FALL 2010
VOLUME 69

The Official Publication of the Kentucky Academy of Family Physicans

Returning to our Roots

Using Statins Safely

The Times They Are A-Changing

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FALL 2010 · VOLUME 69

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STRONG MEDICINE FOR KENTUCKY

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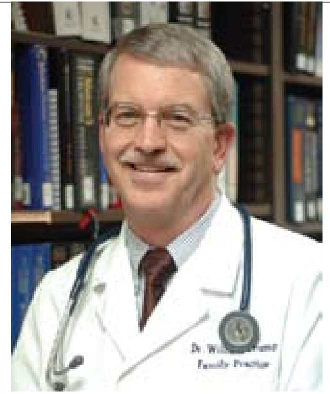

RETURNING TO OUR ROOTS:
What Skills Are Most Needed to Tend the Medical Home?

I'm in a philosophical mood these days, so bear with me. Maybe it's that my daughter and several of her middle-school friends are now third-year medical students at our Campus and I'm getting a close-up view of the making of doctors. Or just that I'm tired of hearing us called providers and cost/revenue centers.

This class of M-3s knows me well enough that I get an unusually unfiltered look into what they think is important in doctoring. Even though they're busy learning the best timing for an operation in gallstone pancreatitis and the controversy about drug-eluting stents for coronary disease, something in our last JKAFP issue stopped them in their tracks.

The piece "Reach Out and Touch" from Dr. Eddie Prunty's article came at the right time for me, and at least for several of these students. I searched and also couldn't find who to attribute it to, so I'll just reference him (1) and repeat a bit of it here:

REACH OUT AND TOUCH

Reach out your hand and touch me – if you dare. I am sick, afraid, insecure, fearful, apprehensive, lonely and misunderstood. I have no particular age, color, creed, or sex, but I share with others one particular emotion – fear of the unknown. I am a patient….

It's easy to love the lovely, but how about me – the dirty, smelly, unlovely bit of humanity that you see. My hair has never been styled in a beauty salon. I know so little of the niceties you enjoy, and I stand in awe of you in your immaculate white – so cool, sweet-smelling and secure. My world is different from yours. What do you know of near starvation and trying to rear six children on a pitiful amount of money, of no heat in the winter and outside toilets? "Anyone can stay clean," you say. Maybe in your world, but everything is more difficult in mine. It's easy for you to turn away. Don't reduce me still further. Touch my hand or my arm. Explain what's about to happen to me. Don't let me see the distaste in your eyes. Let me see instead your humility.

On and on we come – as unhappy children, misunderstood teenagers, elated new parents and tired old folks. We are all different, but our needs are exactly the same.

Can you think of me as a person and not just a patient? Are you willing to smile when your feet hurt, to linger when you need to hurry, to always remain calm and unruffled? To keep offering the cup of kindness time and time again, even when it's

not returned to you? Do you really care what happens to me, and is there enough of you to handle all the details of your job and still have time to show genuine concern for me? Do you love enough to reach out and touch me? I wonder.

How could any doctor, or really anyone, fail to be moved by these words? It's confusing being a doctor these days. When I'm in our free clinic, I rediscover just how much fun it is to see patients. I don't have to worry about how many "bullets" I need to record to be able to code for a 99214. I don't have to worry about how in the world I'm going to get this story of human misery collapsed down to fit an EMR template that requires categorization of the human experience. I don't have to worry about which drug formulary I must use for this patient - Wal-Mart has most of what I really need.

All I really have to do is connect with the patient and family in the room with me -really hear, really understand their concerns. Skip the Review of Systems, since I've never learned anything important from this futile exercise. Do a minimum physical exam, because almost all I usually need to make a diagnosis is a good history. Do a minimum of lab, and almost no imaging, because it's unnecessary. There's no need for defensive medicine here. And our patients are truly appreciative.

The confusion begins when I leave this free clinic environment and re-enter the real world of modern primary care. There are just so many distractions to connecting - really connecting - with my patients and their families. In the past I've told students that if they're willing to make about half of the typical doctor's income and see about half the number of patients per day, they can practice this idyllic medicine. The distractions and digital noise all around us put even this model in jeopardy. As I contemplate what's next for primary care, I'm reminded of the words of Gayle Stephens, one of the "Founding Fathers" of family medicine. I was lucky enough to have him as an early mentor when I was a resident at UAB in the early 80s. These words from 30 years ago still ring true:

A DECALOGUE FOR FAMILY PRACTICE RESIDENTS ENTERING PRACTICE

DON'T give up the reform ethos. Keep on the side of responsible change in education, practice, and social justice.

DON'T lose faith in the power of relationships and the therapeutic use of self. (Or, don't hire anybody to save you from spending time with patients.)

DON'T turn your practice into a mere business. It may not be less, and it should be a great deal more.

LEARN to distinguish between uncertainty and ignorance; only the latter is remediable and potentially culpable.

FIND some way to practice charity; i.e., willingly give a part of your services consistently to those who cannot pay.

TRY to see that the groups in which you hold membership are at least as moral as you are.

HUMANIZE and personalize the microsystems in which you work.

ACT at all times as if the patient is fully autonomous; the weaker the patient is, the more vulnerable you are to violating his/her personhood.

REFLECT on your professional experiences. Within the bounds of protecting patients' privacy, think, talk, and write about your clinical stories.

WORRY less about patients becoming overly dependent on you than about your becoming undependable.

G. Gayle Stephens

(Originally presented as part of an address to the Department of Family Practice, Medical University ofSouth Carolina, June 1979.)(2)

WHEN FUTURE MEDICAL STUDENTS FIRST DREAM ABOUT DOCTORING, THIS IS WHAT THEY HOPE TO GET UP EVERY MORNING TO DO...BUT SOMETHING HAPPENS ALONG THE WAY, AND MANY BECOME JUST TECHNICIANS TINKERING WITH THE HUMAN BODY AND LOSING TOUCH WITH THE SOUL.

