather, the ideas seem to be based in 'common sense'. The bottom line is a plea for all of us in family medicine to look at the 'systems' with which we struggle daily and seek new approaches to change through building new systems of care, a new set of assumptions and new measures for success. These can be achieved through regional alliances facilitated by our Centers for Rural Health. Important learning through research and effective educational experiences through rural rotations can be achieved. We can make the health care environment much better for our patients, our communities and ourselves. It's possible, it's worth the effort and only we can do it!

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__Forrest W. Calico MD, MPH__ is Director of the UK Center for Excellence in Rural Health in Danville, KY. He served as Senior Advisor for Quality with the National Rural Health Association (2005-2007), and as the Health Systems Advisor for the Federal Office of Rural Health Policy (1999-2004), where he was responsible for the Medicare Rural Hospital Flexibility Program and actively promoted rural healthcare quality improvement.

Dr. Calico graduated from the University Of Kentucky College Of Medicine and the Harvard School of Public Health. He served in the United States Air Force for thirteen years as a Flight Surgeon and Family Physician, after residency training and Board certification in both Family Medicine and Aerospace Medicine. Subsequently he has directed Family Medicine Residencies (military and civilian) and served as a physician executive in a large rural healthcare organization. He resides on his farm in Lincoln County, KY, with his family.

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Impact of Real and Threatened Cuts for **Kentucky's** Healthcare Providers and Patients:

The Robert Graham Center Presents A Medicare Payment Report

INTRODUCTION

Since the advent of Sustainable Growth Rate (SGR) legislation in 1997, avoiding negative adjustments to Medicare payment rates has become an annual ritual of balancing fiscal discipline against threats to health care access for millions of Americans. Citing payments that scarcely meet their overhead costs, primary care physicians find themselves increasingly forced to consider limiting or ceasing to see Medicare patients. Even against this backdrop, Medicare payments and access faced a unique challenge in the summer of 2008, in which several overlapping cuts were proposed. Most primary care physicians do not fully appreciate the extent to which these cuts could again impact payment and access in their states.

In May, the Robert Graham Center, the independent policy research organization of the American Academy of Family Physicians, released a report on the potential impact of the cuts we faced in 2008. (One of these cuts was actually passed, eliminating bonus payments for designated Physician Scarcity Areas.) We analyzed the impact of both actual and proposed cuts in order to prepare physicians to understand the many ways in which future changes might affect their practice. We also performed a state-by-state analysis in which we modeled the average loss potential for both the state and the county of interest. (For methodology please see http://www.graham-center.org/online/graham/home/tools-resources/maps/maps/medicare-payment/methods.html.)

IMPACT FOR KENTUCKY

The results of our modeling show that Kentucky physicians who qualified for bonuses under the Physician Scarcity Area designation[1,2] lost approximately $6.42 per Medicare visit due to the discontinuation of this program. That amount may sound trivial until one considers that it equates to $8,451 per year for a primary care physician seeing an average caseload of Medicare patients. As is depicted in Figure 1, **these cuts occurred in every area of the state**, sparing only those counties near universities or large population centers.

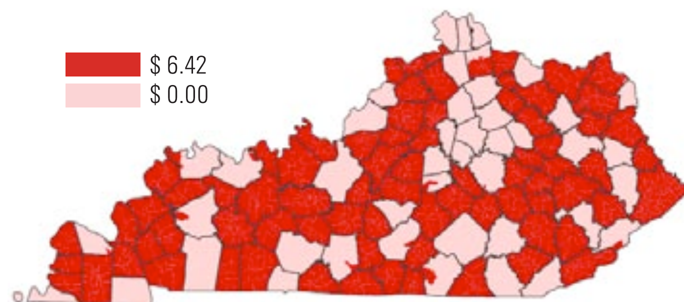

FIGURE 1. Kentucky's dollar losses per Medicare visit due to expiration of the Physician Scarcity Area bonus.[3]

If all the Medicare payment mechanisms[3-6] debated last year had been discontinued, losses in Kentucky would have ranged from 12.05 percent to 23.52 percent of baseline Medicare revenue (Table 1). For those experiencing the maximum cuts, that percentage would have been equivalent to approximately $45,717 a year. **The hardest hit area, shown clearly in Figure 2, would be the central Appalachian region.** These counties depend on the bonus payments they receive for providing access to the most underserved of our state and would be unlikely to have the resources to continue that service if cuts this large were approved. The average loss would have been 13.25 percent, significantly above the 10.6 percent across-the-board cut that was extensively reported in the media.

