KAFP JOURNAL

SPRING 2010
VOLUME 67

The Official Publication of the Kentucky Academy of Family Physicans

Improving Diabetes Education in Family Medicine

SCHOLARLY ACTIVITY IN FAMILY MEDICINE

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STRONG MEDICINE FOR KENTUCKY

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2010 KAFP CALENDAR

MARK YOUR CALENDAR FOR UPCOMING MEETINGS!

NATIONAL CONFERENCE ON SPECIAL CONSTITUENCIES AND ANNUAL LEADERSHIP FORUM
April 29-May 1, 2010
Hyatt Regency Crown Center
Kansas City, MO

2010 KAFP 59TH ANNUAL SCIENTIFIC ASSEMBLY
June 10-13, 2010
Marriott Cincinnati Riverfront
Covington, KY

SOUTH EASTERN FORUM
August 19-21, 2010
Nashville, TN

AAFP COD
September 27-29, 2010
Denver, CO

AAFP SCIENTIFIC ASSEMBLY
September 29-October 2, 2010
Denver, CO

59TH ANNUAL SCIENTIFIC ASSEMBLY AT THE MARRIOTT CINCINNATI RIVERCENTER IN COVINGTON, KY

Physicians, please join the KAFP for two days of CME, networking and activities. This event will be held June 11-12, 2010. The following are the CME highlights for the annual assembly:

- Changes in the Disability Insurance Market Place and How It Affects Physicians
- Seven Mistakes to Avoid in Investing and Planning for Retirement in an Uncertain World
- Guidelines for Protecting Sensitive Information
- Billing and Accounts Receivable and the Business of Medicine
- Kentucky All Schedule Prescription Electronic Reporting (KASPER)
- Two SAMs will be offered

Other activities will include the Annual Awards Banquet, Resident Research Projects and Resident Quiz Bowl. Registration Brochures will be mailed in April and posted on our Web site at www.kafp.org.

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message from the PRESIDENT

If you have not been on the KASPER web site, I have found it to be much quicker than faxing a request for a report.

Hopefully by the time you are reading this we will have had a good legislative session in both Frankfort and Washington. Keep contacting your legislators. For those of you who missed Doctor's Day at Frankfort, we had a good day and were successful in negotiating for voluntary CME for Reflex Sympathetic Dystrophy (RSD) instead of mandatory CME. Representative C.B. Embry introduced HR 56 that would have required CME for RSD every ten years exactly like the HIV CME. After talking with him, he agreed that as long as we would provide education on RSD, his constituent would be happy, and he would not push the bill forward. Marty White from KMA and Gerry Stover are working on the details for the RSD CME. The CME schedule for the annual meeting in June is already full.

We also learned a great deal about prescription drug abuse. Dave Hopkins from the Office of the Inspector General spoke in the afternoon about the status of prescription drug abuse in the state of Kentucky and KASPER. Last month, he gave another presentation at my office for my office staff. One thing he added in the second presentation is that it may be more helpful to contact the DEA inspector in your area instead of the police department. In many situations, the DEA inspector may be able to enforce more regulations and help you with any questions or problems that you may have. Keep running KASPER reports and doing drug screens to try to prevent abuse of controlled substances in Kentucky. If you have not been on the KASPER Web site, I have found it to be much quicker than faxing a request for a report. It has only taken seconds to be able to access the reports, and they are archived in the system for review in the future. It is best to only reference the report number in the patient's chart. Do not place the KASPER report in the patient's chart, because it is a felony to inadvertently give it to someone not authorized to have it. Protect yourself from office staff copying the patient's record and giving it to an unauthorized person by mistake.

In many situations, the DEA inspector may be able to enforce more regulations and help you with any questions or problems that you may have.

I would also like to extend our deepest sympathy to Dr. Dennis Sandlin's family and patients, due to his untimely death in December at the hands of a drug abuser. Make sure that your office staff knows to take any threat seriously and to obtain an emergency protective order when necessary.

The Ten State meeting was great, and many thanks to Gerry and Janice for a great meeting. We had fun at the Louisville Slugger Factory & Museum. You may see pictures of that day. We also had great speakers as well. Hope to see you all in June in Northern Kentucky. Keep up the great work you are doing taking care of your patients.

SCHOLARLY ACTIVITY IN FAMILY MEDICINE EDUCATION

I am fortunate to be able to work with a great group of individuals who produce the Kentucky Academy of Family Physician Journal each quarter. I especially appreciate Dr. William Crump's mentoring as I learned how to do this job. It is crucial for us to communicate with the family physicians across the state about policies, practice designs, clinical care, opportunities for professional growth, and the various and sundry pieces that make up the Family Medicine quilt. I often see myself as the "nudge" that gets people to put their thoughts down on paper so that we all can learn from others' experiences and expertise.

WE KNOW THE PRACTICE OF MEDICINE IS CONSTANTLY CHANGING. SOMETIMES, IT IS THE SMALL CHANGE WE IMPLEMENT IN OUR OFFICES THAT SEEM TO MAKE PATIENTS FEEL AND LIVE BETTER. WHEN YOU MAKE THOSE DISCOVERIES ON YOUR OWN, LOOK AT THEM, EVALUATE THEM, DO IT AGAIN, AND THEN TELL US ABOUT IT.

This month, I am excited that we have two articles that grew out of resident scholarly projects. One comes from Madisonville and the other from Lexington. In 2007, the Accreditation Council for Graduate Medical Education (ACGME) through the Family Medicine Residency Review Committee (RRC) added a requirement that all family medicine residents "should participate in scholarly activity." Previously, the language of the RRC spoke more of "encouraging" scholarly activity, so these changes were quite significant in the tone of the expectations of residency programs. The RRC goes on to state that "the curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care." I particularly like that one about explaining research to patients. How often are we faced with addressing a patient's concern about their medication in light of the most recent CNN story that spent 30 seconds explaining a research project that took 15 years to develop, implement, and analyze?

The Family Medicine RRC goes further to describe the extent of residents' involvement. They are expected to engage in scientific inquiry by performing research projects with the ultimate goal of being able to apply emerging, evidence-based scientific data on their panel of patients. In other words, residents will learn how to gather information that is clinically relevant both from their own patients and from other research studies, and use that to improve the care they provide. This is practice-based learning and improvement, one of the ACGME's core competencies.