I'm naturally an optimist. What is next for doctoring? It is my fondest wish that the Patient-Centered Medical Home (PCMH) allows us to practice the kind of medicine I describe above (3). Imagine if you were paid for keeping your patients healthy and could share their care, when they need it, with your office staff. The diabetic could get advice on medication changes from your nurse without having to see you, and the practice would still be paid. A group of your obese patients could visit in your office with one of your patients who has been successful losing weight while you were spending time with your family. A smoking cessation class also run by one of your patients could be going on while you are at your daughter's soccer game. Maybe a 12-step meeting can even occur in your office while you're at a birthday party. And your practice would be rewarded for it all.

But wait, are we breaking Dr. Stephens' second rule? I think not. Imagine if, in addition to advising all your office staff and group leaders each day, all you had to do was see the 10-12 patients who really need YOU (not some nameless, faceless "provider") that day.

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When their illnesses have come to a level of suffering at which only someone with your training, your skills, and your deep understanding of them as a human being can help, you're there for them. You are freed from the repetitive management questions of routine chronic disease issues and, most importantly, freed from the documentation monster. You are paid the same regardless of how well or badly your note corresponds to some arbitrary coding template. Your notes, once again, are for you and other physicians.

I hope that this new model allows us to Reach Out And Touch in the way that we do best. When future medical students first dream about doctoring, this is what they hope to get up every morning to do, and I know this because of the very many personal statements I've read on medical school applications. But something happens along the way, and many become just technicians tinkering with the human body and losing touch with the soul. Is this what my daughter and her classmates are out there learning as I write this? I sincerely hope not.

The PCMH may not bring my idyllic vision into reality, but it's certainly worth a try. Your comments are appreciated, and I'll close with a quote from Daniel Sulmasy, a general internist and Franciscan friar, from one of my favorite books (4):

The human body is the place where human life and human love happen. The crafts of medicine, nursing, dentistry, and all the other healing arts require at least two human bodies – that of the healer and that of the one who is healed. It is in human bodies that the spirit of God transforms the air we merely breathe into the grace of God that touches every cell in our mortal bodies, forms any words of Good News we will ever proclaim, and moves us to works of charity and worship.

Let's go heal.

REFERENCES

1. Prunty ME. Message from the president. JKAFP. 2010;68:8
2. Stephens GG. The Intellectual Basis of Family Practice. Tucson, AZ. Winter Publishing. 1982, p 237.
3. http://fmignet.aafp.org/online/fmig/index/family-medicine/pcmh.html
4. Sulmasy DP. A Balm for Gilead. Washington, D.C. Georgetown University Press. 2006.

Kentucky's Seniors May Pay Steep Price for Medical Equipment

Seniors and people with disabilities who rely on durable medical equipment may pay a steep price under Medicare's mislabeled "competitive" bidding program, which starts in parts of Kentucky next year. More than 150 experts on bidding systems, including two Nobel laureates, recently told Congress that this bidding system will fail and may degenerate into a "race to the bottom." In fact, the bidding program will discourage competition, reduce access to home-based care, and put hundreds of medical equipment suppliers out of business state-wide in Kentucky.

Durable medical equipment includes oxygen and respiratory devices, wheelchairs, beds, infusion therapy, and other medically required equipment and supplies used in the home. Durable medical equipment represents less than two percent of Medicare spending, but it saves money by facilitating a smooth, timely transition from hospital to home and by keeping seniors out of the ER and nursing homes.

Find out more at www.aahomecare.org/competitivebidding, or speak with a representative of the Kentucky Medical Equipment Suppliers Association, www.kymesa.org.

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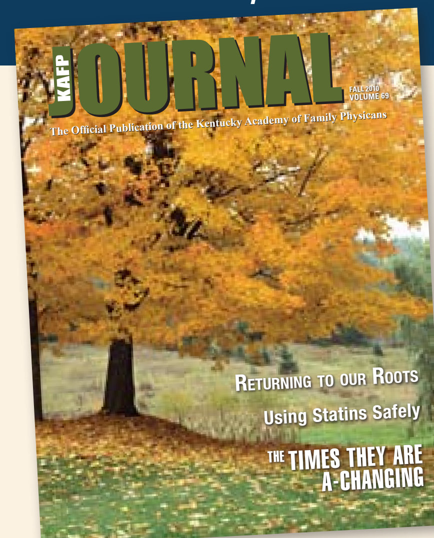

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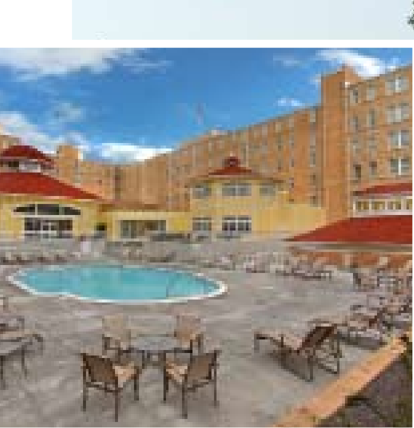

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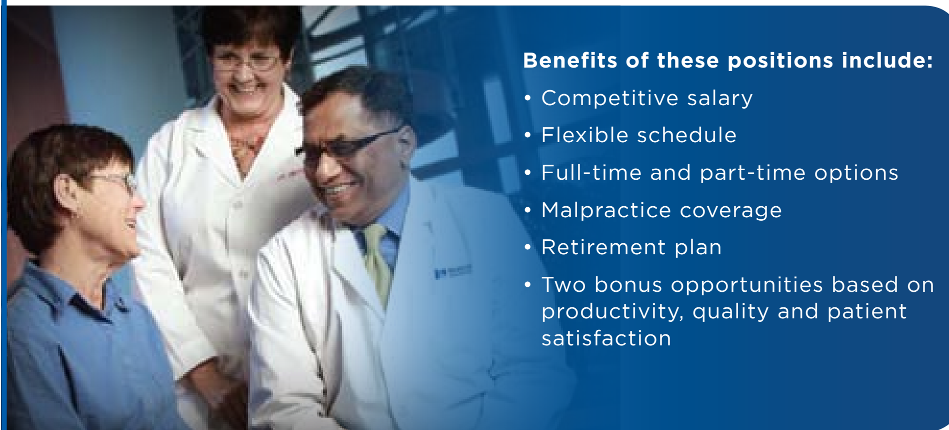