EXPLANATION OF PAYMENT MECHANISMS

What were these various cuts? The first is **the conversion factor dictated by the sustainable growth rate (SGR)**. The conversion factor transforms the "relative value" of billed E&M or CPT codes to dollar figures. Because Medicare payments are determined by the pre-set formula of the SGR, and because the total Medicare expenditure is capped by law, Congress must regularly reduce the conversion factor.[5] In House Bill HR 6331 of 2008, that cut was equivalent to 10.6 percent. Congress rescinded the change, but the current bill holds rates only until 2010, at which time the formula calls for a 21 percent cut.[6]

We analyzed the impact of both actual and proposed cuts in order to prepare physicians to understand the many ways in which future changes might affect their practice.

The second payment cut involved **Physician Scarcity Areas (PSA's)**[1,2] PSA status conferred quarterly 5 percent incentive pay-

ments for physicians in scarcity areas. As a condition of avoiding the 10.6 percent SGR loss in June 2008, P*SA designations were allowed to expire*. Providers in qualifying areas have now been experiencing a reduction of revenue since July 2008.[1,2]

The third proposed change involved **Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/MUPs)**, which were scheduled to be merged under a new rule. These areas of under-service are designated based on separate criteria under different authorities. HPSAs receive a 10 percent bonus and initial eligibility to recruit National Health Service Corps participants, while MUAs do not receive automatic payments but are eligible for grants. HPSA and MUA providers were all at risk of losing these designations and would have had to undertake a costly re-application based on new criteria. This change was not enacted in 2008, but will be re-addressed this year.[3,6,7]

The final cut was the elimination of the "floor" factor of the **Geographic Practice Cost Index (GPCI)**. This cost-of-practice adjustment allows for higher payments in regions with higher cost-of-living. Under the original plan, rural areas serving the most vulnerable Medicare patients would have lost revenue due to low GPCI scores. To prevent these losses, a payment floor was instituted in the 1990s. This floor adjustment is currently still in place but will also be re-addressed in 2010.[4,5]

IMPLICATIONS

In Jan. 2010, Congress will again be faced with cutting Medicare payments via a scheduled 21 percent overall reduction according to the sustainable growth rate formula. In addition, removal of the GPCI floor will be under consideration. HPSA designation rules will be reviewed again in 2009. These policies were designed to assure access to care for all Medicare beneficiaries. In Kentucky, many practices have already lost significant revenue that supported Medicare patients and clinics serving the most underserved in the state, and are at risk of losing much more if more cuts occur. These changes are a matter of access for Kentucky's citizens dependent on Medicare. Physicians, healthcare organizations, policymakers and stakeholders will want to be familiar with all these Medicare payment policies and their local impact in order to understand health system revisions and advocate for appropriate Medicare policy. Given the current attention to health care reform in Congress, the next three through 12 months will be crucial in establishing a system that is both rational and equitable, and preserves access for patients.

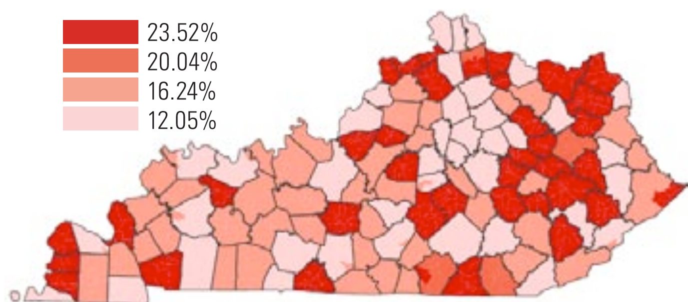

FIGURE 2. Percent losses on Medicare visits that would have been experienced if all proposed cuts of 2008 had been enacted.[3]

TABLE 1. Combinations of proposed payment reductions threatening Kentucky 2008.[3,4]