How will residency directors demonstrate that their residents are engaged in scholarly activity? They must show the research their residents performed. The residents might present their project at a national, state, or local meeting. If you have been to one of the KAFP Annual Scientific Assemblies recently, you have seen the product of the residents' labors with multiple research posters representing the seven Family Medicine Residencies across the state. If you have not attended, you should, because the educational sessions are excellent, and these posters are well worth viewing. Finally, the residents should publish their findings when possible, and the KAFP Journal is an ideal forum for that.

I did a quickie research project of my own and looked at the last five years of KAFP journals. There were a total of 16 journals reviewed in that time period (2005-2010) and 33 articles that were not editorials by the KAFP president, editor, or associate editors (my study, my inclusion criteria). I found three articles with medical students as author or co-author, and one article from a family medicine resident. I am certain that the recent RRC changes will help us increase those numbers. Perhaps this is a challenge to those residency program directors and predoctoral directors out there, but I think we should strive to have pieces from medical students and residents several times a year, if not in every journal. After you read the pieces from Dr. Patel and his faculty collaborator, Dr. Hanke, and Dr. Kingery (who is now faculty in Hazard), I think you will agree that there is a lot that can be learned from our new generation of doctors.

We know the practice of medicine is constantly changing. Sometimes, it is the small changes we implement in our offices that seem to make patients feel and live better. When you make those discoveries on your own, look at them, evaluate them, do it again, and then tell us about it. That is how we become better at what we do. I may be wrong, but something tells me that practice improvements discovered in Sandy Hook or Columbia, Ky. may be especially relevant to practices in Hopkinsville, Murray, and Hazard. I hope that reading about what these residents found in their scholarly projects encourages us to continue to critically look at our patients and practices so that we, likewise, can work to improve the care we provide.

ACOs – Friend or Foe

Throughout the health care reform debate in Congress, all of the proposed bills contained provisions for promoting development of Accountable Care Organizations (ACOs). So, what is an ACO? Will ACOs be good for patients? Are ACOs a positive step in the right direction for family physicians and other primary care physicians?

At the core, this proposed care model is a means by which physicians and other health care providers are part of a network responsible for quality and certain components of the cost of care for a defined patient population. An ACO is dependent upon a strong foundation of primary care. Ideally, this foundation is based upon the Patient-Centered Medical Home (PCMH) Model of care. From this perspective, the ACO can be thought of as the "medical home neighborhood" aligning the goals and incentives of non-primary care physicians and other providers with those of a network of PCMH practices.

Federal health care reform efforts in the U.S. are focused on increasing health insurance coverage, improving quality and controlling cost. From a health care reform perspective, the ACO model of care is aimed at cost and quality. The main goal of the ACO model is to reduce health care cost, or at least "bend the cost curve" down while at the same time improving clinical quality and patient satisfaction. An ACO is NOT a health maintenance organization (HMO), as it does not accept insurance risk – the risk of whether a patient who is part of the defined ACO population is sick or well.

Accountable care organizations can have various structures to fit the environment in which they function. These include:

- A collection of primary care practices working together through an Independent Practice Association (IPA) or some other organizational structure
- A collection of primary care practices and non-primary care specialists working together through an Independent Practice Association (IPA) or some other organizational structure
- A clinically integrated system of primary care practices, non-primary care specialists, and hospitals working together though an integrated delivery system (all physicians employed) or through a physician-hospital organization (PHO) of independent providers who are clinically integrated
- Physician and non-physician health care providers, public health agencies, social service organizations and other community organizations working jointly to improve health care for a broad patient population.

Elliott Fischer, one of the pioneer proponents of ACOs, supports the concept of virtual ACOs as long as three key ACO elements are supported:

- Local accountability for quality and per capita cost for the local patient population
- Standardized performance measurement
- Payment reform that transitions payments from encouraging volume and procedures to increasing quality outcomes and value (quality/cost).

The concept of a virtual ACO is particularly important for small- and medium-sized independent practices, especially those located in more rural areas. Formation of virtual networks of practices with infrastructures that can support data sharing and the collection of quality measures across practices will be a requirement for ACO formation.

ACOs will not happen overnight. Just like PCMH practice transformation, the medical home neighborhood transformation to an ACO model will require well-organized planning, decision making and implementation under strong physician leadership. Most importantly, the foundation of the ACO care model is effective family medicine (primary care) emphasizing access to care, continuity of care, comprehensiveness, and coordination. Harold Miller, in his white paper *How to Create Accountable Care Organizations*, identifies eight prerequisites for primary care practices to participate in ACOs:

- Complete and timely information about patients including the services they are receiving
- Technology and skills to support population management and coordination of care
- Adequate resources for patient education and self-management support
- A culture of teamwork in the practices
- Coordinated relationships across all practices, specialities and providers
- The ability to measure and report on quality of care
- Infrastructure and skills for management of financial risk
- A commitment by senior leadership to improving value as a top priority backed by a system to drive improved performance.

Effective and sustainable accountable care organizations cannot happen without significant payment reform. Since primary care is foundational to the ACO, the blended payment model – fee-for-service, care management fee and outcomes-based payments – is critical to the support of primary care within the ACO model. In addition to the blended payment model for primary care, the overall ACO payment structure should support several goals:

- Baseline payment that adequately covers the expected costs of the defined population
- Avoidance of penalties for taking on sicker patients or experiencing "adverse selection"
- Flexibility to deliver the right services at the right time in the right place
- ACO profitability is enhanced if it keeps its population healthier (relative to baseline) or reduces unnecessary services
- Enhanced payments for higher quality care

and encouragement of patients to become engaged and seek out higher quality care.

Although a mature ACO system might thrive under a global payment model, as long as it avoids the pitfalls of traditional capitation, developing ACOs should avoid global payments and look toward transitional payment models including combinations of shared savings, episode-of-care payments, and hybrid models (partial comprehensive care payments with bonuses based on quality outcomes and savings). Most importantly for primary care physicians, the ACO payment model must effectively set levels of "internal" physician payments that recognize the dependence of ACO success on a strong foundation of primary care and PCMH practices. (See Table 1 for a comparison of payment models).