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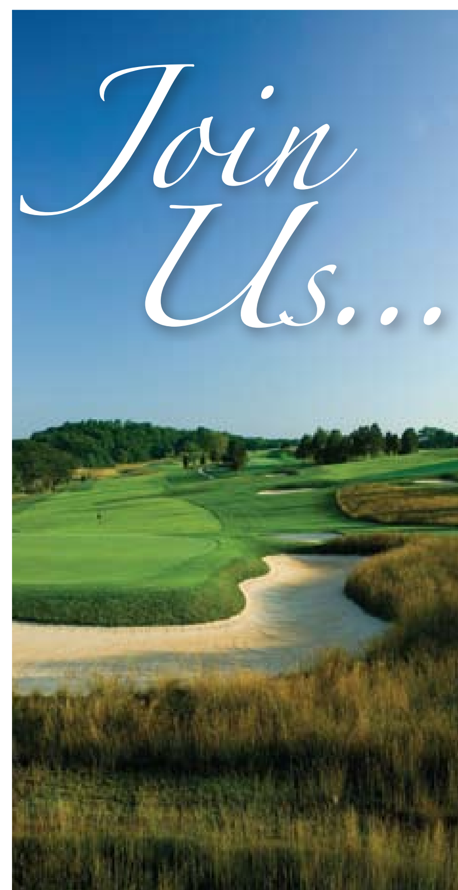

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Using Statins SAFELY

The debate rages on in the professional and popular media as to whether statins are being used appropriately. The Nov. 17, 2008, health section of the New York Times advised, "A Call for Caution in the Rush to Statins," while a recent article in the American Journal of Cardiology seriously wonders if a statin-containing condiment should be offered at fast food outlets. (1) The commentary sections of studies and articles on statins are packed with physicians, other health care personnel and patients weighing in on the "rights" and "wrongs" of statin use. (2) Pharmacologists and epidemiologists warn of serious inadvertent toxicities in terms that clinicians sometimes find difficult to translate into practice. (3) The long term safety of statins or effects of suppressing HMG co-reductase are still unknown. (4) Clearly, however, the possibility of rare side effects shouldn't dissuade persons who are good clinical candidates from taking a statin. A thoughtful strategy for their safe use should be the least-debatable factor in the current statin environment.

THE POSSIBILITY OF RARE SIDE EFFECTS SHOULDN'T DISSUADE PERSONS WHO ARE GOOD CLINICAL CANDIDATES FROM TAKING A STATIN.

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INSURANCE • FINANCIAL SERVICES
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EFFICACY:

Treat to efficacy, or don't treat at all. A patient started on a statin should have cholesterol lowering efficacy documented regularly. As patients' ages, nutritional habits, lifestyles, body compositions and liver synthesis abilities (including of cholesterol) change, the need for and effects of statins may be altered. Some patients fail mono-therapy. Too often patients are on statins without the monitoring necessary to assess appropriateness of therapy. (5)

DOSING:

Dosing of statins needs to be highly individualized because of the complex pharmacokinetics of each agent. Renal and hepatic adjustments may be necessary. Initial statin dosing recommendations are based upon a 30-40 percent reduction of LDL. Indeed, most LDL reduction comes from the initial dose. Doubling the statin dose only provides up to 6-7 percent of additional LDL reduction. (6)

The studies from which recommended doses were obtained did not consider the participants' genetic statin clearing capacity or the total competition for clearance of other drugs; these factors are now known to be significant. (7, 8) Statin side effects are most often related to dose and drug interactions. The lowest effective dose is optimal. Relative dose equivalents are listed in Table 1 to assist with efficient statin use.

ADVERSE REACTIONS:

Appropriate monitoring can make a difference in the incidence of adverse reactions. While statin toxicity is being further clarified in the literature, there are steps that can be taken to reduce poor outcomes. The checklist below (Table 2) can help minimize risk with statin use.

STATINS IN THE ELDERLY

Should an 85-year-old frail woman with Parkinson's disease in a nursing home receive a statin? Probably not. This is the profile of

TABLE 1

Rosuvastatin 2.5mg = Atorvastatin 5mg = Simvastatin 10mg = Lovastatin 20mg = Pravastatin 20mg = Fluvastatin 40mg

Approximate equivalences adapted from Miller AE et al Pharmacotherapy 2008; 28:553-61

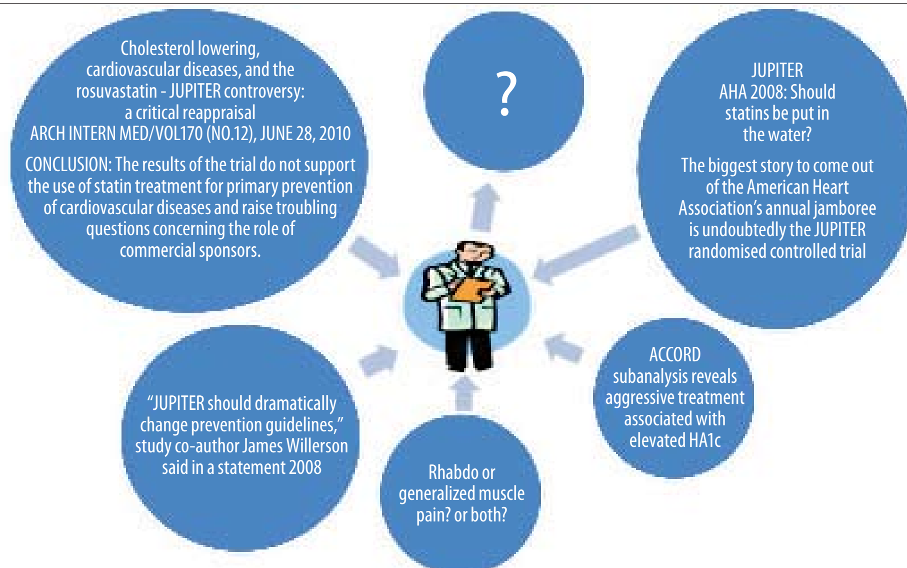
TABLE 2 (9, 10, 11)