	SGR, GPCI floor, PSA, HPSA	SGR, GPCI floor, HPSA	SGR,GPCI floor, PSA	SGR, GPCI floor
% of state primary care physicians in group	4.89%	1.81%	11.94%	81.36%
Potential loss/visit after all threatened cuts	$34.73	$28.31	$21.89	$15.47
Payment reduction	23.52%	20.04%	16.24%	12.05%
Dollar loss/provider over year	$45,717	$37,265	$28,814	$20,362

The table uses estimates modeled on a typical provider within each geographic category* designated as both PSA and HPSA, only HPSA, only PSA, or neither, and whether each area currently receives the GPCI floor.

- based on status as PSA or HPSA as of June 2008. Note that the entire state has GPCI floor in place.

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***Keisa Bennett, MD, MPH** recently completed a faculty development fellowship at Georgetown University in Washington, D.C., and was the Primary Care Policy Fellow at the Robert Graham Center. The Graham Center is the policy research arm of the American Academy of Family Physicians. Dr. Bennett received her M.D. and M.P.H. at the University of Kentucky and completed her residency at Lawrence Family Medicine Residency in Lawrence MA. Dr. Bennett will begin a faculty appointment at the University of Kentucky Department of Family Medicine in Aug. 2009.*

JUST EXACTLY WHAT DOES A FAMILY DOCTOR **do?**

"HERE I AM, AN OLD MAN IN A DRY MONTH, BEING READ TO BY A BOY, WAITING FOR RAIN."

MY CARE BEGINS FOR A PATIENT WHEN HE OR SHE IS STILL INSIDE THE WOMB AND CONTINUES IN THE OFFICE, THE HOSPITAL AND UNTIL I SAY GOODBYE IN THE HOSPICE OR NURSING HOME (OR IN THEIR OWN BED AT HOME PREFERABLY!).

T.S. Eliot's *Gerontion*. I have just completed my CAQ in Geriatrics for the last time. In July, I hope to recertify in family medicine, most likely for the last time. Your reflections in the winter KAFP Journal prompted my own. Exactly what have I done in my 31 years since residency? What have I taught others to do?

This question concerning what we do has been around since the inception of our specialty. During decades in family practice education as full-time faculty and as a residency director, I observed that it was not posed by the doc in the office nor the patients in the exam room. It was reflected in new physicians from an old biased university based mentality that placed family medicine somewhere between psychiatry and chiropractic because we chose to be doctors for people, not fixers of diseases in organs. Our refusal to relinquish relationship for proceduralism has garnered us little from our colleagues in other specialties, especially at the medical school level. But our patients have always been grateful and I think will continue to be so as long as we practice the basic principles of family medicine in our professional lives.

I fear we are ceasing to do so. I fear we are asking the "what do we really DO" question now to ourselves. The answer to the question is the core of Dr. Kurfees' message in the same journal, but I would like to put it more succinctly and pointedly, not just as information but also as a challenge from the old guard to the young women and men taking my place.

I am a "second generation" family physician, one of the first to be board

certified through exam and residency training rather than grandfathering. I had a very hard time grasping the principles and the knowledge/skills from my early mentors who were obstetricians, pediatricians, internists and surgeons. All believed in family medicine. All sacrificed careers in their previous specialties to pioneer this new (and misunderstood) profession. "Oh, a GP," was awful to hear as a young doctor who wanted the professional self respect that comes from knowing who I am and what I do. And, that I do it better than anyone else. That's why I am a specialist. The inability of my teachers to convey this almost drove me to another field. Then arrived on my faculty the first residency trained family physicians I ever met. Never again did I get the answer, "Go ask the pediatrician (or the surgeon or the internist)." They had a thorough working knowledge of the principles of family medicine and actively taught them by precept and example. These are the principles I taught as a residency director, and the principles that I believe, if followed, will see us through the current healthcare crisis. I offer them back as a reminder.

PRINCIPLE 1: Family doctors provide comprehensive care.

The family physician does not discriminate by gender, age, or disease process. We provide care to all members of the family. We handle 80-90 percent of what we see in our office or hospital setting. We obtain consultation from other specialists when we have a complex problem requiring a highly specialized knowledge base or a procedure we have chosen not to include in our own armamentarium.