In late summer 2009, the American Academy of Family Physicians Board of Directors appointed a task force to study ACOs, especially from the perspective of small- and medium-sized family medicine practices. The ACO Task Force defines an ACO as "a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the quality and cost of care provided to a defined patient population." The task force developed a series of ACO principles aimed primarily at small- and medium-sized family medicine practices considering participation in or development of an ACO. Key principles include:

- The core of an ACO is accessible, team-based primary care such as the PCMH
- ACOs require strong physician leadership and a true partnership among all participants
- A clinically integrated information system for point-of-care decision making is ultimately required
- The ACO encourages continuous innovation to identify and implement best patient care practices
- Organization structure and payment reform should be implemented in an incremental manner and monitored closely to prevent "unintended consequences"
- ACO should strive to incentivize active patient participation in health and wellness decision making

continued on page 12

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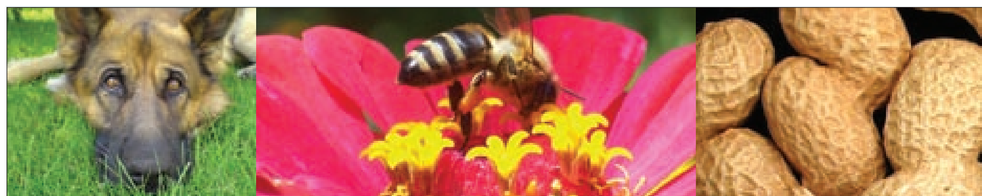

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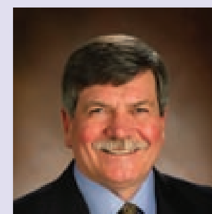

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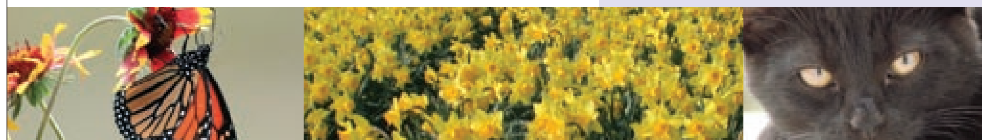

CHOCOLATE MILK

SO GOOD AND SO GOOD FOR YOU

By Ann Tyndall, Ph.D.

Milk rules in the world of nutrient-rich beverages. It far exceeds all other beverages, including juices, in delivering a powerful package of protein, calcium, vitamins, minerals and electrolytes. Yes, milk is the champion over even the sports drinks in all nutrients. The key is to get children to drink the milk.

"The emerging science shows that a whopping 70 percent of children and adolescents are deficient in vitamin D. Low levels of vitamin D have been linked to higher blood pressure, heart disease and diabetes in adults. Three 8 ounce glasses of low-fat milk provide 75 percent of the daily vitamin D requirements," explains Dr. Douglas Gregory, past president of the Virginia Academy of Pediatrics.

Soft drinks and sports drinks (which have no nutritional value) are aggressively marketed to children and sold in schools. Flavored milk, such as low-fat chocolate milk, is very popular with children and is an excellent way to get children to drink milk when they might otherwise choose sodas instead. However, critics of flavored milk voice concerns about high fructose corn syrup used as a sweetener and also the added calories and impact on body weight.

A review of the scientific literature indicates that chocolate milk consumed in moderation does not cause overweight, obesity, or hyperactivity in children. The American Heart Association's scientific statement, Dietary Sugar Intake and Cardiovascular Health, states, "When sugars are added to otherwise nutrient-rich foods, such as sugar-sweetened dairy products, the quality of children's and adolescents' diets improves, and in the case of flavored milks, no adverse affects on weight status were found." The American Medical Association reports a meta-analysis of 23 studies performed over a 12-year period concluded that sugar intake does not affect children's behavior and does not contribute to hyperactivity. In the case of hyperactivity, the caffeine in chocolate milk is negligible-the same as decaffeinated tea-and should not be cited as the cause.

"When sodas replace milk in the diet, it's hard for children to get the key nutrients they need for growth and development," says Dr. Stewart Gordon, chief of pediatrics of the Louisiana State University Health Sciences Center at Earl K. Long Medical Center in Baton Rouge, LA. "Low-fat and fat-free flavored milk are good beverage choices for children because they are packed with calcium, vitamin D and potassium and have fewer added sugars than the soft drinks they are replacing." The Journal of the American Dietetics Association (June 2002) reported that children who consumed flavored milk in school had higher total milk intake and lower soft drink and fruit drink intake. Flavored milk contains an additional 60 calories per 8 ounces from the addition of sweeteners. This is less than half as much added sweetener as is found in fruit drinks and soft drinks. Flavored milk did not increase total sugar intake as a result of lowering intake of soft drinks and fruit drinks. Protein, calcium and other nutrients, milk has more. Do the math—milk has more of everything good.

Milk Math

Milk Has More of Everything Good.

	Calories 8 oz.	Protein gms	Calcium mgs	Other Nutrients
Low-fat chocolate milk	160	9	300	Vitamin D, potassium, Vitamin B12, riboflavin, niacin, phosphorous
Fruit punch	120	o	o	Vitamin C
Soft drinks	100	o	o	o
Sports drinks	70	o	o	Riboflavin, Vitamin B 12

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Adding Chocolate to Milk Doesn't Take Away Its Nine Essential Nutrients

All milk contains a unique combination of nutrients important for growth and development - including three of the five "nutrients of concern" for which children have inadequate intakes. And, flavored milk accounts for less than 3.5% of added sugar intake in children ages 6-12 and less than 2% in teens.

5 Reasons Why Flavored Milk Matters

1 KIDS LOVE THE TASTE!

Milk provides nutrients essential for good health and kids will drink more when it's flavored.

2 NINE ESSENTIAL NUTRIENTS!

Flavored milk contains the same nine essential nutrients as white milk - calcium, potassium, phosphorous, protein, vitamins A, D and B12, riboflavin and niacin (niacin equivalents) - and is a healthful alternative to soft drinks.

3 HELPS KIDS ACHIEVE 3 SERVINGS!

Drinking low-fat or fat-free white or flavored milk helps kids get the 3 daily servings* of milk recommended by the *Dietary Guidelines for Americans*.

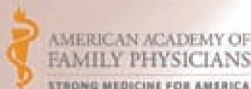
4 BETTER DIET QUALITY!