STATIN MONITORING	
Lipid Panel	At Baseline, 6 Weeks, 3 Months, then every 6 Months
Liver Function Tests (LFTs)	At Baseline, 12 weeks after starting or increasing therapy, then annually or if symptomatic *> Modest increase <3X upper limit of normal are not contraindication to continued use; do repeat LFT, try reducing dose (LFT elevation is dose related)*
Creatine Kinase (CK) Test	At Baseline, then as needed in presence of muscle soreness, tenderness or pain
Ask re Headache or Dyspepsia	Initially, 6-8 weeks after starting therapy, then at each follow up
Ask re Muscle Soreness, Tenderness or Pain	Initially, 6-12 weeks after starting therapy, then at each follow up visit *> Myopathy: muscle pain, soreness, weakness, cramps with elevated CK (>10X upper limit of normal (ULN))* *> Rhabdomyolysis: CK >10,000 IU/L or CK > 10XULN with elevated serum creatinine or requiring IV hydration.* *> If CK <10X ULN, continue statin therapy despite tolerable muscle symptoms* *> Increased risk: multiple medications, chronic diseases and age >80, especially women*
Kidney	At Baseline. Adjust the dose of rosuvastatin, lovastatin, or pravastatin based on results per drug monograph. Fluvastatin not recommended in patients with Creatinine Clearance <30ml/min (www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation)
Ask re Neurological	Peripheral neuropathy, sleep changes, cognition changes and depression *> Stop statin for 1-3 months if statin possibly contributory.*
Hemoglobin A1C (HA1C)	The ACCORD study (www.accordtrial.org/web/public/index.cfm) found that statin use may be associated with elevation in HA1C
STATIN INTERACTIONS	
Impairment of statin metabolism	*> Fibrates, Niacin, Cyclosporine, Erythromycin, Clarithromycin, Itraconazole, Ketoconazole, Protease Inhibitors, Verapamil, Amiodarone, Nefazodone, acetaminophen.* *> Avoid grapefruit juice > 1 quart daily and alcohol abuse* *> Pay particular attention to number of drugs metabolized by cyp 3A4 enzyme system: clonazepam, omeprazole, citalopram, ciprofloxacin and many others.*
Statins and Warfarin	Fluvastatin, simvastatin, lovastatin and atorvastatin can raise International Normalized ratio (INR) by slowing warfarin clearance and rosuvastatin displaces warfarin from protein binding, resulting in elevated INR.

the patient most likely to have statin-induced problems and least likely to benefit from statin therapy. Frail elders tend to have high medication burdens and are therefore at greater risk of impaired clearance from competition for drug elimination. They are also more likely to experience statin-induced neuro-psychiatric problems and less likely to benefit from statin disease prevention. Finally, it is important to consider that none of the literature documenting the value of statin therapy has included the oldest old. Initially, the headlines in the press about the JUPITER study (2) touted the benefits of statins for primary prevention in elders, but the age range of subjects was 60-71 years old, with a median age of 66. The effectiveness of statins in patients greater than 80 years of age is relatively unexplored. For example, the PROSPER study (11) focused on statin use in elders, but the oldest subject was 82 years, and the mean age was 75 years. PROSPER is the only significant statin study to include this maximal age; the next highest age limit to date is 75 years. (12)

TRIAL DISCONTINUATION OF STATINS

If a patient is having possible adverse effects from statins, a trial discontinuation of therapy can be undertaken. According to most reports in the literature, resolution of side effects such as cognitive impairment, insomnia, muscle pain and LFT elevation occurs within days of discontinuation of statin therapy, if such problems were indeed statin induced. Up to six weeks of discontinuation does not appear to increase the risk of cardiac events in stable patients. (12) Reintroduction of statin therapy with another or the same agent at a lower dose is acceptable.



REFERENCES

1. Ferenczi, EA., Azaria P., Highes AD., et al. Can a Statin Neutralize the Cardiovascular Risk of Unhealthy Dietary Choices? American Journal of Cardiology Volume 106, Issue 4 , Pages 587-592, 15 August 2010.
2. Kritek P., Campion EW., JUPITER Clinical Directions — Polling Results N Engl J Med 2009; 360:e14.
3. Jacobson TA. Comparative pharmacokinetic interaction profiles of pravastatin, simvastatin, and atorvastatin when co-administered with cytochrome P450 inhibitors. Am J Cardiol 2004;94:1140-6.
4) Hlatkky MA., Expanding the Orbit of Primary Prevention-Moving beyond JUPITER. NEJM 359; 21 www.nejm.org November 20,2008.
5) Abookire, S., Carson AS., Fiskio J., et al. Use and Monitoring of "Statin" Lipid-Lowering Drugs Compared With Guidelines. Arch Intern Med. 2001;161:53-58.
6) Grundy SM, Cleeman JI, Merz CN, et al. for the National Heart, Lung and Blood Institute, the American College of Cardiology Foundation, and the American Heart Association. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidleines. Circulation 2004; 110:227-239.
7) Williams D., Feely J. Pharmacokinetic-pharmacodynamic drug interactions with HMG-CoA reductase inhibitors. Clin Pharmacokinet 2002; 41:343-70.
8) Bottorff, MB. Safety and Statins: Pharmacologic and Clinical Perspectives. Preventive Medicine in Managed Care. November 2004 S30-S37.
9) Pasternak RC, Smith SC Jr., Bairey-Merz CN et al., for the American College of Cardiology, the American Heart Association, and the National Heart, Lung and Blood Institute. ACC/AHA/NHLBI clinical advisory on the use and safety of statins. J Am Coll Cardiol. 2002; 40: 567-572.
10) McKenney JM, Davidson MH, Jacobson TA, et al., for the National Lipid Association Statin Safety Assessment Task Force. Am J Cardiol. 2006; 97: 89C-94C.
11) Shepherd J, Blauw GJ, Murphy MB, et al., on behalf of the PROSPER study group. Pravastatin in elderly individuals at risk of vascular disease (PROSPER): a randomized controlled trial. Lancet. 2002;360:1623-1630.
12) McGowan MP. There is no evidence for an increase in acute coronary syndromes after short term abrupt discontinuation of statins in stable cardiac patients. Circulation 2004; 110:2333–5.