PRINCIPLE 2: Family doctors provide continuity of care.

The structure of my residency training was brutal and I wouldn't recommend it. But it was designed to hammer home this principle. No matter what rotation I was on, I was responsible day and night for my panel of families. I took calls, I delivered babies, I admitted to any area of the hospital. One night, I had just finished with an unsuccessful resuscitation of a man in the CCU and was explaining the outcome to his tearful wife. I received a stat page to labor and delivery where I ran the code successfully on a severely compromised newborn. On my way back up the stairs to the widow in the CCU, I realized that no other specialty offered me this view of my patients' lives. I wasn't just doing things to them; I was being a part of life with them. I was sold.

My care begins for a patient when he or she is still inside the womb and continues in the office, the hospital and until I say goodbye in the hospice or nursing home (or in their own bed at home preferably!).

PRINCIPLE 3: Family doctors are well-trained in practicing behaviorally oriented medicine.

Family physicians recognize over half of what is seen in the office and hospital is heavily influenced by human behavior. Failing to address this will be reflected in a failure of treatment. Family practice residencies give more than lip-service to behavioral medicine, family dynamics, family structure and function. Residency directors realize this is the CORE of what we do. The well trained family physician will be comfortable and enthusiastic about dealing with anxiety, depression, substance abuse, adolescent rebellion, school problems, etc. I didn't say "successfully deal with" because we begin to see success differently.

PRINCIPLE 4: Family physicians integrate healthcare services when other specialties are involved.

In a large conference on critical care medicine in Boston a few years ago, the famed Harvard geriatrician John W. Rowe presented a case to us for consideration. The patient was an 80 year old man who had suffered a large myocardial infarction and cardiogenic shock. He was in CCU on dopamine and dobutamine (the treatment of the day) and mechanical ventilation. His lungs were filling and the pulmonary/ critical care specialist had recommended thoracentesis and high dose diuretics. Fever was present. The infectious disease specialist recommended broad spectrum antibiotics. The nephrologist was considering hemodialysis for the rapidly climbing creatinine and potassium level. The cardiologist was called in. Urgent angioiography and intervention? The group was asked, "What do you think this man needs most at this time?" Answers from the crowd came fast and furious. A Swan-Ganz catheter. PEEP added to the vent settings. Hyperbaric oxygen. Urgent coronary intervention and aortic balloon pump. Dr. Rowe surprised everyone by saying that what this man needed desperately was a good family physician! He then went on to talk about family physicians seeming to be the only ones who knew how to coordinate care and help families and patients navigate the complex territory of hospital medicine in which so many get lost.

We keep the basic problem list. We keep the basic med list. We know the patient's desires for the future and their wishes about death and extraordinary care. We are the ones the patient can seek to help make complex decisions about surgery, cancer treatment, and other frightening issues. We know how to talk with people, not to people. And not intuitively. We've been trained to do it.

So when a medical student asks, "What's different about family medicine from med/peds?", I have a concise answer. All doctors should be relationship oriented. The fact that some choose not to be is reflected in their malpractice premiums. But only family physicians do what we do. Can a med/peds program give you the core training in the above principles? Of course not. It's a "/" program that tries to glue pieces of two specialties together. It is not a comprehensive, integrated program related to families where they live.

My challenge to family physicians and residency directors is this. Are we continuing to train doctors who will provide comprehensive, continuous care for every member of the family regardless of their gender, age, disease, or site of service? Or will we abandon the principles of family medicine for political and financial expediency and become "primary care physicians", the new epithet for GP? There are plenty of nurse practitioners and generalists claiming to be able to take our place.

Thoughts of a dry brain in a dry season.

Are we continuing to train doctors who will provide comprehensive, continuous care for every member of the family regardless of their gender, age, disease or site of service?