Children who drink flavored milk meet more of their nutrient needs; do not consume more added sugar, fat or calories; and are not heavier than non-milk drinkers.

5 TOP CHOICE IN SCHOOLS!

Low-fat chocolate milk is the most popular milk choice in schools and kids drink less milk (and get fewer nutrients) if it's taken away.

These health and nutrition organizations support 3-Every-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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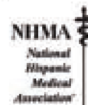

www.nationaldairycouncil.org/childnutrition

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* DAILY RECOMMENDATIONS - 3 cups of low-fat or fat-free milk or equivalent milk products for those 9 years of age and older and 2 cups of low-fat and fat-free milk or equivalent milk products for children 2-8 years old.

- Changes to antitrust regulations and to Stark self-referral regulations likely will be needed to allow full participation of physicians, especially those in small- and medium-sized independent practices
- Payment models must align mutual accountability and evolve over time as the ACO model transitions
- The ACO should be financially rewarded based upon a combination of absolute standards, relative performance and improvement
- Primary care and the PCMH model should be supported by blended payments – fee-for-service, care management payments and quality outcomes payments.

At the core, this proposed care model is a means by which physicians and other health care providers are part of a network responsible for quality and certain components of the cost of care for a defined patient population.

So, is the ACO family medicine's friend or foe? The simple answer is "Yes, ACOs can be friend or foe." The real life answer will depend upon the details of ACO structure and operation. The greatest ACO strength for family physicians is that ACO success requires strong physician leadership and strong primary care. The physician leadership must be characterized by true knowledge-based decision making in an environment of mutual support, collaboration and transparency by all ACO participants. This cannot be the façade of physician leadership characteristic of the many independent practice associations (IPAs) and physician-hospital organizations (PHOs) seen during the heyday of managed care. True collaboration and mutual trust, supported by data and transparency and across diversity of geography, demographics, processes of care and technology will be challenging. If done without an intense commitment to do the right thing for patient care and health care value, the ACO model could swallow up primary care into an ambiguous medical neighborhood of "more of the same by a different name." Most family physicians espouse the need for true, meaningful health care reform that supports and rewards access to primary care, comprehensive care and coordinated care. These should be the goals that guide family physicians in the exploration of ACOs as friend or foe.

Table 1

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

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GAUTAM PATEL, M.D. AND FORREST HANKE, M.D.

Improving Physician Understanding and Treatment of LDL Cholesterol Using Outcomes-based Educational Interventions

ABSTRACT

The ability of educational interventions such as didactic lectures to change resident physician's behavior is questioned in this study. An outcomes-based educational intervention project was undertaken to teach the evidence-based goal of LDL cholesterol value of less than 100 mg/dl. Six didactic lectures were supplemented with pre- and post-testing using an electronic audience response system. Each lecture included information from the Adult Treatment Panel III. Patient's LDL cholesterol values were followed over the six month span of these lectures. The number of patients meeting an LDL goal of less than 100 mg/dl went from 36 percent before the lecture series to 63 percent after the series. Our conclusion is that outcomes-based educational interventions do change resident physician's knowledge and practice behavior.

INTRODUCTION:

An outcomes-based Educational Intervention Project was undertaken to improve the diagnosis and treatment of cardiac risk factors. LDL had long been known to be a significant cardiac risk factor for coronary artery disease. The National Cholesterol Education Program "NCEP"[1] was first launched in 1985 by the National Heart, Lung, and Blood Institute (NHLBI) with the goal of reducing illness and death from coronary heart disease by improving cholesterol levels. The report of the expert panel on detection, evaluation, and treatment on high blood cholesterol in adults was first published in 1988 and revised in 1993. The Adult Treatment Panel III[2] was published in 2004. These are evidence-based guidelines for the management of cholesterol. These guidelines recommend obtaining an initial lipoprotein level after a nine to 12 hour fast. The primary target of therapy within the ATP III guidelines is the LDL cholesterol. That recommendation is an LDL cholesterol of less than 100 mg/dl for patients with coronary heart disease or coronary heart disease risk equivalents. The coronary heart disease risk equivalents include:

1. Symptomatic Carotid Artery Disease
2. Peripheral Artery Disease
3. Abdominal Aortic Aneurysm
4. Diabetes Mellitus

The current Adult Treatment Panel III Guidelines for treatment recommend that LDL be less than 100 mg/dl for patients with known coronary artery disease or disease equivalents. This study looks at using outcomes-based educational activities as a way not only to teach residents this information, but also to provide evidence that these activities can affect their clinical practice.

Measuring the effectiveness of an outcomes-based Educational Intervention can be done on several levels. The Haven's Model of Outcomes Evaluation was chosen because it measures five different levels of change. These levels start with participant satisfaction and progress through objectively-measured change in treatment outcomes or health status.

METHODS:

A series of six lectures was undertaken to teach the NCEP ATPIII Guidelines for treatment of cholesterol. Each lecture focused on a different aspect of cholesterol treatment, but the overall focus was on LDL cholesterol. Our primary goal was to show that outcomes-based education can be used to improve resident understanding and that this improved understanding would change their practice habits.

Each of the six lectures focused on a different aspect of cholesterol treatment. All physician presenters were considered either local or regional experts in their field. The six lectures were:

1. Hypercholesterolemia as a Risk Factor for Coronary Heart Disease.
2. Review of Current Prescription and Over the Counter Medications for the Treatment of Hypercholesterolemia.
3. Diagnosis and Treatment of Cardiac Risk Factors and Management of LDL.

continued on page 14

THIS REVIEW LOOKED BEYOND A PHYSICIAN'S INTENT TO CHANGE BEHAVIOR TO MEASURING OBJECTIVELY THE CHANGE IN LDL CHOLESTEROL OF THEIR PATIENTS.

4. Managing Patients with Low HDL Cholesterol.
5. Managing Patients with Elevated Triglycerides.
6. Treatment and Solutions for Hard to Treat Hypercholesterolemia.

Each lecture was accompanied by a pre- and post-test to assess the immediate impact of the learning value of each lecture. An electronic audience response system was used to collect pre- and post-lecture data. Speaker evaluations were also filled out by the resident physician audience. A copy of the ATP III Guidelines At-A-Glance Quick Desk Reference was also handed out at each lecture.