BIOGRAPHICAL INFORMATION

Demetra Antimisiaris, PharmD
University of Louisville, Dept. of Family and Geriatric Medicine

Dr. Antimisiaris serves as faculty in the Department of Family and Geriatric Medicine at the University Of Louisville, where she provides oversight for the Polypharmacy Initiative, dedicated to fighting inappropriate medication prescribing and use in elders. Dr. Antimisiaris also regularly teaches pharmacy and medical students, residents, faculty and community physicians and is active in community outreach efforts. Previously Dr. Antimisiaris worked as a consultant pharmacist and assistant professor at the University of Kentucky College of Pharmacy, and completed a joint academic-geriatrics pharmacy residency at UCLA-USC.

Leitchfield, KY

Physician, Doctor of Nursing Practitioner, Nurse Practitioner, and Physician Assistant TRAINING

I am currently serving on a Kentucky Medical Association committee looking into the issue of independent practice for nurse practitioners and physician assistants. Prior to my appointment, I had very little knowledge regarding the differences in education and training for non-physician providers.

My information will focus on education and training of nurse practitioners and the newly created doctor of nurse practitioners. I offer only this basic information with regards to physician assistants. According to the Bureau of Statistics, in 2008, there were 142 education programs for physician assistants that were accredited or provisionally accredited by the Accreditation Review Commission on Education for the Physician Assistant. Of these programs, 113 were master's degrees, 21 offered bachelor's degrees, three awarded associate degrees, and five awarded certificates.[i] [Editor's note: The University of Kentucky has the only physician assistant education program in Kentucky. Applicants must have a bachelor's degree. Graduates complete five semesters and 29 credit hours of summer sessions and receive a Master of Science in Physician Assistant Studies degree.]

All physicians hold a medical degree and certification of three to four years of medical residency training. Many hold fellowships in additional subspecialty training. Five percent of NPs hold an associate or bachelor's degree as their highest degree; 92 percent hold a master's degree; three percent hold a Ph.D. or DNP. [ii]

The below tables offer a side-by-side comparison of the education and training involved in becoming a family physician versus the requirements to become a nurse practitioner.[iii]

conintued on page 16 >>

DEGREES REQUIRED AND TIME TO COMPLETION

	Undergraduate Degree	Entrance Exam	Post-Graduate Schooling	Residency and Duration	TOTAL TIME FOR COMPLETION
Family Physician (MD or DO)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (MD or DO)	REQUIRED, 3 years minimum	**11 years**
Nurse Practitioner (NP, ARNP, etc.)	Standard 4-year BA/BS*	Graduate Record Examination (GRE) and National Council Licensure Exam for Registered Nurses (NCLEX-RN)	1.5 – 3 years, master's program (MSN)	NONE	**5.5 – 7 years**

OCT 1st, 2013

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The change to ICD-10 codes takes effect on October 1, 2013. What do you need to get ready?

Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013. And in preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards.

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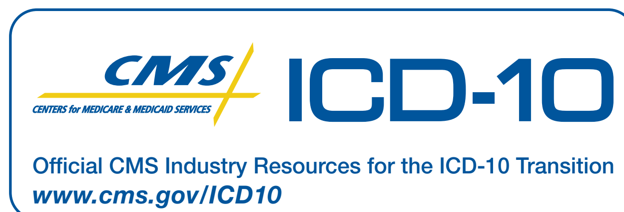
Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.



MEDICAL/PROFESSIONAL SCHOOL AND RESIDENCY/POST-GRADUATE HOURS FOR COMPLETION

	Lecture Hours (Pre-Clinical Years)	Study Hours (Pre-Clinical Years)	Combined Hours (Clinical Years)	Residency Hours	TOTAL HOURS
Family Physician	2,700	3,000**	6,000	9,000 – 10,000	**20,700 – 21,700**
Nurse Practitioner	800 – 1,600	1,500 – 2,250**	500 – 1,500	0	**2,800 – 5,350**
DIFFERENCE	1,100 – 1,900	750 – 1,500	5,500 – 5,000	9,000 – 10,000	**16,350 – 17,900**

*While a standard four-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.
**Estimate based on 750 hours of study dedicated by a student per year.

The below tables offer a side-by-side comparison of the education and training involved in becoming a family physician versus the requirements to become a doctor of nursing practice.

DEGREES REQUIRED AND TIME TO COMPLETION

	Undergraduate Degree	Entrance Exam	Post-Graduate Schooling	Residency and Duration	TOTALTIME FOR COMPLETION
Family Physician (MD or DO)	Standard 4-year BA/BS	Medical College Admissions Test (MCAT)	4 years, doctoral program (MD or DO)	REQUIRED, 3 years minimum	**11 years**
Doctor of Nursing Practice (DNP)	Standard 4-year BA/BS*	GRE and NCLEX required for MSN programs. No entrance exam for DNP programs.	1.5 – 3 years, master's program (MSN) + 2 years, doctoral program (DNP)	NONE	**7.5 – 9 years**

MEDICAL/PROFESSIONAL SCHOOL AND RESIDENCY/POST-GRADUATE HOURS FOR COMPLETION

	Lecture Hours (Pre-Clinical Years)	Study Hours (Pre-Clinical Years)	Combined Hours (Clinical Years)	Residency Hours	TOTAL HOURS
Family Physician	2,700	3,000**	6,000	9,000 – 10,000	**20,700 – 21,700**
DNP	1,000 – 2,000	1,500 – 2,250**	1,000 – 1,800***	0	**3,500 – 6,050**
DIFFERENCE	700 – 1,700	750 – 1,500	4,200 – 5,000	9,000 – 10,000	**15,650 – 17,200**

*While a standard four-year degree, preferably a BSN, is recommended, alternate pathways exist for an RN without a bachelor's degree to enter some master's programs.
**Estimate based on 750 hours of study dedicated by a student per year.
***Only 500 hours additional clinical experience recommended following the 500 – 1,500 hours of clinical training typically received during completion of an MSN program.