***Dr. French** received his medical degree from the University of Texas Health Science Center in San Antonio and completed his residency in family practice at Dewitt US Army Hospital, Ft. Belvoir, Va., and Walter Reed Army Medical Center in Washington, DC. He is board certified in Family Practice with the Certificate of Added Qualifications in Geriatrics from the American Board of Family Practice/ American Board of Internal Medicine. He was formerly the program director of the Residency in Family Medicine at St. Elizabeth Medical Center in Edgewood, Kentucky with a 20 year career in family medicine education. From 2000-2004 he established Senior Care Physicians, a group providing health care services to older adults in a broad range of settings in Northern Kentucky, including geriatric rehabilitation, nursing home care, and housecalls. He is currently Associate Professor of Family Medicine at the University of Kentucky and Clinical Instructor at the University of Cincinnati as well as Chief of Staff at Gateway Rehabilitation Hospital in Florence, Kentucky, specializing in neurologic and orthopedic rehabilitation of the elderly.*

NEWSPAPER

HEALTH & NUTRITION

Nutrition recession: too many calories, too few nutrients

Eating nutrient-rich foods first is a solution, experts say

Based on the concept of nutrient density, a long-standing dietary principle and the cornerstone of the Dietary Guidelines and MyPyramid, the nutrient rich foods approach can help Americans learn how to choose nutrient-dense foods and beverages first within each basic food group – milk, fruits, vegetables, meat, and grains. Recent research shows consumers view the nutrient rich foods approach to eating as a new and positive way to better health.

Nutrient Rich Foods

Six key criteria for nutrient profiling systems*	
Objective	based on accepted nutrition science and labeling practices
Simple	based on published daily values and meaningful amounts of food
Balanced	based on nutrients to encourage and nutrients to limit
Transparent	based on published algorithms and open-source data
Validated	against measures of a healthful diet
Consumer-driven	likely to guide better food choices and more healthful diets

** Nutrient profiling is the science of ranking or classifying foods based on their nutrient composition.*

(Drewnowski A, Fulgoni V 3rd, "Nutrient profiling of foods: creating a nutrient-rich food index," Nutrition Reviews, Jan 2008.)

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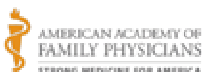
These health and nutrition organizations support 3-A-Day™ of Dairy, a science-based nutrition education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products to improve overall health.



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"NUTRIENT RICH FOODS" FOR THE RIGHT START IN LIFE

Many American children are overweight, but just as troubling is the fact that many are also undernourished. Because kids do not eat enough of the right foods, they aren't getting enough of five key nutrients: calcium, magnesium, potassium, vitamin E, and fiber, according to the 2005 Dietary Guidelines for Americans (DGA).[1]

The guidelines identified four "Food Groups to Encourage" from the USDA's *MyPyramid*: fruits, vegetables, whole grain foods, and low-fat and fat-free milk or milk products. Encouraging kids and families to eat adequate quantities of these nutrient-rich foods can help ensure that they are getting balanced nutrition from their diets.

Dairy Foods: Rich in Nutrients, But Lacking in Some Diets

The dairy group, one of the highlighted food groups, is often underestimated as a source of key nutrients. Known as a superior calcium source, dairy foods also deliver potassium and magnesium – three of the five "nutrients of concern for children."

A number of studies have shown that getting calcium is a key to building peak bone mass and preventing osteoporosis and fractures later in life. The American Academy of Pediatrics calls dairy foods "preferred" sources of calcium compared to supplements and other foods.[2]

Unfortunately, half of children ages 2 through 8 and three quarters of children ages 9 through 19 don't get the recommended daily amount of milk or milk products.[3] The 2003-2004 National Health and Nutrition Examination Survey found that African-American children have lower intakes of calcium, magnesium, and potassium than children of other races and ethnicities.[4] This is consistent with a recent finding that adolescent African-Americans eat and drink less dairy than non-African-Americans.[5]

All children 2 to 8 years should get at least two cups a day of low-fat or fat-free milk or milk products and three cups a day once they turn 9. The American Academy of Pediatrics recommends four dairy servings a day for adolescents.[6] The first step to putting these guidelines into practice is to be aware of them – but 60 percent of parents don't know how much calcium their kids are supposed to be getting.[7]

Arlene Murrell, MS, RD, LD, CLE
Nutrition Affairs Account Manager

Arlene Murrell is a registered dietitian and certified lactation educator and currently serves as the Nutrition Affairs Account Manager for the Southeast Dairy Association. Arlene brings extensive experience in public health in New York City, South Carolina and Georgia to the Dairy Association. As Director of Nutrition for the Women, Infant and Children (WIC) services program, Arlene provided nutrition expertise to the medical community for over 20 years.