Finally, a chart review was done on all patients with coronary heart disease or diabetes mellitus that were seen by the first or second year family medicine residents in their continuity care clinic at the Trover Foundation Family Practice Residency Program. Although all the residents in our study group were not able to attend all six lectures, they were able to attend on average at least 75 percent of the lectures. The charts were reviewed to assess their treatment of cholesterol with specific attention to LDL levels. The review was done one month after the sixth and final lecture and compared to data from one month before the lecture series started. The primary goal was to assess the percentage of patients with coronary heart disease or diabetes that had reached an LDL goal of less than 100 mg/dl.

To assess the effectiveness of these activities, the outcomes were evaluated using the Havens Model of Outcomes Evaluation[3]. This five-level continuing medical education (CME) outcomes evaluation model was developed by Carol Havens, M.D., at Kaiser Permanente. The levels consist of the following:

Level I – Participant satisfaction

Level II – Change in knowledge, attitudes, or skills, or intent to change

Level III – Self-reporting behavioral change

Level IV – Objectively-measured change in practice

Level V – Objectively-measured change in treatment outcomes or health status

Our focus was on the first four levels of change.

In order to evaluate Havens Level I on participant satisfaction, a speaker evaluation form was given to all participants during each of these six lectures to fill out and return. This also collected measurements of physician self-reported change in knowledge to evaluate Haven's Level II. Pre- and post-test questions accompanied each lecture. The pre- and post-test questions primarily focused on the Adult Treatment Panel III Guidelines for cholesterol management with an emphasis on LDL. Finally, measuring change in resident physician's practice was objectively evaluated by chart review of patient LDL levels. This review looked at the patient LDL levels of 12 different first- and second-year Family Medicine residents' patients. The LDL levels after the six-lecture series were compared to the LDL levels before the series began. This review looked beyond a physician's intent to change behavior to measuring objectively the change in LDL cholesterol of their patients.

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RESULTS:

The results of the effectiveness of the six lectures were gathered with focus placed on the Havens Model of Higher Level Outcomes. The Level I outcome measurement of participant satisfaction and Level II outcome measurement of change in knowledge, attitudes, skills, or intent to change was measured by speaker evaluation forms. The Speaker Evaluation Forms for Medicine Grand Rounds focused on learning objectives, outcomes, and inquires as to whether these patient recommendations were based on acceptable practices in medicine. All of the speaker evaluations returned by the PGY1 and PGY2 residents were rated above average, indicating that the learning objective and outcomes were reached. None of these residents felt the material was below average. When asked if the patient recommendations were based on acceptable practices in medicine, more than 90 percent of the resident study group responded yes.

To document the change in knowledge that was or was not gained during these lectures, the pre- and post-tests were given to all participants. The pre- and post-test questions were identical within a given lecture but were different with each lecture within the series. The answers obtained from our study group of first and second year residents were evaluated. Only test questions that were answered on the pre- and posts-test concurrently were graded. Although scores for individual PGY1 and PGY2 residents were not accumulated during the six-lecture series, scores from all the residents in the study group for each individual lecture were tabulated. The combined scores for the pre-test ranged from 23 to 68 percent (mean 55 percent) and for the post-test were 71 to 96 percent (mean 80 percent).

In order to evaluate Havens Level IV - Objectively measure change in practice - a list of patients being treated by our first- and second-year residents group with coronary heart disease was obtained using a computer search. Included in this search were also patients with a diagnosis of diabetes. It was felt that the numbers of patients with symptomatic carotid artery disease, peripheral artery disease, and abdominal aortic aneurism would be small compared to the group with coronary heart disease and diabetes, and they were not included in this computer search. A total of 141 patients were identified within this group. The only measurement of change that we evaluated in this group was the LDL levels mimicking the focus of the ATP III guidelines and our lecture series. The patient population was divided into those with LDL of more than or equal to 100 mg/dl and those with LDL less than 100 mg/dl. Before this educational series was initiated, 51 out of 141 patients (36 percent) were at goal LDL below 100mg/dl. After the six-lecture series, 89 out of 141 patients (63 percent) were at goal (Graph 1). Thirty-eight of the 90 patients (42 percent) patients that were not at goal initially made it to an LDL less than 100 over the time frame in these activities.

LIMITATIONS:

The residents involved in the study were not blinded to our overall intent to improve the LDL cholesterol of their patients with coronary heart disease or CHD equivalents. The residents may have had other educational interventions during the time frame of this study, including precepting encounters in their continuity clinics or experiences on other rotations. This may have influenced the overall outcome of this study.

DISCUSSION:

The Accreditation Council for Graduate Medical Education (ACGME) requires residency programs to demonstrate competency attainment by their residents. This educational intervention on cholesterol management and subsequent evaluation provides an example of how residency programs can improve their learners' knowledge, performance and patient outcomes. However, the education of physicians must continue beyond their participation in medical school and residency. It must continue throughout the lifespan of their practice. This need can be met by effective evidence-based education programs. Several authors have performed literature reviews that show the relative effectiveness of the CME presentation.[4,5] The Havens Model of Outcomes Evaluation is an excellent tool that can be used to assess the value and effectiveness of a CME activity. But beyond that, programs such as ours show that both physician behavior and practice patterns can be influenced by focused educational programs. These changes first come by increasing physicians' knowledge and are reinforced by subsequent changes in behavior. Finally, a measured change in practice behavior such as obtaining a goal of LDL less than 100 mg/dl can be used to document the effectiveness of educational activities. Level V change as presented by Dr. Havens is an objectively measured change in treatment outcomes or health status. Further research needs to be performed to assure that the ultimate goal of improved health status is obtained.

Evidence-based medicine suggests that obtaining a goal of LDL less than 100 mg/dl in patients with coronary heart disease or coronary heart disease equivalents improves health outcomes. This guideline combined with a higher percentage of patients reaching this goal are likely due in part to these focused educational activities should eventually equate to overall improved health status of patients.

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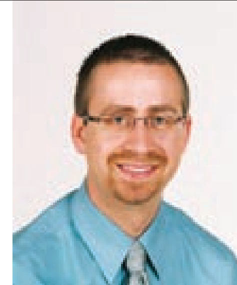
JOE E. KINGERY, D.O.