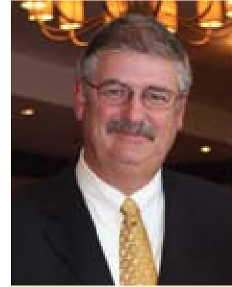
[i] United States. Bureau of Labor Statistics. Occupational Outlook Handbook, 2010-11 Edition. August 30, 2010. http://www.bls.gov/oco/ocos081.htm

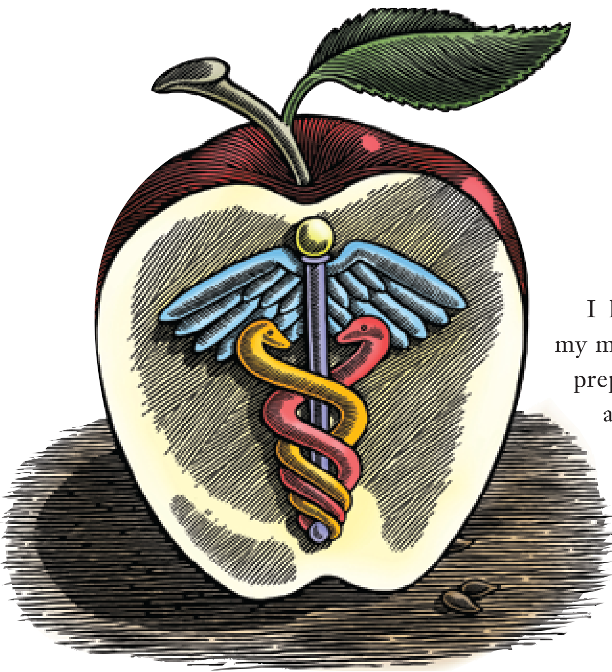
[ii] "A Decade of Growth". Advance for NPs&PAs. January 1, 2008. August 30, 2010. http://nurse-practitioners-and-physician-assistants.advanceweb.com/Article/A-Decade-of-Growth.aspx

[iii] Issue Brief - Education and Training: Family Physicians versus Nurse Practitioners. American Academy of Family Physicians(AAFP). Leawood, KS. United States. 2010. This issue brief is for information only and should not be construed as official AAFP position or policy.

[iv] Issue Brief - Education and Training: Family Physicians versus Doctors of Nursing Practice. American Academy of Family Physicians. Leawood, KS. United States. 2010. This issue brief is for information only and should not be construed as official AAFP position or policy.

THE TIMES THEY ARE A-CHANGING





I have been asked to comment on how my medical education and residency training prepared me to practice solo in a rural area; and, how it has affected my life and my views as to the future directions of Family Medicine. In 1980 I finished my family medicine residency training and prepared for practice in a rural area. I had lived in Louisville my entire life but had made the decision to come to Russell County as I felt it had a great need for medical care and would be a good place to raise a family. During training I did obstetrics and learned to insert central lines, do lumbar punctures, place chest tubes and take care of patients in intensive care. Generally, I tried to prepare to take care of patients in an area that had few doctors and very few specialists.

Although very anxious about my knowledge base I found that I was well prepared for the practice of medicine. However, I was unprepared for the politics and business changes that were about to occur. There was some culture shock moving into the foothills of Appalachia. I learned a new language - "ain't got no turn to him," "of a evening," and "a Gom" are terms that I now understand.

In 1980 I began my practice and introduced "the laboratory" to Russell County. We began doing CBCs, chemistries, microscopic urinalyses, protimes and other labs that had not been done there previously. I was shooting and hand developing my own X-rays. I was making diagnoses and working out of an office. I admitted patients to a hospital in the next county. I have a lecture that I give medical students entitled "Zebras that I have known." In the first 10 years I diagnosed 2 pheochromocytomas, reverse Munchhausen's, sporotrichosis, brucellosis, listeriosis, glioblastomas, Rett's Syndrome, dextrocardia, beta thalassemias, end stage tuberculosis and several other rare and interesting diseases. I was doing solo Obstetrics. I once sewed an ear back on that was almost completely cut off. I did non-operative orthopedics.

When our own hospital opened a year later we were putting in central lines, treating heart attacks, and putting in pacemakers. We covered the ER 24 hours a day. I did all of the OB,

cointinued >>

"The practice of medicine is an art, not a trade, a calling, not a business, a calling in which your heart will be exercised equally with your head."

- William Osler

pediatrics and orthopedics because my other two coverage partners were trained in Internal Medicine. Occasionally, when a surgeon was not available, I put in chest tubes. The 110 hours a week were killers, but the stimulation was exciting and heady. I felt like a real doctor on the front lines.

I have been asked to comment on the future of Family Medicine. First, what has changed? Now we are not just doing acute care or diagnosing but we are also doing preventive care. I see a lot fewer MI's and strokes than I used to, and there are fewer "cardiac cripples." I have seen ejection fractions go from 10% to 35% in 7 years with the new treatment protocols. But in the near future we will be doing predictive medicine. We will look at the genome and decide who needs very early colon cancer or breast cancer screening and who will never need it. We will know who needs their LDL below 70 and who can go without lipid treatment. Which patient needs twice the chemotherapy dose and which one needs a quarter of the dose? Predictive medicine will soon be here.

Another change is a loss of privileges. Liability insurance drove me out of OB. Many OB's have stopped delivering and gone to GYN only. Nurse Midwives and Community Health Centers are picking up the slack in OB care. We should also note that some of the loss of privileges is by choice. As we either lose or give up privileges are we building a better system of care? Younger docs are being taught that personal time supersedes other priorities, and that one should "not let his practice control him." I am sure that almost none of today's graduates would be on call 7 days a week or work 110 hours a week for 7 years. They would have no concept that it was about service, not money. That is not a knock on younger physicians. It is a reality of what they have been taught, and who knows which idea is right? Indeed, what should a Family Doc look like in 2015? And how do we get medical students to choose Family Medicine? Why do politicians, academicians, and CEOs think they can replace Family Docs with nurse practitioners and physician assistants?