An accomplished public speaker, Arlene has conducted presentations for multiple university health programs, as well as the Utah Nurse's Association; Kentucky Cabinet for Health Services; North Carolina Department of Environment, Health and Natural Resources Division of Maternal and Child Health; and the Catawba, N.C. Health District Teen Pregnancy/Parenting Project.

Arlene received her Bachelor of Science degree in foods and nutrition from Marymount College in Tarrytown, N.Y. She completed her dietetic internship and earned her Master of Science degree in foods and nutrition from Winthrop College in Rock Hill, S.C. She is an active member of the American Dietetic Association, the Georgia Dietetic Association and the Greater Atlanta Dietetic Association.

At the dairy association, Arlene consults with key health professionals and helps develop teaching resources. She enjoys teaching health professionals and consumers the importance of dairy throughout life.

A Doctor's Influence – In and Out of the Office

Physicians can start by promoting healthy eating in the counseling room. Asking patients about their eating habits, educating them about the importance of balanced nutrition, and recommending a healthy diet that includes low-fat dairy, fruits, vegetables and whole grains are positive steps a healthcare provider can take. A doctor can also help by referring a patient to a registered dietitian when appropriate.

Outside the office, physicians can make a difference in community schools. A respected voice can encourage schools to promote nutrient-rich foods lacking in children's diets and discourage the marketing and availability of foods and beverages low in critical vitamins and minerals.

Poor nutrition in American children isn't only a behavior gap; it's a knowledge gap. Because of their expertise and the respect they command in their communities, health professionals have an important role to play in closing that gap and steering families onto a healthier path through education, guidance and active involvement.

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7 Opinion Research Corporation for GTC Nutrition

BY A. STEVENS WRIGHTSON, MD AND NIKKI STONE, DMD

FLUORIDE VARNISH:

An Effective Method for Family Physicians to Reduce Childhood Caries in Their Patients

DR. WRIGHTSON

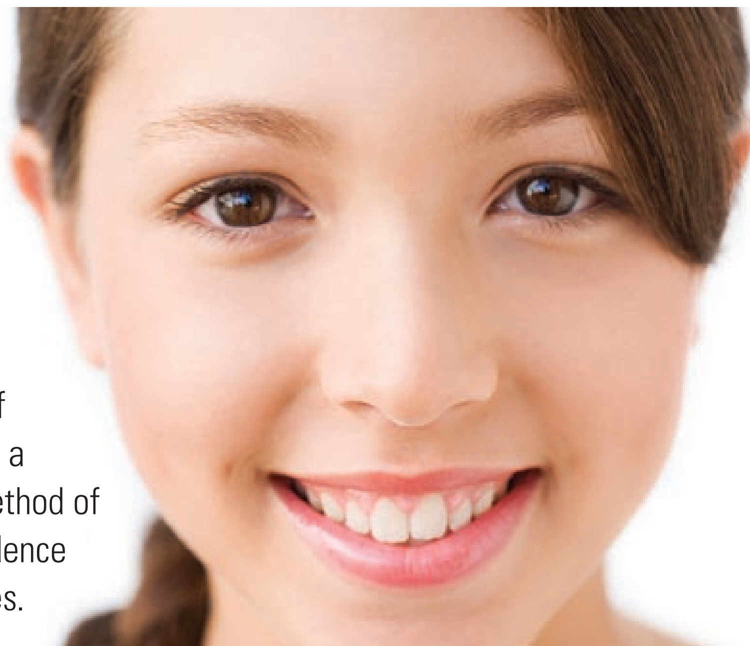
DR. STONE

BACKGROUND:

As the surgeon general stated in his 2000 report, good overall health is tied to good oral health.[1] Yet, in Kentucky the rate of toothlessness in those over 65 was 38 percent in 2004, ranking it 49th out of 50 states and placing it well above the Healthy People 2010 goal of 20 percent.[2] In addition, the rates of late stage oral cancer, periodontal disease and childhood caries remain high and above goals set by Healthy People 2010.[3,4,5] The causes are many and include lack of access to dental care for poor, rural, elderly and otherwise vulnerable populations in this state. Other causes include lifestyle choices (smoking and obesity), a cultural acceptance of poor oral and dental care, and a family history of poor oral health. Included in the list is the lack of dental preventive services for young children and even expectant mothers. Oral health has too often been perceived as the sole responsibility of dentists, and as such, opportunities for preventive counseling and care by physicians are frequently missed.