Improving Diabetes Education in Family Medicine



Providing diabetes education may improve a patient's self management skills. One of the struggles with education in the office is what to discuss with our patients in the brief time we have with them.

INTRODUCTION

Diabetes Mellitus is a leading cause of death in Kentucky and across the nation and contributes to a patient's morbidity as well as mortality. As of 2003, it is listed as the sixth leading cause of death in Kentucky;[1] and as of 2007, is the seventh leading cause of death in the U.S.[2] Much diabetes care is supervised by Family Medicine physicians. The ability to adequately control a patient's blood sugar as well as co-morbidities (e.g. hyperlipidemia, hypertension, coronary artery disease) is very challenging. Despite increased awareness of diabetes, improvements in medications, and decreased cost in some medications, almost half of diabetics are still not at goal for glycemic control.[3] This brings to question what can we do to improve outcomes in our diabetic patients?

As noted in the summer 2009 issue of KAFP Journal, the chronic care model (CCM) provides a guide to improve the management of chronic illnesses in primary care. The CCM consists of six components including clinical information systems, decision support, self-management support, delivery system design, organization of health system and community resources.[4] Using the CCM as a guide to medical delivery has been shown to improve outcomes for those with chronic illness.[5] Self-management support, including patient education, is one of the six key components. Providing diabetes education may improve a patient's self management skills. One of the struggles with education in the office is what to discuss with our patients in the brief time we have with them. As we begin to shift to a patient-centered medical home model, this is even more important to explore.

METHODS

At the University of Kentucky Department of Family and Community Medicine, we started a research study to find out what is important to learn about diabetes from the patient's perspective. We used a HRSA grant aimed at implementing the CCM into residency training in order to engage in clinical quality improvement. We created a survey consisting of 13 topics in diabetes education (Figure 1). The topics were created by residents, faculty and staff based on the most common topics and problems in diabetes. We then gave out surveys with those topics to our clinic providers (residents in various levels of training and faculty, N=16) and our diabetic patients (convenience sampling, N=24). They were asked to rank the top five most important topics. The providers were also asked about the frequency that they give out educational materials. The patients were asked about satisfaction with diabetes care in our clinic and if they thought the education materials received were helpful and improved their overall care.

RESULTS

There were several major differences between providers and patients. In terms of most important topics, patients chose topics related to prevention of end-organ damage such as kidney disease and heart, brain and extremity vascular disease. Providers tended to choose things such as diabetes overview, diet and exercise. (Figure 2)

In regards to the frequency of education materials being given out in clinic, only 19 percent of providers state they give out educational materials with high frequency, and 44 percent report almost never using education materials. However, 100 percent of patients who received educational materials thought they were both helpful and improved their overall care.

DISCUSSION OF RESULTS

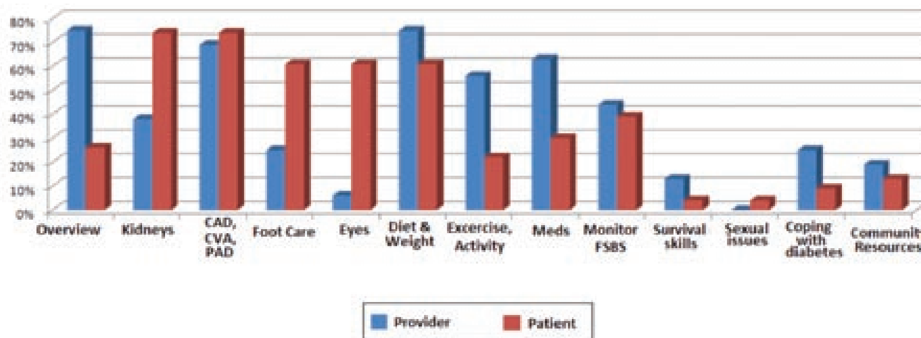
There seem to be several take home messages from this study. What seems important to physicians in diabetes education may not be

FIGURE 1. PATIENT PROVIDER SURVEY

Please select the **top five topics** that are most important to you and how you care for your diabetes. **ONLY PICK FIVE** and rank them in order of importance from **"1"** (most important) to **"5"** (least important). NOTE: NOT ALL ITEMS WILL BE RANKED.

Topic	Rank
Diabetes overview: disease process and treatment options	
Protecting your kidneys	
Preventing heart attack, stroke, blood vessel disease, loss of limb	
Caring for your feet, diabetic neuropathy (numbness or tingling)	
Protecting your eyes	
Diabetes diet and weight control	
Exercise and physical activity	
Diabetes Medications: Pills and/or insulin	
Self-monitoring of blood sugar	
Survival Skills: manage sick days, hypoglycemia	
Sexual Issues: Pregnancy, vaginal dryness, erectile dysfunction	
Coping with diabetes, depression in diabetes	
Community Resources for diabetes education, support groups, etc.	

FIGURE 2. TOPICS MOST IMPORTANT TO PROVIDERS VS. PATIENTS IN DIABETES



what is most important to our patients. As we move toward a patient-centered medical home, it is important that we address what our patients want to know. While the overview of diabetes, diet, exercise, medication education, etc. are all necessary, our patients may be interested in hearing about other aspects of diabetes management. In addition, patients may be more open to further educational opportunities if their questions and needs are addressed in the beginning.

Secondly, of patients who received diabetes education materials, 100 percent of them found them useful and thought they improved their overall care, yet 44 percent of providers in our clinic are not giving them out at all. Since the CCM has been proven to help improve outcomes in chronic disease and includes education, we should strive to give more education about diabetes, including handouts if patients feel they may be useful. Some very useful resources include FamilyDoctor.org (http://familydoctor.org/online/famdocen/home/common/diabetes.html), the American Diabetes Association (http://www.diabetes.org/), the National Diabetes Information Clearinghouse (http://diabetes.niddk.nih.gov/), and the National Diabetes Education Program (http://www.ndep.nih.gov/).

CONCLUSIONS

Implementing changes to educate patients on topics they find most important could help improve compliance in diabetic patients. Whether this changes outcomes is yet to be seen and should be investigated further. However, in a previous randomized trial, education did decrease hemoglobin A1C levels significantly compared to those not receiving education.[6] Research has also shown that patient adherance is more likely if patients and their doctors agree on what is important in regards to their medical problems.[7] While these findings may not apply to all primary care clinics, it should at least serve as a reminder that we may be missing opportunities to improve patient care by listening to what patients want and need.