How do we get students into Family Medicine and then back to underserved areas? The first requirement has got to be better pay, either through loan forgiveness or increased reimbursement (at a much higher rate than 10% increase projected Medicare fee as outlined in the federal health reform package.) Specialists make money by using technology. Cardiology groups have their own echo machines, doppler and stress testing facilities and OB-GYNs their own ultrasound machines. We need to limit the costs of superfluous procedures and reemphasize history taking, physical exam and common sense. These are the *forte* of Family Medicine. We need to choose medical students, or at least a portion of them, on criteria that make them more prone to do primary care. When I look at our rural 45 bed hospital, most of us doctors are Family Physicians who are not from Russell County. What do we have in common? We are all from lower to middle class working families. We all worked our way through school and did "public work" at young ages.

I think work ethic needs to be investigated as a criteria for medical school entrance. Do you know how to work? Are you willing to work? I am not saying exclude children from upper class families. My daughter chose Primary Care Pediatrics, but she did work at McDonalds at 16 years of age and has worked ever since. We should look at the concept of "working class" as a possible marker for those who will go into Primary Care. The legislature

should directly tie medical school funding to numbers of Primary Care (particularly Family Medicine) physician graduates who practice in underserved inner city and rural areas. The Deans would then discourage the bashing of students who gravitate toward Family Medicine. Comments like "You are too smart to do Family Medicine" must stop!

We need the best and brightest in Family Medicine. The knowledge base is much greater and more challenging than that of many of the higher paid specialties. Dr. Larry Fields, past president of the AAFP, pointed out that if we ask that Family Docs get paid more and take a larger role in the delivery of healthcare, we must "send warriors" to do the job. The old model is a doc who could take care of 95% of all the problems. FP's worked long hours and did patient care less expensively. They saved the system money by using therapeutic diagnosis before expensive testing. We were more than just triage docs. But in those days we did more episodic care and less preventive care. Preventive care takes about 30% more face to face patient time, and we know it saves lives, decreases morbidity and improves quality of lives.

We as Family Physicians must learn to work smarter and more efficiently. . . The future Family Doc will do it differently than I did it, but professionalism and compassion must still be the centerpiece of the art.

We need a new model that fits both the preventive and predictive models. By 2020 there will not be enough Family Doctors and we need to work with ancillary providers to fill the gaps. A Family Doctor who is just a triage doctor, farming patients out to multiple specialists, can easily be replaced by PAs and Doctors of Nursing. We need doctors who can use that 6 ½ years of additional training above the nurses and PAs to improve the quality of the team's work. The pheochromocytoma or carcinoid tumor may be rare, but that is the 5% difference that makes the doctor count. We must learn to utilize but also actively oversee our ancillary help in a way that picks up that 5%.

The Patient Centered Medical Home (PCMH) concept is new and the advantages to the patient and the financial bottom line are not yet definitely proven. But we must find a way to incorporate group visits, patient education, and home visits that monitor patient compliance. We must teach the patients how to care for themselves. We must transition to an Electronic Medical Record that allows quality improvement, research at the site of care and legible prescriptions and notes. But that EMR has to be one in which the input is intuitive and which blends with practice needs in a manner that we as providers can use it. It should not be some scheme of templates concocted by a computer programmer. Our profit margins are so slim that most small practices would close if they lost 30% productivity for 6 weeks. The incentives offered over 5 years by the government barely cover hardware expense much less the lost revenue from decrease in productivity.

We as Family Physicians must learn to work smarter and more efficiently. Preventive, predictive, acute care and team care must be incorporated into our PCMHs. The training centers must be involved in this transition. The future Family Doc will do it differently than I did it, but professionalism and compassion must still be the centerpiece of the art.

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The Department of Family Medicine seeks qualified family physicians for positions at our main campus and satellite facilities.

- In **Madisonville, KY** – Employment with Trover Health System, opportunity for Family Medicine physician to join as the Associate Director of the THS Family Medicine Residency Program. This practice is 80% teaching and 20% clinical, with no Obstetrics. We have a large service area to provide a diverse patient population. Work with a collegial group of physicians with strong interest in teaching. Applicants must be BC in Family Medicine.
- In **Hopkinsville, KY** – Employment with Trover Health System in our largest satellite facility as Family Medicine physician. Outstanding opportunity to join board certified, well established physicians in a very busy outpatient practice. Specialists rotate to clinic. BE or BC required.
- In **Central City, KY** – Employment with Trover Health System in high-volume clinic. This is a traditional practice to follow patients in a local community hospital. New physician to join another BC Family Medicine physician in a successful practice.

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Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/ patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

Bertka, Kenneth, MD. ACOs-Friend or Foe. KAFP Journal Spring 2010, Vol 67: 62

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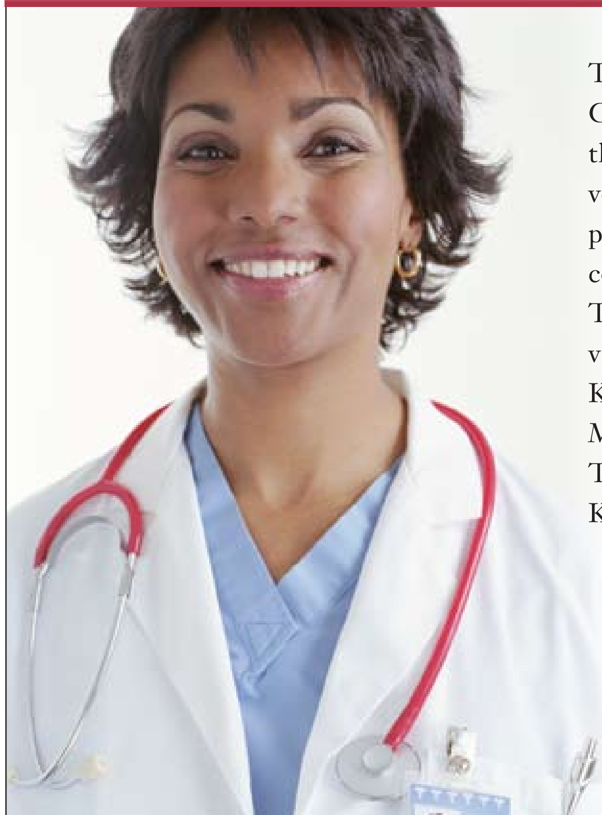