Fluoride has been recognized as a necessary component for good oral health for years. Fluoride supplementation of community water supplies has been heralded as one of the greatest public health achievements of the 20th century.[6] Those who provide care to newborns and young children are familiar with prescribing fluoride supplements to families without community water or whose water source is deficient in fluoride. Dentists have long recognized the benefits of topical fluoride applications in the management of their children and adult patients.

The application of fluoride varnish is a relatively new method of reducing the incidence of childhood caries. Childhood caries is any of the conditions that primary teeth sustain, from enamel demineralization to frank cavities, as a result of three coexisting negative forces: streptococcus mutans bacteria infection, sugar substrate causing acid formation, and teeth at risk due to poor oral hygiene or other factors such as tooth morphology or defects. Early childhood caries disproportionately affects those underserved populations that are poor, rural and with low health literacy.[5] Table 1 demonstrates the rate of early childhood caries in multiple at-risk groups, including eastern Kentucky children. Up to 80 percent of early childhood caries occurs in 20 percent of the population.[1] Fluoride helps maintain and improve tooth health. It alters bacterial metabolism to prevent acid formation. It prevents demineralization of the enamel and promotes remineralization, particularly in areas already damaged. These effects are mostly topical and are also seen with the use of fluorinated water, toothpastes and fluoride varnish.[7]



The application of fluoride varnish is a relatively new method of reducing the incidence of childhood caries.

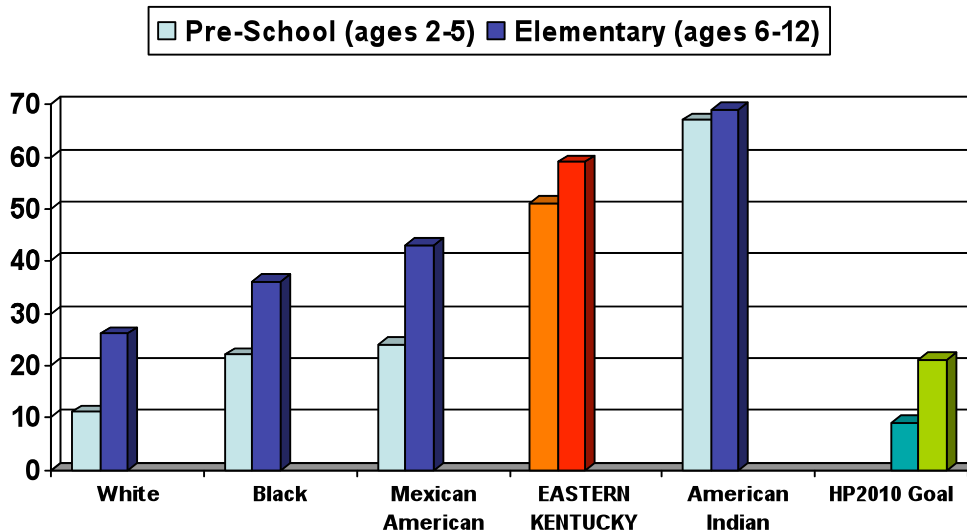
EVIDENCE:

Fluoride varnish application can be easily performed in a physician's office. The taste is tolerable and varnish application has been shown to prevent and even reverse the "white spots" characteristic of early demineralization. Multiple European and Canadian studies have demonstrated the benefit of fluoride varnish application on children.[8,9] In a study performed in San Francisco on low income Chinese and Hispanic children, Weintraub et al, demonstrated that even a single fluoride varnish application reduced the incidence of early childhood caries.[10] In his study, he found the incidence of caries significantly decreased over a two year period from 12 percent to 6 percent with the application of fluoride varnish.