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Joe Kingery is from Tompkinsville, Ky., went to medical school at Pikeville College School of Osteopathic Medicine in Pikeville, Ky., and completed residency at the University of Kentucky Department of Family and Community Medicine in Lexington, Ky. Dr. Kingery is currently an assistant professor of family medicine and associate director of medical education at the East Kentucky Family Medicine Residency Program in Hazard, Ky.

This study, which grew out of a residency scholarly project, was presented at the 2009 Society of Teachers of Family Medicine (STFM) Annual Spring Conference in Denver. Dr. Kingery would like to acknowledge other faculty and residents who contributed to this project including Jordan Prendergast, D.O., Holly Hall, M.D., Michael King, M.D., Elizabeth Tovar, Ph.D., RN, FNP-C, and Shersten Killip, M.D.

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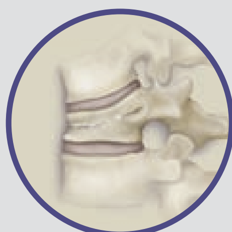

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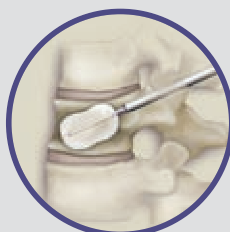

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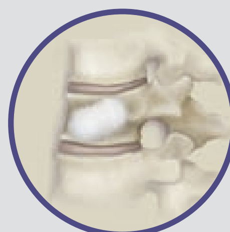

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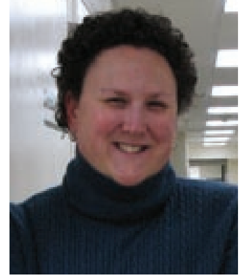

FEDERALLY QUALIFIED HEALTH CENTERS

James, a 53-year-old man with a history of diabetes, hypertension and hypothyroidism presented to me as a new patient recently. His previous primary care doctor discharged him because he'd not been seen for over a year. James stopped going to his physician because he'd lost his insurance and could no longer afford the cost of the visits. Collectively, his monthly medications were over $600. He bought them as he could and split or skipped doses to make them stretch. He finally stopped taking the medicines months ago when his physician refused to refill them any longer and he received the letter in the mail dismissing him from the practice. His glucose meter was broken, so he had no idea what his glucose was other than "high," an assessment he made based on how he felt. His physical symptoms were miserable: dry mouth, nocturia, blurry vision. When I met him as a new patient, his A1C was 11.6, his blood pressure was 178/105 and his TSH was 27. More importantly though, he felt hopeless, depressed and abandoned.

We spent 45 minutes together at that first visit. We spent a long time discussing his medical history, but even longer discussing his social history. He was married and his children grown. He'd been a laborer all his life, mostly construction or shift work. Together, he and his wife were raising two grandchildren and struggling to keep a small farm afloat. He'd smoked since childhood and read "fair." He loved fried taters and deer hunting. He hurt all over, didn't sleep well and worried about the cost of coal, because it's how they heated their house, and winter was coming.

While he was talking, I was thinking, processing, planning. When James checked in for his appointment at the front desk, he was directed to meet with our financial counselor first. She met with him, explained to him that as a federally qualified community health center (FQHC), we were able to provide our services on a sliding fee basis and that his co-pay would be based on his ability to pay. Our sliding fee program is based on the federal poverty guidelines, and our lowest co-pay is $10. His co-pay would cover the cost of his visit and any laboratory, in-house testing (like x-rays, EKG, spirometry and audiometry) and vaccinations he needed.

After I examined James, noting that he had calluses and brittle nails on his feet, I ordered the labs he needed to get up to date for his chronic disease care. I reviewed his medications and made multiple switches from expensive, branded and combination meds to older, generic and evidence-based medications for his hypertension and diabetes. His co-pays went from $600 a month to less than $40. I arranged to get him insulin and a new meter through a patient assistance program; our financial counselor helped him fill out the paperwork. I made him an appointment with our nurse practioner for foot care and with our nutritionist and diabetes educator who comes to our office through the St. Joseph Outreach program. Her services are free to our patients. I gave him a recipe book with his favorites made healthier (including biscuits and gravy), and wrote down all of the changes we made so he could go home and tell his wife everything we discussed. I sent him home with hemoccult cards to screen for colon cancer, and the nurse gave him a pneumococcal vaccine.

As a federally qualified community health center, we operate from a unique position within our health care system. FQHCs have been providing care to people who need it most and can least afford it for more than 35 years. FQHCs receive funding, in the form of federal grants, to provide comprehensive primary health care regardless of ability to pay. The first community health centers were funded as demonstration projects through the Office of Economic Opportunity in 1965. Over the next 30 years, additional funding came for migrant and homeless health centers; Medicare and Medicaid were legislated; and America's primary care safety net was formed. Today, there are more than 1,100 FQHC organizations with more than 4,000 sites nationwide. We serve more than 23 million patients, making it the country's largest primary care network. The program is administered through the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. In Kentucky, we are 18 organizations with 94 delivery sites serving more than 243,000 Kentuckians.

We are charged with providing comprehensive primary care services as well as other services to facilitate access to care including referral services, translation, transportation, and case management services. We are also mandated to reduce health disparities and improve access to care. We do this through other enabling services like literacy programs and partnerships with churches, local health departments, community-based mental health services and substance abuse recovery programs. Our offices provide primary medical, dental and mental health services as well as pharmacy, laboratory and radiology services. Since we are federally mandated to be board-governed by our patients, FQHCs take the form that best meets our community's needs. FQHCs are mobile, to follow migrant communities, and are found in schools, low income

continued on page 20

housing developments and in both rural and urban health care professional shortage and medically underserved areas.

We improve access to primary care; we effectively manage chronic disease; we reduce health disparities, and we create jobs and stimulate economic growth in our communities.

Because rural areas have disproportionately high numbers of patients who are either uninsured or depend on Medicaid or Medicare and are also disproportionately older, sicker and more likely to be disabled, it is extremely difficult for private rural practices to survive financially. New physicians are largely drawn to urban areas with more conveniences, larger practices and access to specialty services. FQHCs (and also rural health clinics) bring a much needed health care work force that is frequently native to the area and encouraged to enter health care through the Area Health Education Center (AHEC) programs as well as generous scholarship and loan repayment availability. Encouraging professionals to come back home makes it more likely that they will stay with the organization for the long term.