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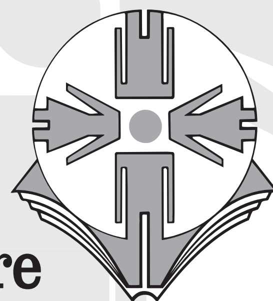

The Core Content Review of Family Medicine

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GET INVOLVED

The Kentucky Academy of Family Physician's Executive Committee needs your involvement. A standing committee list with a brief synopsis is listed below. If you are interested in serving, you can either send us your preference by faxing this page to (888)287-0662 or by e-mailing janice.hechesky@gmail.com.

We recognize your time is valuable, and therefore, we structure our committee meetings as needed. Typically, committees meet as directed by their chairs via conference call. The agenda is sent in advance of conference call with the objective of holding the meeting under 50 minutes. Delegates to the KAFP Congress typically meet annually at the Scientific Assembly for approximately two hours.

ADVOCACY COMMITTEE: *Chaired by* **Nancy Swikert, M.D.**, and **Brent Wright, M.D.**; this committee identifies members' interests and uses mechanisms to advocate for those interests, effectively and efficiently using the resources of the KAFP; identifies the needs of our patients and advocates for those interests, effectively and efficiently using the resources of the KAFP; and, educates the public, public, private and governmental agencies about the importance of a "Medical Home."

BYLAWS COMMITTEE: *Chaired by* **E.C. Seeley, M.D.**, and **Robert Wood, M.D.;** this committee is responsible for providing guidance to KAFP leadership on policies and procedures for Chapter Governance.

COMMUNICATION COMMITTEE: *Chaired by* **Bill Crump, M.D.**, with the assistance of **Stevens Wrightson, M.D.**, and **Stephen Wheeler, M.D.**; this committee is responsible for communicating the activities of the KAFP as it pertains to the present and the future via Journal, Web site and e-mail.

EDUCATION COMMITTEE: *Chaired by* **Paul Dassow, M.D.**, and **Charles Kodner, M.D.**; this committee is responsible for developing CME that is targeted to the needs of membership.

FINANCE COMMITTEE: *Chaired by* **Treasurer Robert Thomas, M.D.**; this committee is responsible for financial operations of the KAFP.

KAFP FOUNDATION: *Chaired by* **Nancy Swikert, M.D.**, and **Baretta Casey, M.D.**; this committee is responsible for the operation of the philanthropic organization that supports undergraduate and graduate education in Kentucky, and for KAN's research initiatives that support the private practice of family medicine.

DELEGATES TO THE KAFP CONGRESS: *Chaired by* **John Darnell, M.D.**, and **Vice-Speaker Drema Hunt, M.D.**; the KAFP Congress of Delegates meets annually or as called by the Board of Directors of the KAFP to review future and prior year programs and proposals; resolutions submitted by districts to be presented at the AAFP; and provide guidance to the KAFP Board of Directors on activities of the KAFP.

YES, I AM INTERESTED IN:

____

print name

____

list committee/committees preference

____

e-mail/fax number

If you're over 50 or have osteoporosis, it's important that you don't ignore your back pain. It may signal a spinal fracture. See your doctor right away if you think you may have one.

TAKE CHARGE

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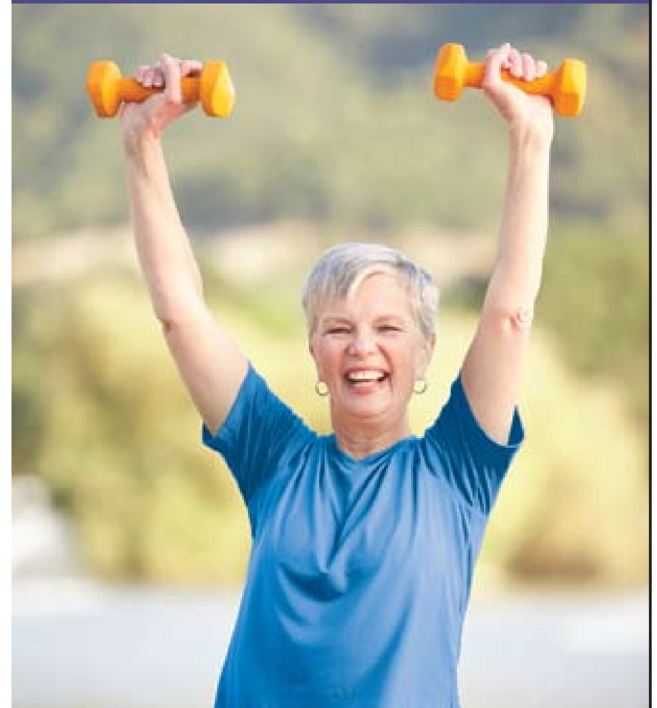

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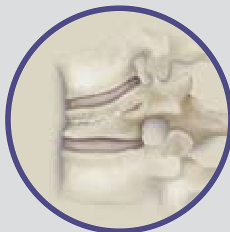

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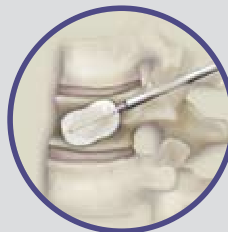
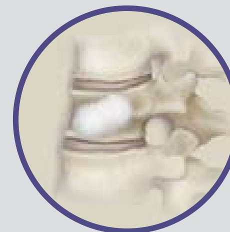


balloon kyphoplasty



after

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