MATERIALS, COSTS AND REIMBURSEMENT:

Fluoride varnish comes from several manufacturers and has several brand names, including Cavity Shield, Enamel Pro Varnish and Duraflor. The easiest to use are the single use packets. The average cost of these materials is $1 to $2. Currently, Medicaid in Kentucky is reimbursing two applications a

TABLE 1: Oral Health Disparities: Untreated Tooth Decay in Eastern Kentucky Children Compared with National Data (NHANES)[13]



year at $15 each, at least 90 days apart for children up to four years of age. The code used is D1206 in conjunction with an office visit code.[11] A fluoride varnish manual, entitled Healthy Smile Happy Child has been developed by the Kentucky Cabinet for Health and Family Service and Kentucky Department for Medicaid Services.[11]

INDICATIONS AND PROCEDURE:

Children at moderate to high risk for early childhood caries should receive fluoride varnish applications twice a year from the eruption of their first tooth, starting somewhere between six and 12 months of age. At risk children include those at lower socioeconomic status (including all children with state Medicaid insurance or no insurance), those with already demonstrated early childhood caries, children with poor dietary habits (bottle at bed time, bottle propping, drinks other than milk or water in the bottle, excessive use of sippy cups or sugary, sticky snacks) or family history of multiple caries or lost teeth from caries or periodontal disease. These applications should continue in the medical office until the establishment of a dental home.

The application of fluoride varnish is simple and relatively quick. It can be applied by physicians, other clinicians, nurses or medical assistants. The materials required are: gauze, a toothbrush and the fluoride varnish. With the child laying on the exam table or with his/her head in the lap of the health care provider, the teeth are first cleaned of debris with the toothbrush. The teeth are then dried with the gauze and the fluoride is painted on the teeth, usually one arch at a time. It is important to make sure that both the front (buccal) and back (lingual) side of the teeth are treated with varnish. The child is then told not to eat or drink anything for an hour, and not to brush the teeth until the next morning.

The risk of fluorosis, the white to brown staining of teeth with excessive fluoride supplementation, occurs with concentrations of fluoride in excess of .06mg/kg/day that are ingested over time while the teeth are developing. Though the amount of fluoride applied with fluoride varnish approaches 6 mg, it is applied topically and episodically, and is so adherent to the teeth, the amount that ends up in the blood and urine is negligible. Thus, fluorosis does not occur from the use of topical applications.

DISCUSSION AND FUTURE DIRECTIONS:

A comprehensive self study module on both childhood oral health and fluoride varnish application, complete with a video on the application technique can be found at www.smilesforlife2.org. This is an American Academy of Family Physician (AAFP) and a Society of Teachers of Family Medicine (STFM) supported curriculum that provides across-the-lifespan information on oral health from prenatal to

continued on page 22

Children at moderate to high risk for early childhood caries should receive fluoride varnish applications twice a year from the eruption of their first tooth, starting somewhere between six and 12 months of age.

geriatric patients. There are also links to other educational resources and materials.

Oral health is vital for good overall health. Physicians and other providers of health care for children need to address the oral health needs of their patients. Applying fluoride varnish will help in reducing the burden of poor oral health to Kentuckians, particularly children, though it is only one part in the comprehensive management of our patients that includes education and counseling on health behaviors, such as smoking and poor nutritional choices, that add to the severity of dental disease in this state. In Kentucky in 2006, only 35 percent of KCHIP-eligible children under age 18 had a dental care visit.[12] Because many children do not see a dentist, it is up to the clinicians in the child's medical home to initiate counseling about good oral health habits, as well as providing treatments such as fluoride varnish, that can reduce early childhood caries.

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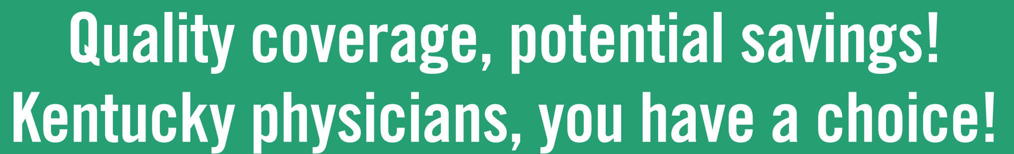

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