Patients without ready access to primary care often flood local emergency rooms and end up receiving urgent care for acute complications of chronic illness like hypertensive emergencies, profound hyperglycemia, COPD exacerbations and acute congestive heart failure. FQHCs have a proven track record in improving chronic disease management and reducing emergency room visits. As part of our grant, each organization develops a health care plan with targeted goals across the lifespan. For example, at the White House Clinics, our goal is to have more than 90 percent of our two year olds be vaccinated completely, to have >60 percent of our women be up to date on cervical and breast cancer screening, and have more than 80 percent of our patients over 65 be vaccinated for influenza and pneumococcal disease. HRSA also mandates reporting on the percentage of our patients who have controlled diabetes (A1C <9 percent) and hypertension (<140/90). We report this information annually and must also submit a plan with steps we will take over the next year to meet our goals. The pay-for-performance measures currently in development by Medicare have been tested on FQHCs first.

Meeting our goals means we need to collaborate with community partners. For example, many of our young women receive their breast and cervical cancer screening services through the local health department through Kentucky's breast and cervical cancer screening program. We work with our local health departments to refer women and share screening results. We also collaborate on community grants and for emergency preparedness. FQHCs also collaborate with each other. We have Web sites, meetings and listservs that operate in the spirit of sharing what works and what doesn't. Post a question or a problem and policies, flow charts, Web sites and ideas from health centers all over the country will pour in within hours. We are leaders in lean management techniques and in novel models of health care delivery like shared visits, collaborative team care and integrative behavioral health. We champion open access scheduling, the concept of a medical home and the biopsychosocial model of health. We are open with our successes and the often bumpy road it took to get there. We are charged with reducing health disparities and do this through culturally competent care. In short, we speak the language of the people we're working with.

We also stimulate economic growth in our communities. We are frequently one of the largest local employers and use local vendors for supplies and expansion/construction projects.

I am proud to be a part of a FQHC through the White House Clinics. We provide high-quality cost-effective health care to people who need it most. We are a working model of comprehensive primary care that shares broad bipartisan support in Congress. Because we have a proven record, with 30 years of data, funding for FQHCs continues to grow in spite of cuts to other programs. As a family physician, I find it deeply rewarding to work for a FQHC. For me, it is the very definition of service learning. I can think of no better use for 30 years and nearly $500,000 worth of education than to use it in the service of those who need my skills most. Working with a tight budget and scarce resources forces me to be both creative and evidence based. The depth and breadth of my practice is intellectually stimulating, and the relationships I develop with my patients are emotionally satisfying. My presence in Jackson County, Ky., makes a difference in that community and is appreciated by our patients.

The work is certainly not without its frustrations. Getting patients to specialty care is challenging at best and downright infuriating at its worst. It is a daily challenge to recognize the limits of my ability to solve my patient's problems and not to work harder than they are willing to work for themselves. It is disheartening to know that we will continue to be short medical providers for the foreseeable future in spite of our best efforts to recruit young physicians and mid-level providers. But just when I think I've reached my limit, a patient like James comes along. He returned for his follow-up visit upbeat and feeling better than he had in years. He took my hand, and with emotion in his voice, thanked me for taking the time to treat him like "a decent human being." That was all I needed to hear; I decided I'd stay on awhile longer.

AS A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER, WE OPERATE FROM A UNIQUE POSITION WITHIN OUR HEALTH CARE SYSTEM. FQHCs HAVE BEEN PROVIDING CARE TO PEOPLE WHO NEED IT MOST AND CAN LEAST AFFORD IT FOR MORE THAN 35 YEARS.

Melissa Zook grew up in Pennsylvania and received her undergraduate education from Gettysburg College and Bryn Mawr College. She attended Penn State College of Medicine and completed her residency at the Moses Cone Family Medicine Residency Program in Greensboro, N.C., in 2004. She came to Kentucky as a National Health Service Scholar and is currently practicing in McKee, where she also serves as the medical director for the White House Clinics located in Jackson, Madison and Estill Counties. Dr. Zook is a single mom of a 3 3/4-year-old son and an amateur banjo player. Besides striving to improve the health of her community, Dr. Zook also states that one of her goals in life is to "knit two socks that are the same size."

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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 **Monty 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* **the Speaker Rick Miles, 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. ***Scheduled meeting Friday, June 11, 2010, at 11:45 a.m. at the Marriott Cincinnati at RiverCenter, Covington, Ky.***

YES, I AM INTERESTED IN:

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Call for Resolutions
for 2010 KAFP Congress of Delegates

Please note the following deadlines for submission of Resolutions to be presented to the 2010 KAFP Congress of Delegates:

Deadline for receipt of Resolutions for reproduction and inclusion in Delegates' handbook is May 1, 2010. If a Resolution is not received by the KAFP office prior to May 1, 2010, any member of the KAFP may present in WRITING at the opening of the KAFP Congress of Delegates' meeting on June 11, 2010, any Resolutions pertinent to the objectives of the KAFP. Resolutions so offered shall be presented to the Congress of Delegates without debate at that time. Resolutions presented from the floor of the Congress are to be provided in triplicate form, with one copy to the KAFP speaker, one copy to the KAFP executive vice president and one copy retained by the presenter.

Tidbits on Resolution Writing

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

Official Call for
the 2010 KAFP Congress of Delegates

Notice is hereby given of the 59th Annual Scientific Assembly Session of the Kentucky Academy of Family Physicians to be held in Covington, Ky., June 10-12, 2010, at the Marriott Cincinnati at RiverCenter.

Pursuant to Article VII Bylaws of the Kentucky Chapter, American Academy of Family Physicians, the 50th Annual Meeting of the Congress of Delegates will be held June 11, 2010, at 11:45 a.m. - 1:45 p.m. to receive and act upon reports of officers and committees, to elect officers and to transact any and all business that may be placed before Congress.

All officers, aafp delegates/alternate delegates, regional/district directors are requested to register in advance. Registrations will be mailed out in April and can be accessed from the KAFP Web site www.kafp.org. *If you should have any questions, please contact Janice Hechesky at 1-888-287-9339.*

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